

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

I. GENERAL RULES

A) Eligibility

1) Hospital - Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

2) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses with the exception of an additional premium computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

3) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

F) Premium Remittance

- The insured premium payment plan may be annual, quarterly or monthly.
 - Quarterly premium installment plans are available to insured whose annual premiums are less than \$500, or for premium for any extension of a reporting period. Quarterly premium installment plans are also available to insured with premium exceeding \$500. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy. Thereafter, the

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2006
SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. Quarterly installment premium payment plans shall include the minimum standards listed below.

- i) An initial payment of no more than 40% of the estimated total premium due at policy inception;
- ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;
- iii) No interest charges;
- iv) Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;
- v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.



II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures



- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.
- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.
- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

- a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

- b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

- c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2006
SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00

DIVISION OF INSURANCE³)
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2006

SPRINGFIELD, ILLINOIS

Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM 25% CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	±10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	±10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	±7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	±5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	±5%
• Certificates of insurance are obtained verifying vendor liability coverage.	±5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	±3%
• Written job descriptions are established for all positions.	±3%
• Each facility has a designated, full-time safety director or safety officer.	±3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	±10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	±10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	±10%
• The quality management and risk management programs are integrated.	±7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	±5%
• Continuing risk management education requirements routinely fulfilled.	±5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	±3%
• Risk management issues are addressed in new employee orientation.	±3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	±3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	±5%
• No citations or penalties by a regulatory agency within the past 3 years.	±5%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	±10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	±7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	±7%
• Emergency department physicians are board certified.	±5%

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2006
SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2006

SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

A) Applicability

Physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

1) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

2) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

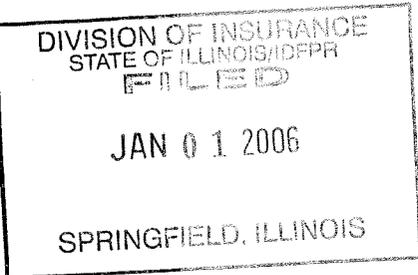
Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

C) Definitions

Physician, surgeon and allied health professional

- Contract physician Physician under contract with a facility to provide professional medical service to or on behalf of such institution



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- **Employed physician** Physician providing health care services, including osteopathic physician and resident, who is considered an employee of an insured business
- **Full-time employee** Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE)
- **Part-time employee** Person employed by the facility less than 40 hours per week expressed in percentage of FTE
- **Resident** Postgraduate medical student (including intern and fellow)

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2006
SPRINGFIELD, ILLINOIS

D) Basis of premium

- **Employed physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Allied health professional** – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
- **Part-time physician and surgeon** – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = 75% subject to note below) Multiply the result by the class premium for each specialty
- **Contract physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Note:** No FTE lower than 25%. FTE equal to 25% or less use 25%. FTE between 25% and 80% use 50%. FTE 80% or higher use 100%. More than 240 hours or 6 FTE use a surcharge of 25%

E) Calculation of premium

1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.

2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate
Nurse Practitioner	Charge 25% of the class 1 rate

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions



Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY – NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE – NI
-

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 1 Continued

- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE – NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI



CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE – INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE – INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS – INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE – INV

CLASS 3

- FAMILY PRACTICE – SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE – SRG
- HOSPITALIST

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM +25% CREDIT/DEBIT
Loss experience(not available in Kansas)	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

See Addendum B

J) Physician prior acts coverage

1) Applicability

Physician's prior acts coverage may be provided only to physicians employed by insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.

2) Coverage

Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 2.1 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2006
SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2006

SPRINGFIELD, ILLINOIS

Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

4) Increased Limits

As stated under J) 2) Physician prior acts coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:

Limits of Liability	Decrease/Increased Limits Factor
\$100,000/300,000	0.46
\$200,000/600,000	0.60
\$250,000/750,000	0.61
\$500,000/1 million	0.84
\$500,000/1.5 million	0.87
\$1/3 million	1.00
\$2/4 million	1.24
\$2/6 million	1.27
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50

5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5 th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2006
SPRINGFIELD, ILLINOIS

L) Extended Reporting Period

Insured is provided a free 60-day extended reporting period to report occurrences. A free 5-year tail is available on claims from occurrences during the policy period and the free 60-day period. Unlimited extended reporting period with limits reinstated (100% of aggregate expiring limits for the duration) is available upon termination of the policy. The unlimited extended reporting period premium is determined by multiplying 200% by the mature claims made annual premium in effect at expiration of the policy. Premium is due within 60 days of quote made after end of policy and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy. The insured must be informed of the extended reporting period premium at the time the last policy is purchased. The extended reporting period must be offered when the policy is terminated for any reason and whether the policy is terminated at the company's or insured's request.

The unlimited extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company ; or permanently retires from the practice of medicine at age 60 or older after three continuous years of coverage with the company; or, 3) to his or her estate if such medical professional dies during the policy period.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Addendum A

Liability Rate Schedule

ILLINOIS

Territory: Entire State

Annual Base Rate Per Risk Index Bed (RIB)

For the base layer of \$1,000,000 limits: \$ 4,401.30

For the 1st layer of \$1,000,000 to \$5,000,000 limits: \$ 1,812.97

For the 2nd layer of \$5,000,000 to \$10,000,000 limits: \$ 526.20

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2006

SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PHYSICIAN AND SURGEON PROFESSIONAL LIABILITY**

Addendum B

Premium Rate Schedule

ILLINOIS

Limits: \$1,000,000/\$3,000,000

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2006

SPRINGFIELD, ILLINOIS

Territory:	Rest of State			
Class 1	14,550.18	Oral Surgeons	16,821.06	
Class 2	20,370.64	Nurse Midwives	16,263.20	
Class 3	29,100.36	CRNA	8,410.53	
Class 4	33,642.12	NP/PA	3,637.55	
Class 5	45,419.64	Optometrists	1,455.02	
Class 6	66,138.94	Dentists	3,364.21	
Class 7	65,052.81	Chiropractors	6,505.28	
Class 8	87,761.28			

Limits: \$1,000,000/\$3,000,000

Territory:	Cook County			
Class 1	22,045.00	Oral Surgeons	28,659.15	
Class 2	30,863.88	Nurse Midwives	27,336.76	
Class 3	44,092.20	CRNA	14,329.58	
Class 4	57,318.30	NP/PA	5,511.25	
Class 5	68,253.71	Optometrists	2,204.50	
Class 6	88,183.49	Dentists	5,731.83	
Class 7	109,347.04	Chiropractors	10,934.70	
Class 8	132,276.11			

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

I. GENERAL RULES

A) Eligibility

1) Hospital - Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

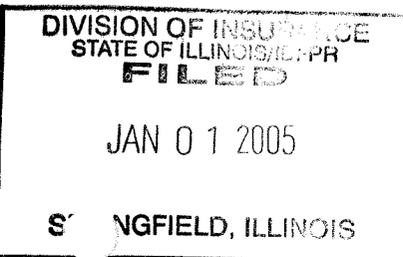
2) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses with the exception of an additional premium computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

3) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

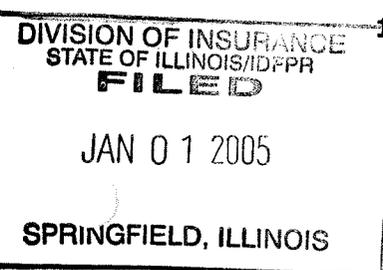
The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures

- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.
- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

- a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

- b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

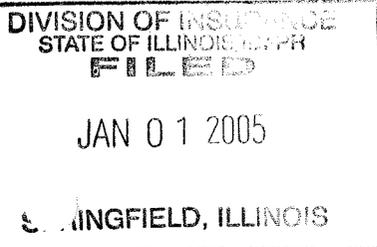
- c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91
163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2005

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans. The maximum of +/- 25% would apply, and not more than 10% additional credit for reduction of expenses.

CRITERIA	25% MAXIMUM CREDIT/DEBIT
Maximum +/- 25%, and not more than 10% additional credit for reduction of expenses	
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	+10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	+10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	+7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	+5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	+5%
• Certificates of insurance are obtained verifying vendor liability coverage.	+5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	+3%
• Written job descriptions are established for all positions.	+3%
• Each facility has a designated, full-time safety director or safety officer.	+3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	+10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	+10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	+10%
• The quality management and risk management programs are integrated.	+7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	+5%
• Continuing risk management education requirements routinely fulfilled.	+5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	+3%
• Risk management issues are addressed in new employee orientation.	+3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	+3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	+5%
• No citations or penalties by a regulatory agency within the past 3 years.	+5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	+10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	+7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	+7%
• Emergency department physicians are board certified.	+5%

DIVISION OF REGULATION
STATE OF ILLINOIS
FIDELITY

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

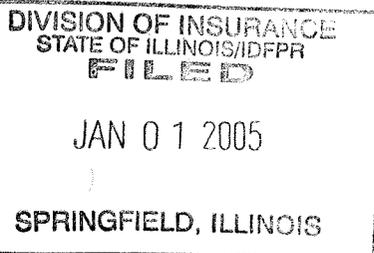
A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2005

SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

A) Applicability

Physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

1) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

2) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Definitions

Physician, surgeon and allied health professional

- Contract physician Physician under contract with a facility to provide professional medical service to or on behalf of such institution

DIVISION OF INSURANCE
STATE OF ILLINOIS/DFPR
FILED
JAN 01 2005
SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- **Employed physician** Physician providing health care services, including osteopathic physician and resident, who is considered an employee of an insured business
- **Full-time employee** Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE)
- **Part-time employee** Person employed by the facility less than 40 hours per week expressed in percentage of FTE
- **Resident** Postgraduate medical student (including intern and fellow)

D) Basis of premium

- **Employed physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Allied health professional** – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
- **Part-time physician and surgeon** – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = 75% subject to note below) Multiply the result by the class premium for each specialty
- **Contract physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Note:** No FTE lower than 25%. FTE equal to 25% or less use 25%. FTE between 25% and 80% use 50%. FTE 80% or higher use 100%. More than 240 hours or 6 FTE use a surcharge of 25%

E) Calculation of premium

1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.

2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate
ER Physician Assistant	Charge 25% of the class 4 rate

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 0 1 2005

SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Nurse Practitioner	Charge 25% of the class 1 rate
Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY - NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE - NI

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2005

SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 1 Continued

- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE – NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

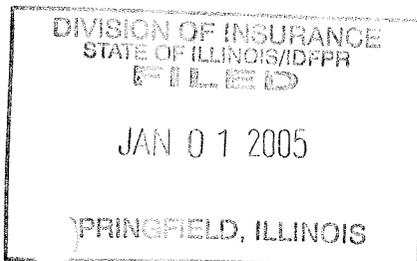
- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE – INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE – INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS – INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE – INV

CLASS 3

- FAMILY PRACTICE – SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE – SRG
- HOSPITALIST

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM CREDIT/DEBIT
Loss experience	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2005
SP: SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

See Addendum B

J) Physician prior acts coverage

1) Applicability

Physician's prior acts coverage may be provided only to physicians employed by insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.

2) Coverage

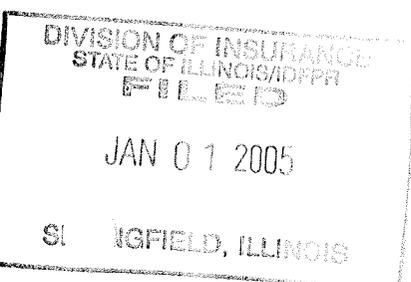
Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 2.1 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

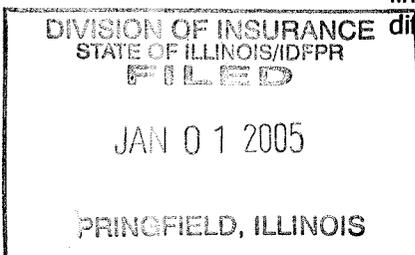
4) Increased Limits

As stated under J) 2) Physician prior acts coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:

Limits of Liability	Decrease/Increased Limits Factor
\$100,000/300,000	0.46
\$200,000/600,000	0.60
\$250,000/750,000	0.61
\$1/3 million	1.00
\$2/4 million	1.24
\$2/6 million	1.27
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50

5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

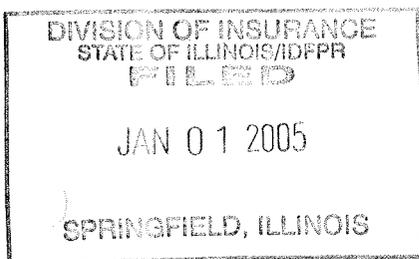
L) Optional Extended Reporting Period

Unlimited extended reporting period is available upon termination of the policy. The premium is determined by multiplying 210% by the mature claims made premium in effect at expiration of the policy. Premium is due within 30 days of quote and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy.

The extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company; or 3) to his or her estate if such medical professional dies during the policy period. An exception to the 5 year requirement for free tail at retirement may be considered by underwriting discretion.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Addendum A

Liability Rate Schedule

ILLINOIS

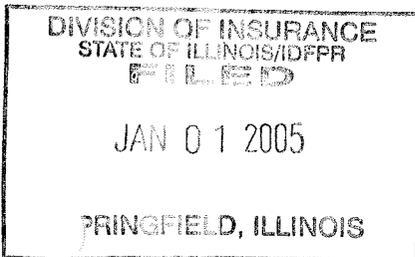
Territory: Entire State

Annual Base Rate Per Risk Index Bed (RIB)

For the base layer of \$1,000,000 limits: \$ 4,401.30

For the 1st layer of \$1,000,000 to \$5,000,000 limits: \$ 1,812.97

For the 2nd layer of \$5,000,000 to \$10,000,000 limits: \$ 526.20



**HEALTH CARE INDEMNITY, INC.
PHYSICIAN AND SURGEON PROFESSIONAL LIABILITY**

Addendum B

Premium Rate Schedule

ILLINOIS

Limits: \$1,000,000/\$3,000,000

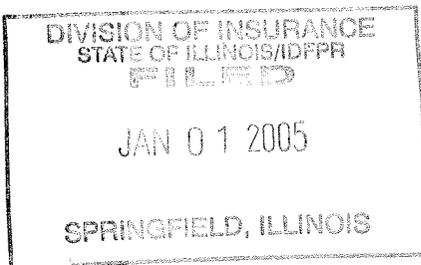
Territory: Rest of State

Class 1	12,125.15	Oral Surgeons	15,763.34
Class 2	16,975.53	Nurse Midwives	15,114.56
Class 3	24,250.30	CRNA	7,881.67
Class 4	31,526.68	NP/PA	3,031.29
Class 5	42,659.67	Optometrists	1,212.52
Class 6	55,115.78	Dentists	3,152.67
Class 7	60,458.24	Chiropractors	6,045.82
Class 8	73,134.40		

Limits: \$1,000,000/\$3,000,000

Territory: Cook County

Class 1	18,370.83	Oral Surgeons	23,882.63
Class 2	25,719.90	Nurse Midwives	22,780.63
Class 3	36,743.50	CRNA	11,941.31
Class 4	47,765.25	NP/PA	4,592.71
Class 5	56,878.09	Optometrists	1,837.08
Class 6	73,486.24	Dentists	4,776.53
Class 7	91,122.53	Chiropractors	9,112.25
Class 8	110,230.09		



HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY

MED. MAL.

I. GENERAL RULES

A) Eligibility

Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

Coverage may be declined for hospital systems based on loss history, financial history, or risk management issues.

Coverage is intended to include employees of covered businesses with the exception of an additional premium is computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist



All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

*HEALTH CARE INDEMNITY
INC.
SUPERCEDED*

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the seven statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	345	0.00290
In-patient Surgeries	60	0.01670
Out-patient Surgeries	250	0.00400
Out-patient Visits	3,333	0.00030
Home Health Visits	8,333	0.00012
Births	8	0.12500

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures

- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.
- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

- a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

- b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

- c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91
163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	±10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	±10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	+7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	±5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	±5%
• Certificates of insurance are obtained verifying vendor liability coverage.	±5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	±3%
• Written job descriptions are established for all positions.	±3%
• Each facility has a designated, full-time safety director or safety officer.	±3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	±10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	±10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	+10%
• The quality management and risk management programs are integrated.	+7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	±5%
• Continuing risk management education requirements routinely fulfilled.	±5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	±3%
• Risk management issues are addressed in new employee orientation.	±3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	±3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	±5%
• No citations or penalties by a regulatory agency within the past 3 years.	±5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	±10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	±7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	±7%
• Emergency department physicians are board certified.	±5%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

A) Applicability

Employed physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist



C) Definitions

Physician, surgeon and allied health professional

- | | |
|----------------------|---|
| • Contract physician | Physician under contract with a facility to provide professional medical service to or on behalf of such institution |
| • Employed physician | Physician providing health care services, including osteopathic physician and resident who is considered an employee of an insured business |
| • Full-time employee | Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE) |
| • Part-time employee | Person employed by the facility less than 40 hours per week expressed in percentage of FTE |
| • Resident | Postgraduate medical student (including intern and fellow) |

D) Basis of premium

- Employed physician, surgeon and resident – Refer to C) Definitions above. The unit of exposure is per FTE.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- Allied health professional – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
- Part-time physician and surgeon – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = .75) Multiply the result by the class premium for each specialty.

E) Calculation of premium

1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.

2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate
Nurse Practitioner	Charge 25% of the class 1 rate
Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY - NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE - NI
- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE - NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE - INV



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE – INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS – INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE – INV

CLASS 3

- FAMILY PRACTICE – SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE - SRG

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE
- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM CREDIT/DEBIT
Loss Experience	+15%
Board certification	+5%
Continuing education within 12 months	+5%
Risk management policies	+5%

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

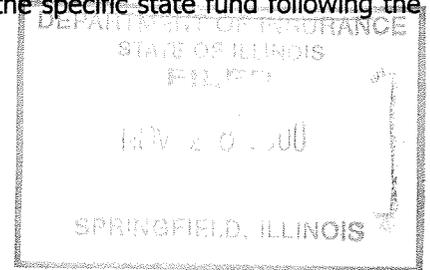
See Addendum B

J) Physician prior acts or "tail" coverage

1) Applicability

Physician's prior acts or "tail" coverage may be provided only to physicians employed by insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

2) Coverage

Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 5/3 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:

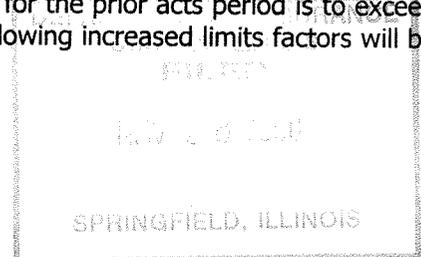
Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

4) Increased Limits

As stated under J, 2) Physician prior acts or "tail" coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Limits of Liability	Increased Limits Factor
\$1/3 million	1.00
\$2/4 million	1.23
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50

5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Addendum B

Premium Rate Schedule

ILLINOIS

Limits: \$1,000,000/\$3,000,000

Territory: Rest of State

Class 1	9327.04	Oral Surgeons	12125.65
Class 2	13058.10	Nurse Midwives	13143.10
Class 3	18654.08	CRNA	6062.82
Class 4	24251.29	NP/PA	2331.76
Class 5	32815.13	Optometrists	932.70
Class 6	42396.75	Dentists	2425.13
Class 7	52572.38	Chiropractors	5257.24
Class 8	63595.13		

Limits: \$1,000,000/\$3,000,000

Territory: Cook County

Class 1	14131.41	Oral Surgeons	18371.25
Class 2	19784.54	Nurse Midwives	17523.56
Class 3	28264.23	CRNA	9185.63
Class 4	36742.50	NP/PA	3532.85
Class 5	43752.38	Optometrists	1413.14
Class 6	56527.88	Dentists	3674.25
Class 7	70094.25	Chiropractors	7009.43
Class 8	84792.38		



I. GENERAL RULES

A) Eligibility

1) Hospital - Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

2) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses with the exception of an additional premium computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist



All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

3) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

HEALTH CARE INDEMNITY
SUPERCEDED 1/
1-1-05

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

DIVISION OF INSURANCE
STATE OF ILLINOIS/ID-PR
FILED

JAN 01 2005

S. SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020



A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures

- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.
- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

- a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

- b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

- c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91
163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	±10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	±10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	±7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	±5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	±5%
• Certificates of insurance are obtained verifying vendor liability coverage.	±5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	±3%
• Written job descriptions are established for all positions.	±3%
• Each facility has a designated, full-time safety director or safety officer.	±3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	±10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	±10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	±10%
• The quality management and risk management programs are integrated.	±7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	±5%
• Continuing risk management education requirements routinely fulfilled.	±5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	±3%
• Risk management issues are addressed in new employee orientation.	±3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	±3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	±5%
• No citations or penalties by a regulatory agency within the past 3 years.	±5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	±10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	±7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	±7%
• Emergency department physicians are board certified.	±5%

DEPARTMENT OF INSURANCE
 STATE OF ILLINOIS
 FILED
 OCT 24 2002
 SPRINGFIELD, ILLINOIS
 6

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

A) Applicability

Physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

1) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

2) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

C) Definitions

Physician, surgeon and allied health professional

- Contract physician Physician under contract with a facility to provide professional medical service to or on behalf of such institution

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- Employed physician Physician providing health care services, including osteopathic physician and resident, who is considered an employee of an insured business
- Full-time employee Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE)
- Part-time employee Person employed by the facility less than 40 hours per week expressed in percentage of FTE
- Resident Postgraduate medical student (including intern and fellow)

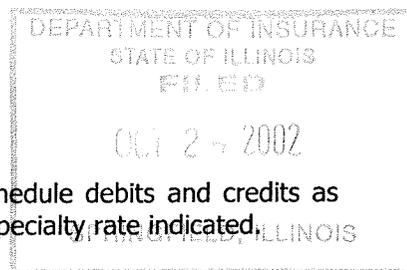
D) Basis of premium

- Employed physician, surgeon and resident – Refer to C) Definitions above. The unit of exposure is per FTE.
- Allied health professional – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
- Part-time physician and surgeon – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = 75% subject to note below) Multiply the result by the class premium for each specialty
- Contract physician, surgeon and resident – Refer to C) Definitions above. The unit of exposure is per FTE.
- Note: No FTE lower than 25%. FTE equal to 25% or less use 25%. FTE between 25% and 80% use 50%. FTE 80% or higher use 100%. More than 240 hours or 6 FTE use a surcharge of 25%

E) Calculation of premium

1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.



2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Nurse Practitioner	Charge 25% of the class 1 rate
Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY – NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE - NI



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 1 Continued

- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE – NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE – INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE – INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS – INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE – INV

CLASS 3

- FAMILY PRACTICE – SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE - SRG

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY



F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM CREDIT/DEBIT
Loss experience	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

See Addendum B

J) Physician prior acts coverage

1) Applicability

Physician's prior acts coverage may be provided ~~only to physicians employed by~~ insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.

2) Coverage

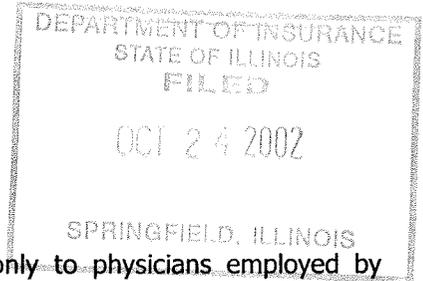
Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 2.1 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

4) Increased Limits

As stated under J) 2) Physician prior acts coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:

Limits of Liability	Decrease/Increased Limits Factor
\$100,000/300,000	0.46
\$200,000/600,000	0.60
\$250,000/750,000	0.61
\$1/3 million	1.00
\$2/4 million	1.24
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50

5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

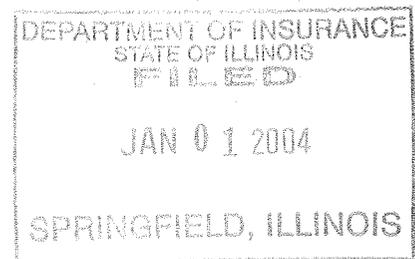
L) Optional Extended Reporting Period

Unlimited extended reporting period is available upon termination of the policy. The premium is determined by multiplying 210% by the mature claims made premium in effect at expiration of the policy. Premium is due within 30 days of quote and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy.

The extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company; or 3) to his or her estate if such medical professional dies during the policy period. An exception to the 5 year requirement for free tail at retirement may be considered by underwriting discretion.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Addendum A

Liability Rate Schedule

ILLINOIS

Territory: Entire State

Annual Base Rate Per Risk Index Bed (RIB)

For the base layer of \$1,000,000 limits: \$ 4,401.30

For the 1st layer of \$1,000,000 to \$5,000,000 limits: \$ 1,812.97

For the 2nd layer of \$5,000,000 to \$10,000,000 limits: \$ 526.20



**HEALTH CARE INDEMNITY, INC.
PHYSICIAN AND SURGEON PROFESSIONAL LIABILITY**

Addendum B

Premium Rate Schedule

ILLINOIS

Limits: \$1,000,000/\$3,000,000

Territory: Rest of State

Class 1	9,327.04	Oral Surgeons	12,125.65
Class 2	13,058.10	Nurse Midwives	13,143.10
Class 3	18,654.08	CRNA	6,062.82
Class 4	24,251.29	NP/PA	2,331.76
Class 5	32,815.13	Optometrists	932.70
Class 6	42,396.75	Dentists	2,425.13
Class 7	52,572.38	Chiropractors	5,257.24
Class 8	63,595.13		

Limits: \$1,000,000/\$3,000,000

Territory: Cook County

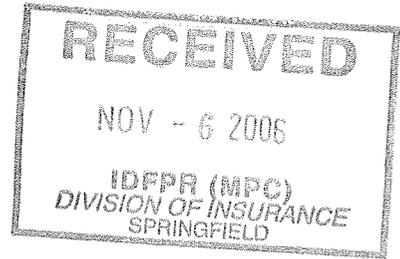
Class 1	14,131.41	Oral Surgeons	18,371.25
Class 2	19,784.54	Nurse Midwives	17,523.56
Class 3	28,264.23	CRNA	9,185.63
Class 4	36,742.50	NP/PA	3,532.85
Class 5	43,752.38	Optometrists	1,413.14
Class 6	56,527.88	Dentists	3,674.25
Class 7	70,094.25	Chiropractors	7,009.43
Class 8	84,792.38		





Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Memphis, TN 37202-0555

Mr. John Gatlin
Illinois Insurance Department
320 West Washington Street
Springfield, IL 62767



RE: Health Care Indemnity, Inc. NAIC 61-0904881
Rate and Rule Filing
Company Identification HCI2007

Dear Mr. Gatlin:

Enclosed for your review are the proposed 2007 Hospital Professional and General Liability and Physician and Surgeon Professional Liability rates. Included in this filing are the following:

Filing Memorandum
Professional and General Liability Rates

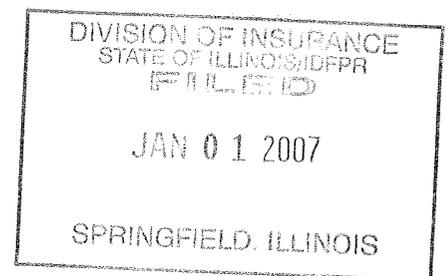
I have enclosed a duplicate copy of this letter and a self-addressed envelope for your stamp and return to my attention.

If you should have any questions, or require additional information, please do not hesitate to call me at (615) 344-1487. For additional convenience, my facsimile number is (877) 766-7099 and my e-mail address is Teresa.Stinson@hcahealthcare.com if needed.

Regards,

Teresa L. Stinson
Senior Compliance Analyst

Enclosure



Property & Casualty Transmittal Document (Revised 1/1/04)

1. Reserved for Insurance Dept. Use Only

2. Insurance Department Use only

a. Date the filing is received:

b. Analyst:

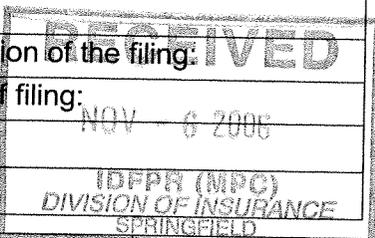
c. Disposition:

d. Date of disposition of the filing:

e. Effective date of filing:

f. State Filing #:

g. SERFF Filing #:



3. Group Name
Not Applicable **Group NAIC #**
NA

4. Company Name(s)	Domicile	NAIC #	FEIN #
Health Care Indemnity, Inc.	CO	35904	61-0904881

5. Company Tracking Number HCI2007

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

6. Name and address	Title	Telephone #s	FAX #	e-mail
Teresa Stinson PO Box 555 Nashville, TN 37202-0555	Sr. Compliance Analyst	(615)344-1487	(877)766-7099	Teresa.Stinson@hcahealthcare.com

7. Signature of authorized filer

8. Please print name of authorized filer Teresa L. Stinson

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

9. Type of Insurance (TOI)	11 Medical Malpractice and General Liability
10. Sub-Type of Insurance (Sub-TOI)	
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	Healthcare Professional and General Liability Coverage Form
13. Filing Type	<input checked="" type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: 1/1/07 Renewal: 1/1/07
15. Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Reference Organization (if applicable)	NA
17. Reference Organization # & Title	NA
18. Company's Date of Filing	10/31/06
19. Status of filing in domicile	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document

20. This filing transmittal is part of Company Tracking # **HC12007**

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

There is no change to the Hospital Liability Rates. The Physician and Surgeon rates reflect various changes by classification.

This filing is proposed to replace existing filed rates and rules effective January 1, 2007 or as soon as possible by receipt of this filing.

<p>22. Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]</p>
<p>Check #: Amount:</p> <p>Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.</p>

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



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

Rate and Rule Filing Memorandum

Date: October 16, 2006

To: Mr. John Gatin
Illinois Department of Insurance

From: Teresa L. Stinson
Senior Compliance Analyst

RE: Health Care Indemnity, Inc.
NAIC Company Number 35904
Company Identification: HCI2007

There is no change to the Hospital Liability Rates. The Physician and Surgeon rates reflect various changes by classification. Currently there is no business written in the state but the Company wants to stay within competitive rate range in the event new business is written.

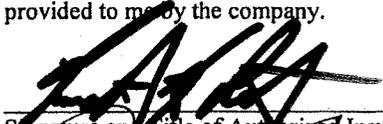
This filing is proposed to replace existing filed rates and rules effective January 1, 2007 or as soon as possible by receipt of this filing.

ILLINOIS CERTIFICATION FOR
MEDICAL MALPRACTICE RATES

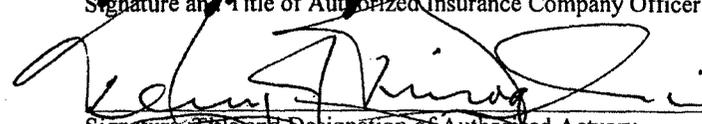
(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Kenneth K. Roth, a duly authorized officer of Health Care Indemnity, Inc., 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, Terry J. Biscoglia, a duly authorized actuary of Madison Consulting Group, Inc., am authorized to certify on behalf of Health Care Indemnity, Inc. making this filing that the company's rates are based on sound actuarial principles. Since the company has no experience in Illinois, the rates are based on competitors' rates adjusted to reflect quantifiable differences. I have reviewed the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing only to the extent they were provided to me by the company.


Signature and Title of Authorized Insurance Company Officer

10/18/06
Date


Signature, Title and Designation of Authorized Actuary

10/18/06
Date

Insurance Company FEIN 61-0904881 Filing Number HCI2006-R

Insurer's Address PO Box 555

City Nashville State TN Zip Code 37202-0555

Contact Person's:

-Name and E-mail Teresa Stinson - Teresa.Stinson@hcahealthcare.com

-Direct Telephone and Fax Number P (615) 344-1487 and F (877) 766-7099



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

October 31, 2006

Ms. Julie Anderson
Illinois Insurance Department
320 West Washington Street
Springfield, IL 62767

RE: Health Care Indemnity, Inc.
Rate and Rule Filing
Company Identification HCI2006

Dear Ms. Anderson:

Please find enclosed the original signed certification form previously submitted for the 2006 rate filing that states the process used by Health Care Indemnity, Inc. to determine its rates for filing. We also want to reaffirm that there is no insured in the state at this time. We maintain our authority and filings in case there is ever a need for us to provide coverage so we will not require additional filings at that time. To my knowledge there is no cause to write any business in the near future. As we have discussed previously, we only insure our parent company and subsidiary, related or previously associated facilities. Please let me know if you need any additional information.

Regards,

A handwritten signature in cursive script, appearing to read "Teresa L. Stinson".

Teresa L. Stinson

Enclosure

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Friday, December 15, 2006 4:46 PM
To: Neuman, Gayle
Subject: FW: Rate/Rule Filing #HCI2007
Attachments: 010107 IL Page 13 Rules.doc; 010107 IL Page 6 Rules.doc

From: Stinson Teresa
Sent: Friday, December 15, 2006 4:45 PM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Please see revised pages 6 and 13 to reflect the 25% minimum and maximum. Since we have no business in Illinois at present, it is difficult for me to justify to management changing our manual that is accepted all other states. Please waive this request at this time. If business is proposed in Illinois at some time in the future, perhaps we could revisit the issue at that time. Please note that the reasons listed in the hospital section on page 6 would not be applicable for physicians. Please allow an opportunity to address any additional concerns prior to a disapproval. I will be out of the office from 11/18 through 11/26. Thank you for your consideration.

From: Stinson Teresa
Sent: Tuesday, December 12, 2006 8:20 AM
To: 'Neuman, Gayle'
Subject: RE: Rate/Rule Filing #HCI2007

No please. Please allow until Friday, Dec. 15. to respond. I have a high volume of filings that I manage and I apologize for any delay.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 12, 2006 8:16 AM
To: Stinson Teresa
Subject: FW: Rate/Rule Filing #HCI2007

As of December 12, 2006, we have not received a response to any of the attached e-mails. Do you wish to withdraw this filing?

From: Neuman, Gayle
Sent: Tuesday, December 05, 2006 8:43 AM
To: 'Stinson Teresa'
Subject: FW: Rate/Rule Filing #HCI2007

The attached e-mails were all sent on November 28, 2006. I am not sure if you got the last one as I don't remember receiving a response. Your immediate attention is appreciated.

From: Neuman, Gayle

Sent: Tuesday, November 28, 2006 10:40 AM
To: 'Stinson Teresa'
Subject: RE: Rate/Rule Filing #HCI2007

That information would be helpful and should be included in the manual.

The schedule modification information on page 6 applies to hospitals and information on page 13 applies to physician/surgeon. So, the overall max/min should be indicated in each section.

Additionally, we would like to see the schedule modification rating plan info for physician/surgeon be expanded to provide the detail which was included on page 6 for the hospitals.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:28 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Thank you.

Our reference on page 13 to + or - 25% is overall. We do not intend for it to be interpreted as each item is allowed 25%. I can add a clarifying statement to the actual rules if needed.

Thank you.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 10:14 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

HCI2006-R is still pending. We are fine with manual pages in filing #HCI2007 showing the changes made in #HCI2006-R even though it is still pending.

Is there any language in the rate/rule manual that indicates the 25% overall minimum/maximum for the scheduled rating plan?

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:04 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Yes, attached is a copy of the currently approved Page 17, then also a copy of page 17 per HCI2006-R (which is still awaiting notice of approval.) there is no change to the rates. Only change was the edition date. We did not try to include an edition date change for 2007.

The company uses 25% as an overall minimum/maximum limit for the schedule rating plan. Rating plan has not changed since original approvals received.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 9:41 AM

To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Teresa,

You provided a copy of the manual – however there was no page 17 (although there was a page 17 in filing HCI2006-R). Is there suppose to be a page 17 still?

In regard to the scheduled rating plan, does the company have any overall minimum/maximum limit for the debits/credits?

Your prompt attention is appreciated.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:52 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Please see response to corresponding numbers below.

1. The actuarial certification was only recently obtained for the last rate filing and due to there is no insured in the states as well as there is no change to the HPL rates planned for 2007, I did not realize a certification would be required again. It was a certification of the process used as discussed with Julie Anderson with the last filing, the physician rates are based on other carriers rates approved by the department. Our information is not enough that we deem it credible and since we have no insured in the state our only purpose in continuing to files rates is to make sure we stay in line with the marketplace should an emergency arise and we need to issue a policy.
2. There is no change to the classes.
3. There are no insured so no information to assemble concerning statistics, premiums etc. There are no insured so no one to notify of any changes. There were no changes to the rules, etc. Our only purpose in making the filing since we have no insured in the state is to make sure that the rates are adequate if ever needed again. The company does not unfairly discriminate.
4. No changes to the rule manual. I have attached another copy for your review.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, November 13, 2006 11:06 AM
To: Stinson Teresa
Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?

3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM +25% CREDIT/DEBIT
Loss experience(not available in Kansas)	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

1) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM 25% CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	+10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	+10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	+7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	+5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	+5%
• Certificates of insurance are obtained verifying vendor liability coverage.	+5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	+3%
• Written job descriptions are established for all positions.	+3%
• Each facility has a designated, full-time safety director or safety officer.	+3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	+10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	+10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	+10%
• The quality management and risk management programs are integrated.	+7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	+5%
• Continuing risk management education requirements routinely fulfilled.	+5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	+3%
• Risk management issues are addressed in new employee orientation.	+3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	+3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	+5%
• No citations or penalties by a regulatory agency within the past 3 years.	+5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	+10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	+7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	+7%
• Emergency department physicians are board certified.	+5%

Neuman, Gayle

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, December 12, 2006 8:20 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

No please. Please allow until Friday, Dec. 15. to respond. I have a high volume of filings that I manage and I apologize for any delay.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 12, 2006 8:16 AM
To: Stinson Teresa
Subject: FW: Rate/Rule Filing #HCI2007

As of December 12, 2006, we have not received a response to any of the attached e-mails. Do you wish to withdraw this filing?

From: Neuman, Gayle
Sent: Tuesday, December 05, 2006 8:43 AM
To: 'Stinson Teresa'
Subject: FW: Rate/Rule Filing #HCI2007

The attached e-mails were all sent on November 28, 2006. I am not sure if you got the last one as I don't remember receiving a response. Your immediate attention is appreciated.

From: Neuman, Gayle
Sent: Tuesday, November 28, 2006 10:40 AM
To: 'Stinson Teresa'
Subject: RE: Rate/Rule Filing #HCI2007

That information would be helpful and should be included in the manual.

The schedule modification information on page 6 applies to hospitals and information on page 13 applies to physician/surgeon. So, the overall max/min should be indicated in each section.

Additionally, we would like to see the schedule modification rating plan info for physician/surgeon be expanded to provide the detail which was included on page 6 for the hospitals.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:28 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Thank you.

Our reference on page 13 to + or - 25% is overall. We do not intend for it to be interpreted as each item is allowed 25%. I can add a clarifying statement to the actual rules if needed.

Thank you.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 10:14 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

HCI2006-R is still pending. We are fine with manual pages in filing #HCI2007 showing the changes made in #HCI2006-R even though it is still pending.

Is there any language in the rate/rule manual that indicates the 25% overall minimum/maximum for the scheduled rating plan?

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:04 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Yes, attached is a copy of the currently approved Page 17, then also a copy of page 17 per HCI2006-R (which is still awaiting notice of approval.) there is no change to the rates. Only change was the edition date. We did not try to include an edition date change for 2007.

The company uses 25% as an overall minimum/maximum limit for the schedule rating plan. Rating plan has not changed since original approvals received.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 9:41 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Teresa,

You provided a copy of the manual – however there was no page 17 (although there was a page 17 in filing HCI2006-R). Is there suppose to be a page 17 still?

In regard to the scheduled rating plan, does the company have any overall minimum/maximum limit for the debits/credits?

Your prompt attention is appreciated.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:52 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Please see response to corresponding numbers below.

1. The actuarial certification was only recently obtained for the last rate filing and due to there is no insured in the states as well as there is no change to the HPL rates planned for 2007, I did not realize a certification would be required again. It was a certification of the process used as discussed with Julie Anderson with the last filing, the physician rates are based on other carriers rates approved by the department. Our information is not enough that we deem it credible and since we have no insured in the state our only purpose in continuing to files rates is to make sure we stay in line with the marketplace should an

emergency arise and we need to issue a policy.

2. There is no change to the classes.

3. There are no insured so no information to assemble concerning statistics, premiums etc. There are no insured so no one to notify of any changes. There were no changes to the rules, etc. Our only purpose in making the filing since we have no insured in the state is to make sure that the rates are adequate if ever needed again. The company does not unfairly discriminate.

4. No changes to the rule manual. I have attached another copy for your review.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]

Sent: Monday, November 13, 2006 11:06 AM

To: Stinson Teresa

Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?
3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Tuesday, December 12, 2006 8:16 AM
To: 'Stinson Teresa'
Subject: FW: Rate/Rule Filing #HCI2007

As of December 12, 2006, we have not received a response to any of the attached e-mails. Do you wish to withdraw this filing?

From: Neuman, Gayle
Sent: Tuesday, December 05, 2006 8:43 AM
To: 'Stinson Teresa'
Subject: FW: Rate/Rule Filing #HCI2007

The attached e-mails were all sent on November 28, 2006. I am not sure if you got the last one as I don't remember receiving a response. Your immediate attention is appreciated.

From: Neuman, Gayle
Sent: Tuesday, November 28, 2006 10:40 AM
To: 'Stinson Teresa'
Subject: RE: Rate/Rule Filing #HCI2007

That information would be helpful and should be included in the manual.

The schedule modification information on page 6 applies to hospitals and information on page 13 applies to physician/surgeon. So, the overall max/min should be indicated in each section.

Additionally, we would like to see the schedule modification rating plan info for physician/surgeon be expanded to provide the detail which was included on page 6 for the hospitals.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:28 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Thank you.

Our reference on page 13 to + or - 25% is overall. We do not intend for it to be interpreted as each item is allowed 25%. I can add a clarifying statement to the actual rules if needed.

Thank you.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 10:14 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

HCI2006-R is still pending. We are fine with manual pages in filing #HCI2007 showing the changes made in #HCI2006-R even though it is still pending.

12/12/2006

Is there any language in the rate/rule manual that indicates the 25% overall minimum/maximum for the scheduled rating plan?

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:04 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Yes, attached is a copy of the currently approved Page 17, then also a copy of page 17 per HCI2006-R (which is still awaiting notice of approval.) there is no change to the rates. Only change was the edition date. We did not try to include an edition date change for 2007.

The company uses 25% as an overall minimum/maximum limit for the schedule rating plan. Rating plan has not changed since original approvals received.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 9:41 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Teresa,

You provided a copy of the manual – however there was no page 17 (although there was a page 17 in filing HCI2006-R). Is there suppose to be a page 17 still?

In regard to the scheduled rating plan, does the company have any overall minimum/maximum limit for the debits/credits?

Your prompt attention is appreciated.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:52 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Please see response to corresponding numbers below.

1. The actuarial certification was only recently obtained for the last rate filing and due to there is no insured in the states as well as there is no change to the HPL rates planned for 2007, I did not realize a certification would be required again. It was a certification of the process used as discussed with Julie Anderson with the last filing, the physician rates are based on other carriers rates approved by the department. Our information is not enough that we deem it credible and since we have no insured in the state our only purpose in continuing to files rates is to make sure we stay in line with the marketplace should an emergency arise and we need to issue a policy.
2. There is no change to the classes.
3. There are no insured so no information to assemble concerning statistics, premiums etc. There are no insured so no one to notify of any changes. There were no changes to the rules, etc. Our only purpose in making the filing since we have no insured in the state is to make sure that the rates are adequate if ever needed again. The company does not unfairly discriminate.
4. No changes to the rule manual. I have attached another copy for your review.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, November 13, 2006 11:06 AM
To: Stinson Teresa
Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?
3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Tuesday, December 05, 2006 8:43 AM
To: 'Stinson Teresa'
Subject: FW: Rate/Rule Filing #HCI2007

The attached e-mails were all sent on November 28, 2006. I am not sure if you got the last one as I don't remember receiving a response. Your immediate attention is appreciated.

From: Neuman, Gayle
Sent: Tuesday, November 28, 2006 10:40 AM
To: 'Stinson Teresa'
Subject: RE: Rate/Rule Filing #HCI2007

That information would be helpful and should be included in the manual.

The schedule modification information on page 6 applies to hospitals and information on page 13 applies to physician/surgeon. So, the overall max/min should be indicated in each section.

Additionally, we would like to see the schedule modification rating plan info for physician/surgeon be expanded to provide the detail which was included on page 6 for the hospitals.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:28 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Thank you.

Our reference on page 13 to + or - 25% is overall. We do not intend for it to be interpreted as each item is allowed 25%. I can add a clarifying statement to the actual rules if needed.

Thank you.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 10:14 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

HCI2006-R is still pending. We are fine with manual pages in filing #HCI2007 showing the changes made in #HCI2006-R even though it is still pending.

Is there any language in the rate/rule manual that indicates the 25% overall minimum/maximum for the scheduled rating plan?

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:04 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

12/5/2006

Yes, attached is a copy of the currently approved Page 17, then also a copy of page 17 per HCI2006-R (which is still awaiting notice of approval.) there is no change to the rates. Only change was the edition date. We did not try to include an edition date change for 2007.

The company uses 25% as an overall minimum/maximum limit for the schedule rating plan. Rating plan has not changed since original approvals received.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 9:41 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Teresa,

You provided a copy of the manual – however there was no page 17 (although there was a page 17 in filing HCI2006-R). Is there suppose to be a page 17 still?

In regard to the scheduled rating plan, does the company have any overall minimum/maximum limit for the debits/credits?

Your prompt attention is appreciated.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:52 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Please see response to corresponding numbers below.

1. The actuarial certification was only recently obtained for the last rate filing and due to there is no insured in the states as well as there is no change to the HPL rates planned for 2007, I did not realize a certification would be required again. It was a certification of the process used as discussed with Julie Anderson with the last filing, the physician rates are based on other carriers rates approved by the department. Our information is not enough that we deem it credible and since we have no insured in the state our only purpose in continuing to files rates is to make sure we stay in line with the marketplace should an emergency arise and we need to issue a policy.
2. There is no change to the classes.
3. There are no insured so no information to assemble concerning statistics, premiums etc. There are no insured so no one to notify of any changes. There were no changes to the rules, etc. Our only purpose in making the filing since we have no insured in the state is to make sure that the rates are adequate if ever needed again. The company does not unfairly discriminate.
4. No changes to the rule manual. I have attached another copy for your review.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, November 13, 2006 11:06 AM
To: Stinson Teresa
Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?
3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Tuesday, November 28, 2006 10:40 AM
To: 'Stinson Teresa'
Subject: RE: Rate/Rule Filing #HCI2007

That information would be helpful and should be included in the manual.

The schedule modification information on page 6 applies to hospitals and information on page 13 applies to physician/surgeon. So, the overall max/min should be indicated in each section.

Additionally, we would like to see the schedule modification rating plan info for physician/surgeon be expanded to provide the detail which was included on page 6 for the hospitals.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:28 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Thank you.

Our reference on page 13 to + or - 25% is overall. We do not intend for it to be interpreted as each item is allowed 25%. I can add a clarifying statement to the actual rules if needed.

Thank you.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 10:14 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

HCI2006-R is still pending. We are fine with manual pages in filing #HCI2007 showing the changes made in #HCI2006-R even though it is still pending.

Is there any language in the rate/rule manual that indicates the 25% overall minimum/maximum for the scheduled rating plan?

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:04 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Yes, attached is a copy of the currently approved Page 17, then also a copy of page 17 per HCI2006-R (which is still awaiting notice of approval.) there is no change to the rates. Only change was the edition date. We did not try to include an edition date change for 2007.

The company uses 25% as an overall minimum/maximum limit for the schedule rating plan. Rating plan has not changed since original approvals received.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 9:41 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Teresa,

You provided a copy of the manual – however there was no page 17 (although there was a page 17 in filing HCI2006-R). Is there suppose to be a page 17 still?

In regard to the scheduled rating plan, does the company have any overall minimum/maximum limit for the debits/credits?

Your prompt attention is appreciated.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:52 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Please see response to corresponding numbers below.

1. The actuarial certification was only recently obtained for the last rate filing and due to there is no insured in the states as well as there is no change to the HPL rates planned for 2007, I did not realize a certification would be required again. It was a certification of the process used as discussed with Julie Anderson with the last filing, the physician rates are based on other carriers rates approved by the department. Our information is not enough that we deem it credible and since we have no insured in the state our only purpose in continuing to files rates is to make sure we stay in line with the marketplace should an emergency arise and we need to issue a policy.
2. There is no change to the classes.
3. There are no insured so no information to assemble concerning statistics, premiums etc. There are no insured so no one to notify of any changes. There were no changes to the rules, etc. Our only purpose in making the filing since we have no insured in the state is to make sure that the rates are adequate if ever needed again. The company does not unfairly discriminate.
4. No changes to the rule manual. I have attached another copy for your review.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, November 13, 2006 11:06 AM
To: Stinson Teresa
Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?
3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering,

administering, or

applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, November 28, 2006 10:04 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007
Attachments: 2004 Addendum A Page 17 Liability Rates.doc; 05 0929 IL 2006 Addendum A Page 17 Liability Rates.doc

Yes, attached is a copy of the currently approved Page 17, then also a copy of page 17 per HCI2006-R (which is still awaiting notice of approval.) there is no change to the rates. Only change was the edition date. We did not try to include an edition date change for 2007.

The company uses 25% as an overall minimum/maximum limit for the schedule rating plan. Rating plan has not changed since original approvals received.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, November 28, 2006 9:41 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Teresa,

You provided a copy of the manual – however there was no page 17 (although there was a page 17 in filing HCI2006-R). Is there suppose to be a page 17 still?

In regard to the scheduled rating plan, does the company have any overall minimum/maximum limit for the debits/credits?

Your prompt attention is appreciated.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:52 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Please see response to corresponding numbers below.

1. The actuarial certification was only recently obtained for the last rate filing and due to there is no insured in the states as well as there is no change to the HPL rates planned for 2007, I did not realize a certification would be required again. It was a certification of the process used as discussed with Julie Anderson with the last filing, the physician rates are based on other carriers rates approved by the department. Our information is not enough that we deem it credible and since we have no insured in the state our only purpose in continuing to files rates is to make sure we stay in line with the marketplace should an emergency arise and we need to issue a policy.
2. There is no change to the classes.
3. There are no insured so no information to assemble concerning statistics, premiums etc. There are no insured so no one to notify of any changes. There were no changes to the rules, etc. Our only purpose in making the filing since we have no insured in the state is to make sure that the rates are adequate if ever needed again. The company does not unfairly discriminate.
4. No changes to the rule manual. I have attached another copy for your review.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, November 13, 2006 11:06 AM
To: Stinson Teresa
Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?
3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:52 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007
Attachments: 010106 Rules.doc

Please see response to corresponding numbers below.

1. The actuarial certification was only recently obtained for the last rate filing and due to there is no insured in the states as well as there is no change to the HPL rates planned for 2007, I did not realize a certification would be required again. It was a certification of the process used as discussed with Julie Anderson with the last filing, the physician rates are based on other carriers rates approved by the department. Our information is not enough that we deem it credible and since we have no insured in the state our only purpose in continuing to files rates is to make sure we stay in line with the marketplace should an emergency arise and we need to issue a policy.
2. There is no change to the classes.
3. There are no insured so no information to assemble concerning statistics, premiums etc. There are no insured so no one to notify of any changes. There were no changes to the rules, etc. Our only purpose in making the filing since we have no insured in the state is to make sure that the rates are adequate if ever needed again. The company does not unfairly discriminate.
4. No changes to the rule manual. I have attached another copy for your review.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, November 13, 2006 11:06 AM
To: Stinson Teresa
Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?
3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:37 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Thank you so much. I am working on the 11/13/06 request now. Have a wonderful, safe holiday.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, November 22, 2006 9:34 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2007

Teresa,

Filing HCI2006-R is still pending but hopefully will be concluded before the end of the year. I will extend the date date for your response to my 11/13/06 e-mail to December 1, 2006.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, November 22, 2006 9:27 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2007

Gayle, please allow an opportunity to address the items listed below. I totally missed the respond by date and did not realize until I started to work on the item this morning. I also need to find out if the last 2006 filing was approved yet. My company reference # was HCI2006. Any help is appreciated. Thank you.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, November 13, 2006 11:06 AM
To: Stinson Teresa
Subject: Rate/Rule Filing #HCI2007

Ms. Stinson,

We are in receipt of the above referenced filing submitted by your letter dated October 31, 2006.

Please address the following:

1. The certification indicate a previous filing number.
2. How are the classes being changed? Wouldn't this require changes to the Class Code Listings on pages 11 through 13?
3. The filing did not include a statement regarding the gathering of statistics; no written statement indicating all changes made were disclosed; and no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
4. We additionally require the filing include a copy of the complete rate/rule manual.

We request receipt of your response by no later than November 20, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

I. GENERAL RULES

A) Eligibility

1) Hospital - Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

2) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses with the exception of an additional premium computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

3) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

F) Premium Remittance

- The insured premium payment plan may be annual, quarterly or monthly.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures

- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.
- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

- a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

- b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

- c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91
163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	±10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	±10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	±7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	±5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	±5%
• Certificates of insurance are obtained verifying vendor liability coverage.	±5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	±3%
• Written job descriptions are established for all positions.	±3%
• Each facility has a designated, full-time safety director or safety officer.	±3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	+10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	+10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	+10%
• The quality management and risk management programs are integrated.	±7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	±5%
• Continuing risk management education requirements routinely fulfilled.	±5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	±3%
• Risk management issues are addressed in new employee orientation.	+3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	±3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	±5%
• No citations or penalties by a regulatory agency within the past 3 years.	±5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	±10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	±7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	±7%
• Emergency department physicians are board certified.	+5%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

A) Applicability

Physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

1) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

2) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

C) Definitions

Physician, surgeon and allied health professional

- Contract physician Physician under contract with a facility to provide professional medical service to or on behalf of such institution

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- **Employed physician** Physician providing health care services, including osteopathic physician and resident, who is considered an employee of an insured business
- **Full-time employee** Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE)
- **Part-time employee** Person employed by the facility less than 40 hours per week expressed in percentage of FTE
- **Resident** Postgraduate medical student (including intern and fellow)

D) Basis of premium

- **Employed physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Allied health professional** – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
- **Part-time physician and surgeon** – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = 75% subject to note below) Multiply the result by the class premium for each specialty
- **Contract physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Note:** No FTE lower than 25%. FTE equal to 25% or less use 25%. FTE between 25% and 80% use 50%. FTE 80% or higher use 100%. More than 240 hours or 6 FTE use a surcharge of 25%

E) Calculation of premium

1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.

2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate
Nurse Practitioner	Charge 25% of the class 1 rate

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY – NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE – NI
-

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 1 Continued

- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE – NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE – INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE – INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS – INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE – INV

CLASS 3

- FAMILY PRACTICE – SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE – SRG
- HOSPITALIST

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM CREDIT/DEBIT
Loss experience(not available in Kansas)	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

See Addendum B

J) Physician prior acts coverage

1) Applicability

Physician's prior acts coverage may be provided only to physicians employed by insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.

2) Coverage

Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 2.1 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

4) Increased Limits

As stated under J) 2) Physician prior acts coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:

Limits of Liability	Decrease/Increased Limits Factor
\$100,000/300,000	0.46
\$200,000/600,000	0.60
\$250,000/750,000	0.61
\$500,000/1 million	0.84
\$500,000/1.5 million	0.87
\$1/3 million	1.00
\$2/4 million	1.24
\$2/6 million	1.27
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50

5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

L) Optional Extended Reporting Period

Unlimited extended reporting period is available upon termination of the policy. The premium is determined by multiplying 210% by the mature claims made premium in effect at expiration of the policy. Premium is due within 30 days of quote and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy.

The extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company; or 3) to his or her estate if such medical professional dies during the policy period. An exception to the 5 year requirement for free tail at retirement may be considered by underwriting discretion.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.

Contact Person:
 Gayle Neuman
 217-524-6497
 Gayle.Neuman@illinois.gov

Illinois Division of Insurance
 Review Requirements Checklist

320 West Washington Street
 Springfield, IL 62767-0001

Effective as of 8/25/06

<u>Line(s) of Business</u>	<u>Code(s)</u>	
<input checked="" type="checkbox"/> MEDICAL MALPRACTICE	11.0000	***This checklist is for rate/rule filings only.
<input type="checkbox"/> Claims Made	11.10000	
<input checked="" type="checkbox"/> Occurrence	11.2000	See separate form checklist.

<u>Line(s) of Insurance</u>	<u>Code(s)</u>	<u>Line(s) of Insurance</u>	<u>Code(s)</u>	<u>Line(s) of Insurance</u>	<u>Code(s)</u>
<input type="checkbox"/> Acupuncture	11.0001	<input type="checkbox"/> Hospitals	11.0009	<input type="checkbox"/> Optometry	11.0019
<input type="checkbox"/> Ambulance Services	11.0002	<input type="checkbox"/> Professional Nurses	11.0032	<input type="checkbox"/> Osteopathy	11.0020
<input type="checkbox"/> Anesthetist	11.0031	<input type="checkbox"/> Nurse – Anesthetists	11.0010	<input type="checkbox"/> Pharmacy	11.0021
<input type="checkbox"/> Assisted Living Facility	11.0033	<input type="checkbox"/> Nurse – Lic. Practical	11.0011	<input type="checkbox"/> Physical Therapy	11.0022
<input type="checkbox"/> Chiropractic	11.0003	<input type="checkbox"/> Nurse – Midwife	11.0012	<input type="checkbox"/> Physicians & Surgeons	11.0023
<input type="checkbox"/> Community Health Center	11.0004	<input type="checkbox"/> Nurse – Practitioners	11.0013	<input type="checkbox"/> Physicians Assistants	11.0024
<input type="checkbox"/> Dental Hygienists	11.0005	<input type="checkbox"/> Nurse – Private Duty	11.0014	<input type="checkbox"/> Podiatry	11.0025
<input type="checkbox"/> Dentists	11.0030	<input type="checkbox"/> Nurse – Registered	11.0015	<input type="checkbox"/> Psychiatry	11.0026
<input type="checkbox"/> Dentists – General Practice	11.0006	<input type="checkbox"/> Nursing Homes	11.0016	<input type="checkbox"/> Psychology	11.0027
<input type="checkbox"/> Dentists – Oral Surgeon	11.0007	<input type="checkbox"/> Occupational Therapy	11.0017	<input type="checkbox"/> Speech Pathology	11.0028
<input type="checkbox"/> Home Care Service Agencies	11.0008	<input type="checkbox"/> Ophthalmic Dispensing	11.0018	<input type="checkbox"/> Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1 st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		<p>To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings.</p> <p>Please see the separate form filing checklist for requirements related to medical liability forms.</p>	NA
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	<p>215 ILCS 5/4</p> <p>List of Classes/Clauses</p>	<p>To write Medical Liability insurance in Illinois, companies must be licensed to write:</p> <p>1. Class 2, Clause (c)</p>	<p>✓ - Not compliant NA to this filing - No additional doc. included</p>
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		<p>The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately.</p> <p>For requirements regarding form filings, see separate form filing checklist.</p>	Separate filings as noted.
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	<p>215 ILCS 5/155.18</p> <p>50 IL Adm. Code 929</p>	<p>"New Insurers" are insurers who are:</p> <ul style="list-style-type: none"> New to Illinois. New writers of medical liability insurance in Illinois. Writing a new Line of Insurance listed on Page 1 of this checklist, <p>New insurers must file the following:</p> <p>a) Medical liability insurance rate manual, including all rates.</p>	NA

		<p>b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans,</p> <p>c) Classifications and other such schedules used in writing medical liability insurance.</p> <p>d) Statement regarding whether the insurer:</p> <ul style="list-style-type: none"> • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). <p>The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency.</p> <p>Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.</p>	
Amendments to Initial Rate/Rule Filings			
<p>After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.</p>	<p><u>215 ILCS 5/155.18</u></p> <p><u>50 IL Adm. Code 929</u></p>	<p>After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added.</p> <p>Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director.</p> <p>Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents.</p> <p>The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency.</p> <p>Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.</p>	<p><i>Included as Page 18 Edition 0169 No other changes</i></p>
EFFECTIVE DATES OF RATE/RULE FILINGS			
<p>Illinois is "file and use" for medical liability rates and rules.</p>	<p><u>215 ILCS 5/155.18</u></p> <p><u>50 IL Adm. Code</u></p>	<p>A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty</p>	<p><i>As required</i></p>

	<u>929</u>	Compliance Section, except as otherwise provided in Section 155.18.	
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	<u>50 IL Adm. Code 929</u>	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	<i>As Required</i>
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	<u>50 IL Adm. Code 929</u>	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	<i>As required</i>
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u> <u>Company Bulletin 88-53</u> <u>Actuarial Certification Form</u> <u>NAIC Uniform Transmittal Form</u>	All filings must be accompanied by a submission letter which includes <u>all</u> of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify <u>all</u> changes in superseding filings, <u>and all</u> superseded filings, including the following information: <ul style="list-style-type: none"> • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the 	<i>As required</i>

		<p>superseded filing.</p> <ul style="list-style-type: none"> Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. <p>6) Effective date of use.</p> <p>7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division.</p> <p>8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.</p> <p>Companies under the same ownership or general management are required to make <u>separate, individual company filings</u>. Company Group ("Me too") filings are unacceptable.</p> <p>If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.</p>	
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	<p><u>50 IL Adm. Code 929</u></p> <p><u>Form RF-3 Summary Sheet</u></p>	<p>For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use.</p> <p>Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line.</p> <p>If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business.</p> <p>The RF-3 form must indicate whether the information is "exact" or "estimated."</p>	<p>No change to total AS required</p> <p>No business in state</p>
PAYMENT PLANS			
Quarterly premium payment installment	<u>215 ILCS 5/155.18</u>	A company writing medical liability insurance in Illinois shall offer to each of its medical liability	In accordance

<p>plan required as prescribed by the Director.</p>		<p>insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements:</p> <ul style="list-style-type: none"> • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or \$25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than \$500. However, if offered to either, the plan must be made available to all within that group. 	
DEDUCTIBLES			
<p>Deductible plans should be filed if offered.</p>	<p><u>215 ILCS 5/155.18</u></p>	<p>A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.</p>	<p>NA to this filing</p>
DISCOUNTS			
<p>Premium discount for risk management activities should be filed if offered.</p>	<p><u>215 ILCS 5/155.18</u></p>	<p>A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the</p>	<p>NA to this filing</p>

CLAIMS MADE REQUIREMENTS		section that applies.	
<p>Extended reporting period (tail coverage) requirements.</p>	<p>215 ILCS 5/143(2) <u>Company Bulletin 88-50</u></p>	<p>When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals:</p> <ul style="list-style-type: none"> • Offer of an extended reporting period (tail coverage) of <u>at least 12 months</u>. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which <u>must</u> be priced as a factor of one of the following.*** <ul style="list-style-type: none"> ○ the last 12 months' premium. ○ the premium in effect at policy issuance. ○ the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated. • Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request. • Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.*** • Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first. <p>***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must:</p> <ul style="list-style-type: none"> • Offer free 5-year extended reporting period (tail coverage) or • Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate 	<p>NA</p>

		<p>expiring limits for the duration)</p> <ul style="list-style-type: none"> • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage. 	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	<u>50 IL Adm. Code 906</u>	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	<i>NA</i>
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	<i>NA to the ruling</i>
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	<u>215 ILCS 5/155.18</u>	<p>In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory.</p> <p>Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive.</p> <p>The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.</p>	<i>As required</i>
PRICING			

Insurers shall consider certain information when developing medical liability rates.	<u>215 ILCS 5/155.18</u>	<p>Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois.</p> <p>Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers.</p> <p>The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.</p>	<i>As Required</i>
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	<u>215 ILCS 5/155.18</u>	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	<i>As Required</i>
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	<u>215 ILCS 5/155.18</u>	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	<i>As Required</i>
RISK CLASSIFICATION			
Risks may be grouped by classifications.	<u>215 ILCS 5/155.18</u>	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	<i>As Required</i>
Rating decisions based solely on domestic violence.	<u>215 ILCS 5/155.22b</u>	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	<i>As Required</i>
Unfair methods of	<u>215 ILCS 5/424(3)</u>	It is an unfair method of competition or unfair and	<i>As Required</i>

competition or unfair or deceptive acts or practices defined.		deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	<u>215 ILCS 5/429</u>	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	AS Required
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	<u>215 ILCS 5/155.18</u>	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	AS Required
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u> <u>Actuarial Certification Form</u>	Every rate and/or rating rule filing must include a certification by an officer of the company <u>and</u> a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	AS Required
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	AS Required
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code</u>	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The	AS Required

rate filing, as well as any rule filing that affects the ultimate premium.	<u>929</u>	<p>explanatory memorandum shall contain, at minimum, the following information:</p> <ul style="list-style-type: none"> • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing. 	
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	<i>AS required - NA for filing - No premium in 5/15/2020</i>
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	<p>Insurers shall include actuarial support justifying the overall changes being made, including but not limited to:</p> <ul style="list-style-type: none"> • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc. 	<i>AS required</i>
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	<i>AS required</i>
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	<i>AS required</i>
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	<i>AS required</i>
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	<i>NA</i>
Loss Adjustment Expenses			

Insurers shall include support for loss adjustment expenses.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	NA
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	NA
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	NA
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	NA
Other Actuarial Information Required			
Insurers must include the information described in this section.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall also include the following information: <ul style="list-style-type: none"> All actuarial support/justification for all rates being changed, including but not limited to changes in: <ul style="list-style-type: none"> Base rates; Territory definitions; Territory factor changes; Classification factor changes; Classification definition changes; Changes to schedule credits/debits, etc. Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed. 	NA Letter from actuary as required.

		<ul style="list-style-type: none"> Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist. 	
Schedule Rating			
Insurers must include the described information described at right.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	NA



MADISON CONSULTING GROUP

Actuaries • Property/Casualty Consulting Services

October 26, 2006

Ms. Maggie Hayden Kuhlman
Director of Financial Analysis
HCA, Inc.
P. O. Box 550
Nashville, Tennessee 37202-0550

Dear Ms. Kuhlman:

At your request, we have prepared this letter setting forth a description of the procedures underlying the development of rate level indications for Healthcare Indemnity, Inc. (HCI). This overall rate level determination forms the basis of the complete rate structure underlying HCI's 2007 medical professional liability rates.

Distribution and Use

It is our understanding that it is intended for this letter to be included as part of a rate filing to be provided to the Illinois Department of Insurance. Any other use or further distribution is not permitted without our prior consent.

Conditions and Limitations

Madison Consulting Group, Inc. has developed and assisted in implementing an experience based budget system for HCA, Inc. (HCA) and some of its predecessor companies for a number of years. The first step in the process involves conducting a detailed analysis of indicated ultimate losses and allocated loss adjustment expenses (ALAE) for each historical accident year, based on an examination of actual experience of the program in total. As a part of that study, projections are made of ultimate losses and ALAE for the prospective accident year (in this instance, 2007). This projection, along with estimated exposure units, is used to develop the average loss cost, or pure premium, needed to support HCA's program for the prospective period. This pure premium and other rating variables are used to develop the rate structure set forth by HCI.

As is noted in our studies, it must be recognized that the development of medical professional liability rates and budgets involves the projection of future contingent events. Therefore, no guarantee can be made that the projected results will prove to be adequate or not excessive. However, in developing the indications, we utilize methods and assumptions that are in accord with accepted actuarial principles, and we believe the conclusions reached are reasonable.

200 North Second Street • Madison, Georgia 30650

706-342-7750

www.madisoninc.com

Fax: 706-342-7775

Description of Rate Level Determination

Due to its size and statistical reliability, the development of HCI's rate structure begins with a traditional ultimate loss cost study based on an examination of actual historical experience of HCI's parent. The details of that analysis are set forth in a proprietary report provided to HCA. The following discussion describes how the results of that analysis are used to develop rate level indications for the 2007 accident year.

Projected Ultimate Losses and ALAE for Accident Year 2007

HCA has accumulated a significant amount of experience on historical accident years for its medical professional liability program. This information is used in a comprehensive actuarial analysis to determine ultimate losses and ALAE by accident year for the HCA program. Various actuarial projection techniques are used to project ultimate losses and ALAE and to test various characteristics of the program (e.g., trend assumptions, underlying increased limits relationships, etc.). These indications are used to project ultimate losses and ALAE for the prospective accident year. Projections reflect assumed trends in underlying loss costs and expected changes in underlying exposure.

Development of \$1,000,000 Limits Pure Premium for Accident Year 2007

Management combines the ultimate losses and ALAE for accident year 2007 described above with other actuarial indications and projected exposure units for 2007 to produce the underlying average loss cost, or pure premium. Note that in this step, the pure premium is developed at HCI's basic limit of \$1,000,000.

Development of Accident Year 2007 Rates

The basic limit pure premium is further combined by management with other rating variables to develop rates for the 2007 accident year. These rating variables are included according to a traditional ratemaking procedure and reflect the following considerations:

- prospective investment income;
- territorial differentials;
- operational expenses, including premium taxes and profit and contingencies; and
- increased limits relationships for excess layers.

Ms. Maggie Hayden Kuhlman
October 26, 2006
Page 3

Indicated Rate Change

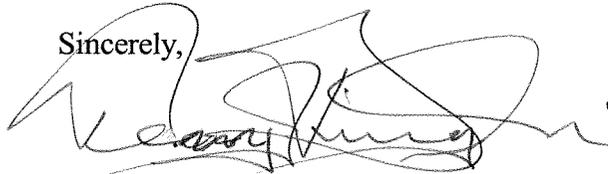
A comparison is made between the rates developed for the 2007 accident year and rates underlying HCI's current rate structure. The resulting rate change is indicated for \$1,000,000 basic limits; \$4,000,000 excess of \$1,000,000 limits; and \$5,000,000 excess of \$5,000,000 limits. As with the lower layers, these rates are based on underlying rating variables and an examination of historical size of loss distributions.

Conclusion

The projected rates developed by HCI reflect an examination of actual historical experience and are based on standard ratemaking principles used for similar types of risks. In our opinion, the process employed by HCI is reasonable and appropriate and follows accepted actuarial standards. We believe the approaches utilized by the company produce rates that are adequate, not excessive, and not unfairly discriminatory.

If you have any questions or require additional information, please let us know.

Sincerely,



Terry J. Biscoglia, FCAS, MAAA

TJB/ms
Attachments

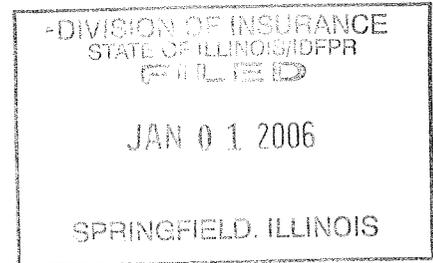
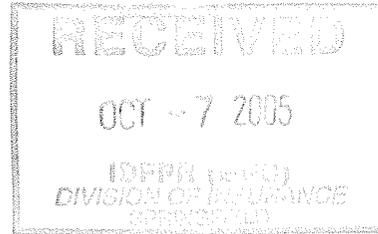


Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

September 29, 2005

Mr. John Gatlin
Illinois Insurance Department
320 West Washington Street
Springfield, IL 62767

RE: Health Care Indemnity, Inc.
Rate and Rule Filing
Company Identification HCI2006-R



Dear Mr. Gatlin:

Enclosed for your review are the proposed 2006 Hospital Professional and General Liability and Physician and Surgeon Professional Liability rates and rules. Included in this filing are the following:

- Filing Memorandum
- Actuarial Opinion
- Professional and General Liability Rates and Rules

I have enclosed a duplicate copy of this letter and a self-addressed envelope for your stamp and return to my attention.

If you should have any questions, or require additional information, please do not hesitate to call me at (615) 344-1487. For additional convenience, my facsimile number is (877) 766-7099 and my e-mail address is Teresa.Stinson@hcahealthcare.com if needed.

Regards,

Teresa L. Stinson
Senior Compliance Analyst

Enclosure

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 1/1/2006.

(1)	<u>Coverage</u>	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger		
	Commercial		
2.	Automobile Physical Damage Private Passenger		
	Commercial		
3.	Liability Other Than Auto	0	0%
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other <i>medical malpractice</i>		
Life of Insurance			

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

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

*Adjusted to reflect all prior rate changes.

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

Health Care Indemnity Inc.
Name of Company
Teresa Stinson, Sr. Compliance Analyst
Official - Title

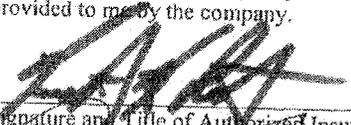


ILLINOIS CERTIFICATION FOR
MEDICAL MALPRACTICE RATES

(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, Kenneth K. Roth, a duly authorized officer of Health Care Indemnity, Inc., 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, Terry J. Biscoglia, a duly authorized actuary of Madison Consulting Group, Inc., am authorized to certify on behalf of Health Care Indemnity, Inc. making this filing that the company's rates are based on sound actuarial principles. Since the company has no experience in Illinois, the rates are based on competitors' rates adjusted to reflect quantifiable differences. I have reviewed the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing only to the extent they were provided to me by the company.


Signature and Title of Authorized Insurance Company Officer

10/18/06
Date


Signature, Title and Designation of Authorized Actuary

10/18/06
Date

Insurance Company FEIN 61-0904881 Filing Number HCI2006-R

Insurer's Address PO Box 555

City Nashville State TN Zip Code 37202-0555

Contact Person's:
-Name and E-mail Teresa Stinson - Teresa.Stinson@hcahealthcare.com

-Direct Telephone and Fax Number P (615) 344-1487 and F (877) 766-7099



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

Rate and Rule Filing Memorandum

Date: September 29, 2005

To: Mr. John Gatin
Illinois Department of Insurance

From: Teresa L. Stinson
Senior Compliance Analyst

RE: Health Care Indemnity, Inc.
NAIC Company Number 35904
Company Identification: HCI2006

There is no change to the base rate \$1,000,000 layer, the 1st layer, \$4,000,000 in excess of \$1,000,000, the 2nd layer and the \$5,000,000 in excess of \$5,000,000. The Physician and Surgeon rates reflect various changes by classification. Currently there is no business written in the state but want to stay within competitive rate range in the event new business is written.

The rules are filed to reflect an edition date of January 1, 2006.

This filing is proposed to replace existing filed rates and rules effective January 1, 2006 or as soon as possible by receipt of this filing.

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, January 23, 2007 3:38 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006
Attachments: 07 0123 IL Rules.doc

I have revised as necessary. Thank you for your patience.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, January 23, 2007 3:17 PM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

The wording does not indicate that the 5 year tail is free also.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, January 23, 2007 3:09 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

My apologies if I attached the incorrect version of the rules on my last email. This revision of the rules page 2 and 16 should have all the required changes. If I have not interpreted something correctly please allow an opportunity to address prior to a disapproval. Thank you for your consideration.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, January 23, 2007 8:38 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

In regard to the extended reporting period, as indicated in my previous e-mails,

1. the insured gets a free 60 day period after the end of the policy to request the e.r.p.
2. the insured must be offered:
 - (a) a free 5 year tail; and
 - (b) an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration) and premium capped
 - (e.r.p. is limited to a 200% cap of the annual premium of the expiring policy)

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, January 23, 2007 3:09 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006
Attachments: 07 0122 IL Rules.doc

My apologies if I attached the incorrect version of the rules on my last email. This revision of the rules page 2 and 16 should have all the required changes. If I have not interpreted something correctly please allow an opportunity to address prior to a disapproval. Thank you for your consideration.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, January 23, 2007 8:38 AM
To: Stinson Teresa
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

In regard to the extended reporting period, as indicated in my previous e-mails,

1. the insured gets a free 60 day period after the end of the policy to request the e.r.p.

2. the insured must be offered:

(a) a free 5 year tail; and

(b) an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration) and premium capped

(e.r.p. is limited to a 200% cap of the annual premium of the expiring policy)

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Monday, January 22, 2007 9:40 AM
To: Neuman, Gayle
Subject: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

<<07 0108 IL Rules.doc>> Ms. Neuman, please find attached the rules with amendments on page 2 and 16 to reflect suggested changes listed in your email of 1/16/07. I have added the quarterly payment option wording as suggested and confirm it would be offered to an insured if the company ever writes in the state again. Please remember we do not currently have any business in the state and are just trying to maintain accurate filings in line with the marketplace in case they are ever needed again. We do only write insurance for our parent company. I have also addressed the extended reporting period items you mentioned. Please allow an opportunity to address any issues prior to a disapproval being issued. Thank you again for your consideration.

Teresa L. Stinson
Health Care Indemnity, Inc.
PO Box 555
Nashville, TN 37202-0555

Phone (615) 344-1487
Fax (877) 766-7099

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

L) Optional Extended Reporting Period

Insured is provided a free 60-day extended reporting period to report occurrences. A 5-year tail is available on claims from occurrences during the policy period and the free 60-day period. Unlimited extended reporting period with limits reinstated (100% of aggregate expiring limits for the duration) is available upon termination of the policy. The premium is determined by multiplying 200% by the mature claims made annual premium in effect at expiration of the policy. Premium is due within 60 days of quote made after end of policy and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy. The insured must be informed of the extended reporting period premium at the time the last policy is purchased. The extended reporting period must be offered when the policy is terminated for any reason and whether the policy is terminated at the company's or insured's request.

The extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company ; or permanently retires from the practice of medicine at age 60 or older after three continuous years of coverage with the company; or, 3) to his or her estate if such medical professional dies during the policy period. An exception to the 5 year requirement for free tail at retirement may be considered by underwriting discretion.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Monday, January 22, 2007 9:40 AM
To: Neuman, Gayle
Subject: Rate/Rule Filing #HCI2006-R Effective January 1, 2006
Attachments: 07 0108 IL Rules.doc

<<07 0108 IL Rules.doc>> Ms. Neuman, please find attached the rules with amendments on page 2 and 16 to reflect suggested changes listed in your email of 1/16/07. I have added the quarterly payment option wording as suggested and confirm it would be offered to an insured if the company ever writes in the state again. Please remember we do not currently have any business in the state and are just trying to maintain accurate filings in line with the marketplace in case they are ever needed again. We do only write insurance for our parent company. I have also addressed the extended reporting period items you mentioned. Please allow an opportunity to address any issues prior to a disapproval being issued. Thank you again for your consideration.

Teresa L. Stinson
Health Care Indemnity, Inc.
PO Box 555
Nashville, TN 37202-0555
Phone (615) 344-1487
Fax (877) 766-7099

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

F) Premium Remittance

- The insured premium payment plan may be annual, quarterly or monthly.
 - Quarterly premium installment plans are available to insureds whose annual premiums are less than \$500, or for premium for any extension of a reporting period. Quarterly premium installment plans are also available to insureds with premium exceeding \$500. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy. Thereafter, the

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. Quarterly installment premium payment plans shall include the minimum standards listed below.

- i) An initial payment of no more than 40% of the estimated total premium due at policy inception;
- ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;
- iii) No interest charges;
- iv) Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;
- v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

L) Optional Extended Reporting Period

Insured is provided a free 60-day extended reporting period to report occurrences. A 5-year tail is available on claims from occurrences during the policy period and the free 60-day period. Unlimited extended reporting period with limits reinstated (100% of aggregate expiring limits for the duration) is available upon termination of the policy. The premium is determined by multiplying 200% by the mature claims made annual premium in effect at expiration of the policy. Premium is due within 60 days of quote made after end of policy and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy. The insured must be informed of the extended reporting period premium at the time the last policy is purchased. The extended reporting period must be offered when the policy is terminated for any reason and whether the policy is terminated at the company's or insured's request.

The extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company ; or permanently retires from the practice of medicine at age 60 or older after three continuous years of coverage with the company; or, 3) to his or her estate if such medical professional dies during the policy period. An exception to the 5 year requirement for free tail at retirement may be considered by underwriting discretion.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.

Neuman, Gayle

From: Neuman, Gayle
Sent: Tuesday, January 16, 2007 9:56 AM
To: 'Stinson Teresa'
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

In regard to the quarterly premium payment installment plan, the language submitted stated such "plans are available to insureds whose annual premiums are less than \$500, or for premium for any extension of a reporting period". Please confirm that Health Care Indemnity has chosen to offer the quarterly installment plan in such situations. Additionally, the wording needs to clarify that it has to be offered to an insured whose premium exceeds \$500.

In regard to the extended reporting period, the insured must be provided a free 60-day extended reporting period to report occurrences, and a 5-year tail on claims from occurrences during the policy period and the free 60-day period. Then, the insurer must offer an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration). The extended reporting period must be offered when the policy is terminated for any reason and whether the policy is terminated at the company's or insured's request.

Your immediate attention is appreciated.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Friday, January 12, 2007 12:21 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Neuman, I have attached a complete copy of the rules manual showing changed areas with a highlight. Pages with changes to comply with items listed below are located on pages 2, 3, 6, 13 and 16 of the manual. Please allow an opportunity to address any additional information prior to a disapproval. Thank you again for your help.



MADISON CONSULTING GROUP

Actuaries • Property/Casualty Consulting Services

September 20, 2005

Ms. Maggie Hayden Kuhlman
Director of Financial Analysis
HCA, Inc.
P. O. Box 550
Nashville, Tennessee 37202-0550

Dear Ms. Kuhlman:

At your request, we have prepared this letter setting forth a description of the procedures underlying the development of rate level indications for Healthcare Indemnity, Inc. (HCI). This overall rate level determination forms the basis of the complete rate structure underlying HCI's 2006 medical professional liability rates.

Distribution and Use

It is our understanding that it is intended for this letter to be included as part of a rate filing to be provided to the Illinois Department of Insurance. Any other use or further distribution is not permitted without our prior consent.

Conditions and Limitations

Madison Consulting Group, Inc. has developed and assisted in implementing an experience based budget system for HCA, Inc. (HCA) and some of its predecessor companies for a number of years. The first step in the process involves conducting a detailed analysis of indicated ultimate losses and allocated loss adjustment expenses (ALAE) for each historical accident year, based on an examination of actual experience of the program in total. As a part of that study, projections are made of ultimate losses and ALAE for the prospective accident year (in this instance, 2006). This projection, along with estimated exposure units, is used to develop the average loss cost, or pure premium, needed to support HCA's program for the prospective period. This pure premium and other rating variables are used to develop the rate structure set forth by HCI.

As is noted in our studies, it must be recognized that the development of medical professional liability rates and budgets involves the projection of future contingent events. Therefore, no guarantee can be made that the projected results will prove to be adequate or not excessive. However, in developing the indications, we utilize methods and assumptions that are in accord with accepted actuarial principles, and we believe the conclusions reached are reasonable.

200 North Second Street • Madison, Georgia 30650

706-342-7750

www.madisoninc.com

Fax: 706-342-7775

Description of Rate Level Determination

Due to its size and statistical reliability, the development of HCI's rate structure begins with a traditional ultimate loss cost study based on an examination of actual historical experience of HCI's parent. The details of that analysis are set forth in a proprietary report provided to HCA. The following discussion describes how the results of that analysis are used to develop rate level indications for the 2006 accident year.

Projected Ultimate Losses and ALAE for Accident Year 2006

HCA has accumulated a significant amount of experience on historical accident years for its medical professional liability program. This information is used in a comprehensive actuarial analysis to determine ultimate losses and ALAE by accident year for the HCA program. Various actuarial projection techniques are used to project ultimate losses and ALAE and to test various characteristics of the program (e.g., trend assumptions, underlying increased limits relationships, etc.). These indications are used to project ultimate losses and ALAE for the prospective accident year. Projections reflect assumed trends in underlying loss costs and expected changes in underlying exposure.

Development of \$1,000,000 Limits Pure Premium for Accident Year 2006

Management combines the ultimate losses and ALAE for accident year 2006 described above with other actuarial indications and projected exposure units for 2006 to produce the underlying average loss cost, or pure premium. Note that in this step, the pure premium is developed at HCI's basic limit of \$1,000,000.

Development of Accident Year 2006 Rates

The basic limit pure premium is further combined by management with other rating variables to develop rates for the 2006 accident year. These rating variables are included according to a traditional ratemaking procedure and reflect the following considerations:

- prospective investment income;
- territorial differentials;
- operational expenses, including premium taxes and profit and contingencies; and
- increased limits relationships for excess layers.

Ms. Maggie Hayden Kuhlman
September 20, 2005
Page 3

Indicated Rate Change

A comparison is made between the rates developed for the 2006 accident year and rates underlying HCI's current rate structure. The resulting rate change is indicated for \$1,000,000 basic limits; \$4,000,000 excess of \$1,000,000 limits; and \$5,000,000 excess of \$5,000,000 limits. As with the lower layers, these rates are based on underlying rating variables and an examination of historical size of loss distributions.

Conclusion

The projected rates developed by HCI reflect an examination of actual historical experience and are based on standard ratemaking principles used for similar types of risks. In our opinion, the process employed by HCI is reasonable and appropriate and follows accepted actuarial standards. We believe the approaches utilized by the company produce rates that are adequate, not excessive, and not unfairly discriminatory.

If you have any questions or require additional information, please let us know.

Sincerely,



Terry J. Biscoglia, FCAS, MAAA

TJB/ms
Attachments

Health Care Indemnity, Inc.

**Updated HCI Gross and Net Reserves
at December 31, 2004 and Forecast
of HCA Ultimate Losses**

July 29, 2005



**TOWERS
PERRIN**
TILLINGHAST



**TOWERS
PERRIN**
TILLINGHAST

July 29, 2005

Mrs. Margaret H. Kuhlman
Director - Financial Analysis
Health Care Indemnity, Inc.
One Park Plaza
Nashville, Tennessee 37203

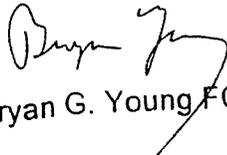
Dear Mrs. Kuhlman:

At your request, we have prepared the attached analysis of net and direct ultimate loss and loss adjustment expense liabilities and implied reserves for Health Care Indemnity, Inc. ("HCI") as of December 31, 2004, and forecasted ultimate losses for HCA, Inc. ("HCA").

As always, it has been a pleasure to work with you and the staff at HCI on this assignment. Please call if you have questions.

Sincerely,

TOWERS PERRIN



Bryan G. Young FCAS, MAAA

BGY:sms

Attachments

Direct Dial: (404) 365-1635



**TOWERS
PERRIN**
TILLINGHAST

Table of Contents

PURPOSE	1
SCOPE	2
DISTRIBUTION AND USE	3
FINDINGS.....	5
Indications – HCI Reserves and Forecasts	5
Indications – Individual Programs	5
Data Observations	8
Overall Observations	10
SUMMARY EXHIBITS	14
Exhibit A – Forecasts	15
Exhibit B – Frequency	16
Exhibit C – \$1.0 Million Limits Severity.....	17
Exhibit D – \$1.0 Million Limits Pure Premium.....	18
Exhibit E – \$10.0 ILF – Combined.....	19
Exhibit F – \$10.0 Million ILF – Paid Basis	20
Exhibit G– \$10.0 Million ILF – Reported Basis	21
SOURCES OF UNCERTAINTY.....	22
Loss Reserve Estimates	22
BACKGROUND.....	23

Ownership and Management	23
Underwriting.....	23
Claim Handling	23
Reinsurance.....	23
DATA UTILIZATION AND RELIANCES.....	24
Data Utilization.....	24
Data Reliance	25
ASSUMPTIONS.....	26
Loss Development Patterns	26
Reinsurance.....	26
Underlying Assets	26
Salvage and Subrogation.....	27
Texas Tort Reform.....	27
ANALYSIS.....	28
Appendices	28
Expected Losses.....	29
Increased Limits Factors Analysis.....	29
Trend Selections.....	29
Forecast of 2005 and 2006 Losses	29
Galen \$1,000,000 Limit Projections.....	30
HCI Projections	30

PURPOSE

The Tillinghast business of Towers Perrin ("Tillinghast") was requested by Health Care Indemnity, Inc. ("HCI") to develop gross (direct and assumed) and net loss reserve estimates as of December 31, 2004. In addition, HCI requested we provide a forecast of 2005 and 2006 ultimate losses for a variety of limits. HCI provides coverage to the following six former separate entities of HCA: Galen Healthcare ("Galen"), Columbia Healthcare ("Columbia"), Hospital Corporation of America ("HCA"), EPIC, HealthTrust, and MCA. HCI also assumed many of the liabilities of Parthenon Insurance Company ("Parthenon"). In addition, HCI is covering the divested entities of Triad and LifePoint.

SCOPE

This analysis represents an independent actuarial analysis of HCI's direct and net loss and loss adjustment expense ("LAE") reserves as of December 31, 2004. "Losses" should be assumed to include allocated loss adjustment expenses ("ALAE") unless otherwise noted. Also, referenced limits apply to indemnity payments only. At HCI's request, we have not reviewed any additional or return premiums or commissions due to or from HCI as a result of loss sensitive reinsurance contracts. Finally, per HCI's request, ultimate losses on reported claims on tail policies are on a report year basis while the unemerged losses are on an issue year basis.

Our analysis is on a net and gross of reinsurance and net of salvage and subrogation basis. All projections are on an undiscounted basis.

As noted in the *Information Provided and Reliances* section of this report, we have not audited or independently verified the data provided for our analysis.

DISTRIBUTION AND USE

This report and the opinions and conclusions contained herein are being provided to HCI solely for internal use in connection with our actuarial analysis of the net and direct loss and LAE reserves of HCI as of December 31, 2004, and forecasted loss levels for 2005 and 2006. We understand that copies of this report may be provided to HCI's external auditors, the regulatory authorities and insurance rating agencies. Permission is hereby granted for this distribution on the following conditions:

- Tillinghast is provided a list of the Recipients to whom this report is provided
- the report is distributed in its entirety
- each Recipient recognizes that Tillinghast is available, at the expense of HCI, to answer any questions concerning the report
- each Recipient agrees not to reference or distribute the report to any other party
- each Recipient recognizes that the furnishing of this report is not a substitute for its own due diligence and agrees to place no reliance on this report or the data contained herein that would result in the creation of any duty or liability by Tillinghast to such party
- each Recipient understands that such RECIPIENT IS DEEMED TO HAVE ACCEPTED THESE TERMS AND CONDITIONS by retaining a copy of this report.

No further distribution of this report may be made without our prior written consent.

This report contains workpapers, trade secrets, and confidential information of HCI and as such, it is not intended to be subject to disclosure requirements under any Freedom of Information Act.

Any reference to Tillinghast in relation to this report in any reports, accounts, or other published documents or any verbal reference issued by HCI is not authorized without our prior written consent.

The exhibits and appendices attached in support of our recommendations and findings are an integral part of this report. These sections have been prepared so that our actuarial assumptions and judgments are documented. Judgments about the conclusions drawn in this

report should be made only after considering the report in its entirety. We remain available to answer any questions that may arise regarding this report. We assume that the user of this report will seek such explanation on any matter in question.

Our conclusions and recommendations are predicated on a number of assumptions as to future conditions and events. Those assumptions, which are documented in subsequent sections of this report, must be understood in order to place our conclusions in their appropriate context. In addition, our work is subject to inherent limitations, which are also discussed in the report.

FINDINGS

Indications – HCI Reserves and Forecasts

Based on our study we provide the following indications.

- The following chart compares our updated net and gross reserve indications to HCI carried levels at December 31, 2004 (in millions):

Type	Indicated		Carried
	Low	High	
Net	\$1,214.4	1,406.2	1,496.6
Gross	1,264.4	1,464.1	1,563.0

In our opinion, HCI carried net and gross reserve levels are reasonable.

- The Summary Exhibit A contains the projections for the 2005 and 2006 coverage years at \$1.0, \$5.0, \$10.0, and \$25.0 million limits with pro rata ALAE. Indications are shown for Triad and HCA facilities. The physician limits are assumed to be \$1.0 million in all cases. It is our understanding that LifePoint facilities will not be covered by HCI in 2005 and 2006 except for exposures in Kansas.

Indications – Individual Programs

- HCA's ultimate professional and general liability losses for accident years 1977-1985 are summarized on Part A, Exhibit D, Sheet 3 and claims made for 1986-1993 on Sheet 4. The tail estimate is contained on Part A, Exhibit D, Sheet 2a. The following chart compares the current and prior July 2004 projected ultimate losses.

Coverage	Limits (Millions)	Ultimates (000's)	
		Prior	Current
1977-1985 Occurrence	\$1.0	\$173,807	\$173,812
1977-1985 Occurrence	10.0	227,774	227,779
1986 Claims-Made	2.0	18,410	18,410
1986-1993 Claims-Made	10.0	279,000	279,216
12/31/1993 Tail	3.0	48,066	48,362
12/31/1993 Tail	10.0	48,066	48,362

After December 31, 1993, HCA losses are included in Galen's loss experience.

- Pre-merger Columbia ultimate professional liability losses are summarized on a claims-made basis on Part A, Exhibit D, Sheet 3 and for tail liability on Part A, Exhibit D, Sheet 2b. The following chart compares the current and prior September 2003 ultimate losses for the requested coverage periods and limits.

Coverage	Limits (Millions)	Ultimates (000's)	
		Prior	Current
12/31/1993 Tail	\$3.0	\$8,063	\$8,114
12/31/1993 Tail	\$10.0	8,826	8,882
7/1/1991-12/31/1993 Claims-Made	5.0	20,583	20,583

The tail amounts do not include a provision for losses reported prior to January 1, 1994.

- Per Part B, Exhibit A, Galen's selected \$1.0 million ultimate professional and general liability losses for coverage periods through December 31, 2001, are \$2,129.1 million based on data at December 31, 2004. The corresponding amount for coverage periods through December 31, 2001 from our prior (July 2004) report was \$2,179.0 million or a decrease of approximately \$50 million.

- Health Trust Inc.'s projected tail ultimate losses are summarized on Part A, Exhibit D, Sheets 2c and 4. EPIC's experience is included in these amounts. The following chart summarizes the indications:

Coverage	Limits (Millions)	Ultimates (000's)	
		Prior	Current
4/24/95 Tail	\$3.0	\$51,356	\$55,384
4/24/95 Tail	10.0	55,289	59,059
Reported Prior to 4/24/1995	3.0	225,000	224,573
Reported Prior to 4/24/1995	10.0	252,000	251,909
Reported Prior to 4/24/1995	15.0 xs 10.0	10,750	10,720

Losses occurring after April 24, 1995, are included in the Galen projections.

- MCA tail ultimate losses are projected on Part A, Exhibit D, Sheets 2d and 4. MCA's occurrences after September 30, 1994, are included in Galen's loss experience. The following chart summarizes the indications.

Coverage	Limits (Millions)	Ultimates (000's)	
		Prior	Current
9/30/1994 Tail	\$3.0	\$1,890	\$1,903
9/30/1994 Tail	10.0	1,890	1,903
1989-9/30/1994 Claims-Made	3.0	6,825	6,813

The following chart summarizes the ultimate losses for several reinsurance transactions. The prior projections are from our July 2004 HCI reserve report.

Summary of Ultimate Losses for Reinsurance Transactions

		Prior	Current
Trans Atlantic 1994-1996	Retained	\$9,484	\$9,001
Trans Atlantic 1997-1999	Retained	7,958	5,606
CNA Excess 1999-2000	Retained	63,108	58,948
CNA Excess 2001	Retained	6,308	2,081

- The following chart summarizes the indicated 2005 and 2006 ultimate losses in 000's for Triad and HCA facilities. The limits reflect pro rata ALAE.

Summary of Indicated 2005 and 2006 Ultimate Losses

	\$1.0 Million Limits		\$5.0 Million Limits	
	2005	2006	2005	2006
Triad	\$37,142	\$38,580	\$51,177	\$53,540
HCA	260,889	270,494	363,493	380,414
Total	\$298,031	\$309,574	\$414,670	\$433,954

The results are shown in more detail on Summary Exhibit A.

- Projected ultimate losses for HCI's physician program are shown on Part A, Exhibit D, Sheet 1. The expected losses are based on the loss ratio approach of the program. The loss ratios are based on our loss ratio studies for each state except for West Virginia, which was based on industry loss ratios. Paid and reported Bornhuetter-Ferguson projections are completed.

Data Observations

Based on our study we have the following data observations:

- The selected \$1.0 million limits accident year payment patterns from our current report are very similar to those selected last year. The selected reporting pattern is a little faster than the pattern selected last year. The following chart compares the patterns.

Months	Payment Pattern		Reporting Pattern	
	Prior	Current	Prior	Current
12	2.5%	2.5%	28.0%	27.6%
24	13.2	13.3	57.1	57.9
36	31.6	32.4	80.6	82.8
48	52.1	53.5	87.7	90.2
60	68.6	70.5	91.3	93.5
72	79.8	81.7	94.2	95.4
84	86.9	88.6	96.4	96.6

- The following chart summarizes the selected emergence pattern from this year and last year's report. The same pattern is selected for \$1.0 million limits and excess of \$1.0 million limits.

Selected Emergence Pattern		
Year	Prior	Current
1	31.9%	32.4%
2	63.7	64.9
3	88.0	90.2
4	92.9	94.7
5	94.3	96.0

The pattern is slightly faster for the earlier valuations but has been lengthened to 13 years. This lengthening increased the tail liability estimates for the tails issued in the mid-90's.

Overall Observations

Based upon our study, we have the following observations:

- Probably the largest uncertainty in the projections is the ultimate impact of Texas tort reform which was effective September 1, 2003. To date, it appears that this reform has reduced both the frequency and severity of claims.

It is our understanding that HCI's Texas reported claims have decreased significantly. The decline in frequency can be seen in Summary Exhibit B. The uncertainty in the reported frequency projections is whether a greater proportion of these claims will close with indemnity in the future and whether there has been a slow down in reporting claims. Because of the long delay in closing reported claims for accident years, we partially reacted to the decline in frequency in our trend selections, as can be seen in our model frequency on Summary Exhibit B.

The decline in severity can be seen in the indicated \$10.0 million ILF in Texas versus excluding Texas shown on Summary Exhibits F and G. The indicated Texas ILF's were significantly greater than the excluding Texas ILF's until accident years 2001 through 2004. The reported and paid ILF's for the more recent accident years are very immature and are potentially subject to significant change as they mature. We have reacted to the change in excess experience by modifying the selected ILF's above \$1.0 million limits for accident years 2001 and subsequent by -5.0%. The adjusted ILF can be seen in the model ILF's on the Summary Exhibits F and G.

Our modifications to frequency, trends, and ILF's attempt to react to the emerging Texas experience to the extent it is credible. The Bornhuetter-Ferguson method adjusts ultimates to reflect actual paid and reported losses as they emerge.

- We have reduced our selected trend rates in the recent years to more closely track HCA's experience, particularly for Texas. Summary Exhibit B contains the indicated and model reported frequency. Similar to our prior reports, the exposures used to develop frequencies and pure premiums are Florida Territory 2 bed equivalent exposures. Summary Exhibit C contains the indicated and model \$1.0 million ultimate severity per reported claim. We have adjusted our selected severity trends to reflect HCI's severity.

- The following chart summarizes the selected trend rates underlying the model.

Summary of Selected Trend Rates

Accident Year	Frequency	Severity	Current Pure Premium	Prior Pure Premium
1999	0.0	4.0	4.0%	4.0%
2000	0.0	0.0	0.0	4.0
2001	0.0	4.0	4.0	4.0
2002	-5.0	4.0	-1.2	4.0
2003-2005	0.0	4.0	4.0	4.0

The analysis assumes lower selected pure premium trend rates during the 2000 and 2002 periods to reflect the reduction in severity in 2000 and frequency in 2002 as noted in our discussion of Texas tort reform described earlier. In our opinion, the experience is too immature to make further adjustments until the recent accident year data becomes more mature.

- The indicated pure premium based on development methods supports the selected trend rates. Summary Exhibit D contains the indicated model \$1.0 million limits pure premiums.
- As a further test of the selected trend rate, loss patterns, and EMF's, we compared expected calendar year paid and reported losses over the past five years to actual paid and reported losses based on the accident year patterns. The following chart summarizes the results, in millions, at \$1.0 million limits.

Comparison of Expected Versus Actual Calendar Year Losses

Calendar Year	Paid		Reported	
	Expected	Actual	Expected	Actual
2000	\$209.8	\$237.7	\$246.8	\$281.3
2001	227.3	219.0	251.4	239.4
2002	239.2	250.3	257.2	294.0
2003	247.9	245.4	264.2	207.6
2004	255.7	247.0	274.0	206.4
Subtotal	\$1,179.9	\$1,199.3	\$1,293.7	\$1,228.7
Excluding 2004			1,019.7	1,022.3

Overall, the paid expected and actual losses are very close while the reported expected and actual losses are close if calendar year 2004 is excluded.

- We continue the approach of using industry ILF's; modified for HCA's experience as initial expected ILF's.

ILF Modifiers

Layer	Prior	Current		Change	
		Pre-2001	2001-2006	Pre-2001	2001-2006
\$2.0M xs \$1.0M	.736	.735	.699	0.0%	-5.0%
\$7.0M xs \$3.0M	.300	.300	.285	0.0	-5.0
\$15.0M xs \$10.0M	.150	.150	.143	0.0	-5.0

The decline in 2001-2006 ILF EMF's reflects the emerging experience in Texas as discussed earlier. All of the actual ILF's have been adjusted to reflect the assumption that physician limits are \$1.0 million limits.

- In order to forecast losses for the 2005 and 2006 years we examined the EMF's by entity. The following chart compares the indicated EMF of the various insureds of HCI for the 1995 through 2004 accident years.

	Indicated EMF (1995-2003)		Selected EMF
	Paid	Reported	
LifePoint	1.574	1.371	1.500
Triad	1.176	1.141	1.190
HCA	1.151	1.078	1.140
Combined	1.159	1.085	1.150
Galen	NA	NA	1.150

The selected EMF's for the combined facilities are the same as the selected Galen EMF's which underlies the HCI projections. The selected EMF's for combined reflect more years of experience and loss patterns based on accident year by report year analysis.

- The closure rate of individual claims appears to be stable. The following chart summarizes the ratio of outstanding claims to reported claims by report year for the combined data.

Report Year	Percent of Claims Remaining Open as of Evaluation Month			
	12	24	36	48
1997	.721	.294	.147	.077
1998	.725	.305	.165	.084
1999	.760	.329	.161	.086
2000	.783	.311	.148	.070
2001	.760	.320	.157	.087
2002	.747	.309	.152	
2003	.717	.317		
2004	.737			

Overall, the closed with indemnity to reported count ratios appear to be declining slightly. It is uncertain whether this decline will result in a decreased ultimate ratio of CWI/reported counts or indicates a slow down in closing claims with indemnity. The following chart summarizes the ratio of closed with indemnity claims to reported claims by report year.

Report Year	Percent of Claims Closing With Indemnity as of			
	12	24	36	48
1997	.102	.213	.278	.321
1998	.098	.228	.298	.343
1999	.084	.212	.282	.321
2000	.078	.201	.267	.310
2001	.081	.195	.270	.308
2002	.082	.191	.269	
2003	.074	.181		
2004	.081			

Exhibit A

HEALTH CARE INDEMNITY, INC.

Forecast of 2005 and 2006 Losses
Professional and General Liability
Summary

Accident Year	Physician or Texas Share of Losses	Modified Expected Unlimited ALAE \$1,000,000	Modified Expected Losses With Pro-Rata ALAE			
			\$1,000,000	\$5,000,000	\$10,000,000	\$25,000,000
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Increased Limit Factors						
2005		1.000	0.963	1.352	1.435	1.481
2006		1.000	0.961	1.360	1.447	1.497
2005						
Triad	7.2%	\$38,583	\$37,142	\$51,177	\$54,148	\$55,808
HCA	3.0%	271,013	260,889	363,493	385,314	397,499
Total		\$309,596	\$298,031	\$414,670	\$439,462	\$453,307
2006						
Triad	0.0%	\$40,126	\$38,580	\$53,540	\$56,790	\$58,636
HCA	2.9%	281,853	270,994	380,414	404,299	417,863
Total		\$321,980	\$309,574	\$433,954	\$461,089	\$476,500

- Notes: (2) Based on Part F, Exhibit A.
(3) Part F, Exhibit A times selected EMF on Exhibits B-F.
(4)-(7) ILF from Part E, Exhibit A. Modified expected losses equal ILF times (3) adjusted so there are no assumed physician losses above \$1.0 million limits.

Exhibit B - Frequency

Accident Year

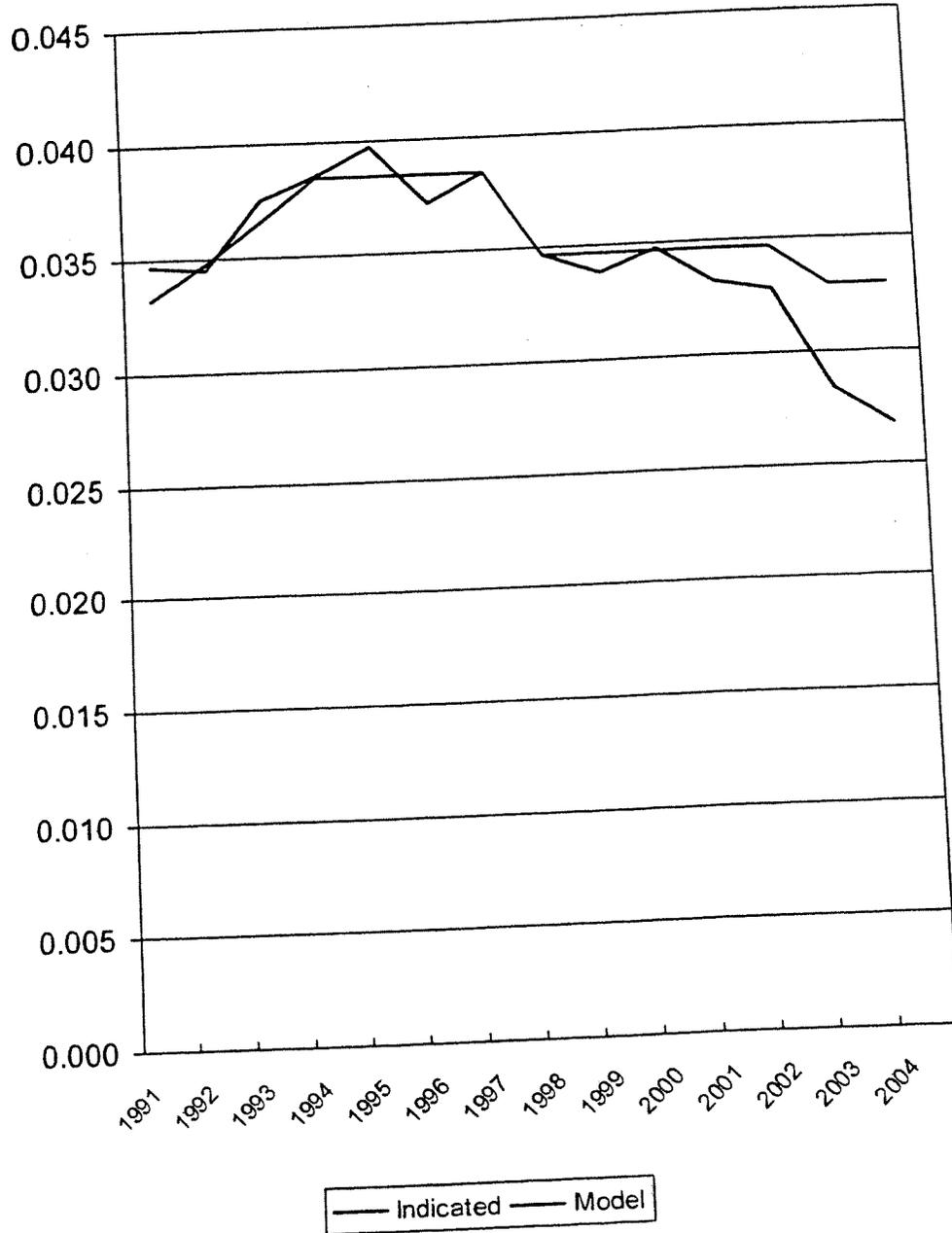


Exhibit C - \$1.0 Million Limits Severity per Reported Claim

Accident Year

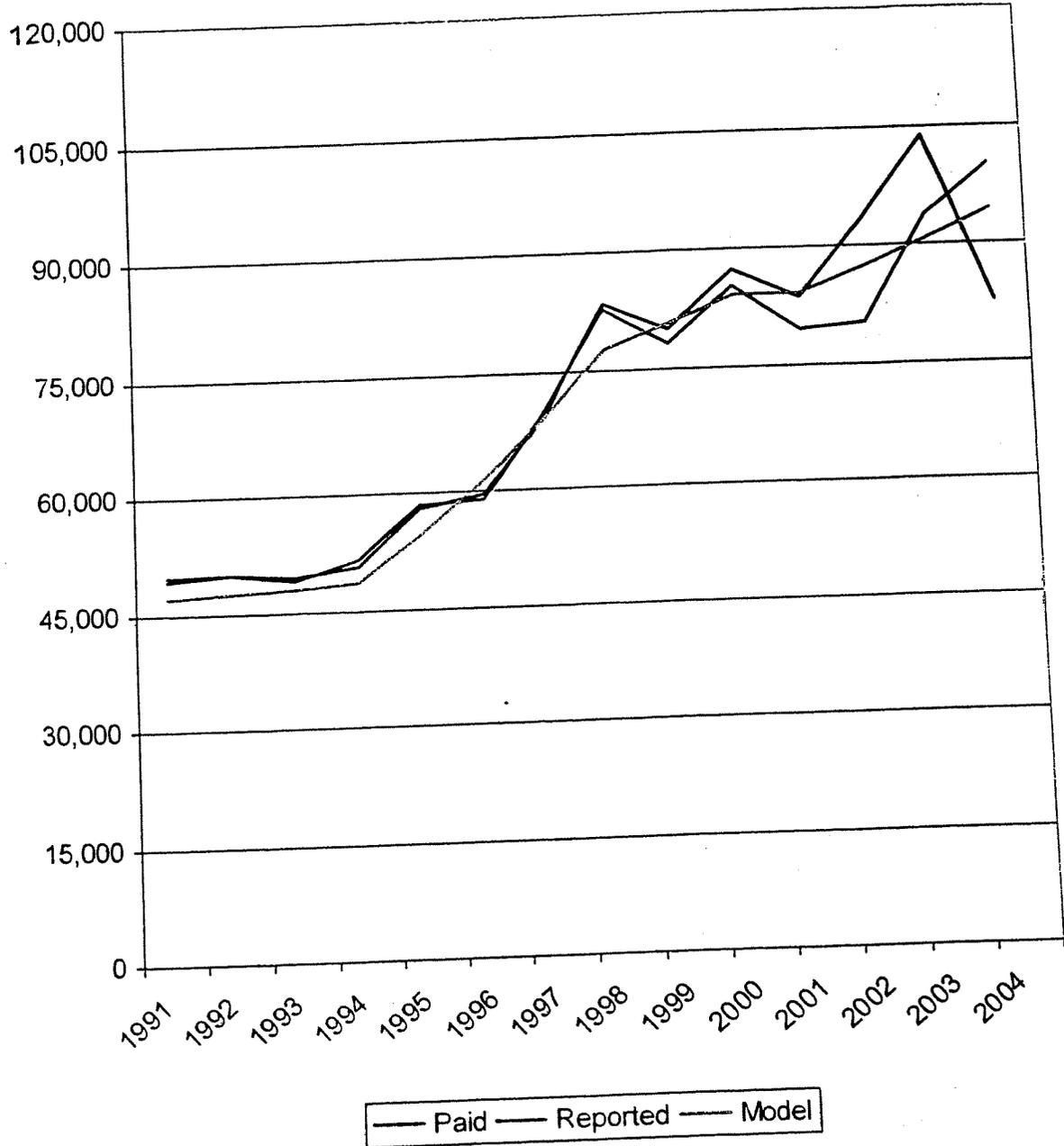


Exhibit D - \$1.0 Million Limits Pure Premium

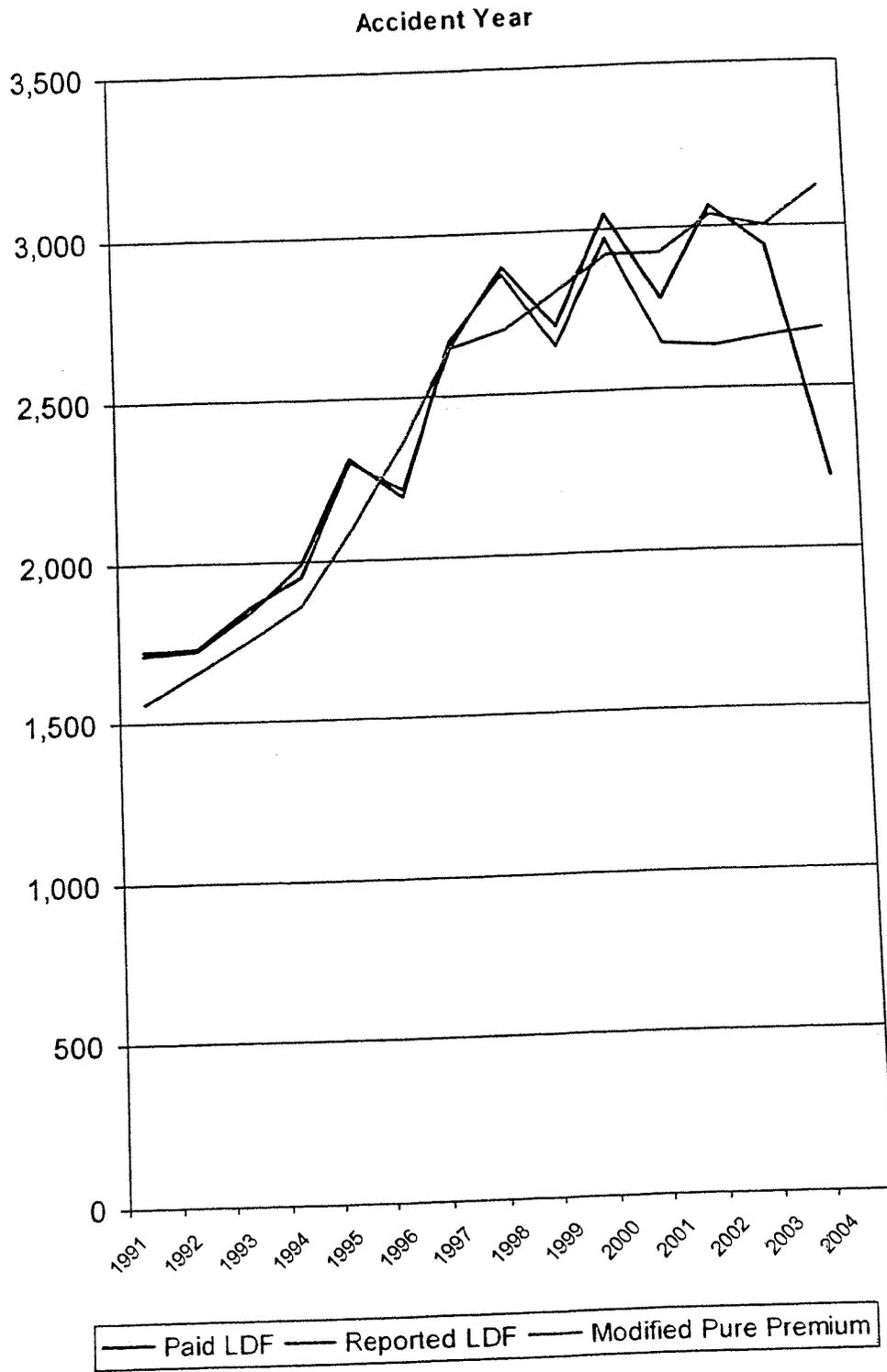


Exhibit E - \$10.0 ILF - Combined

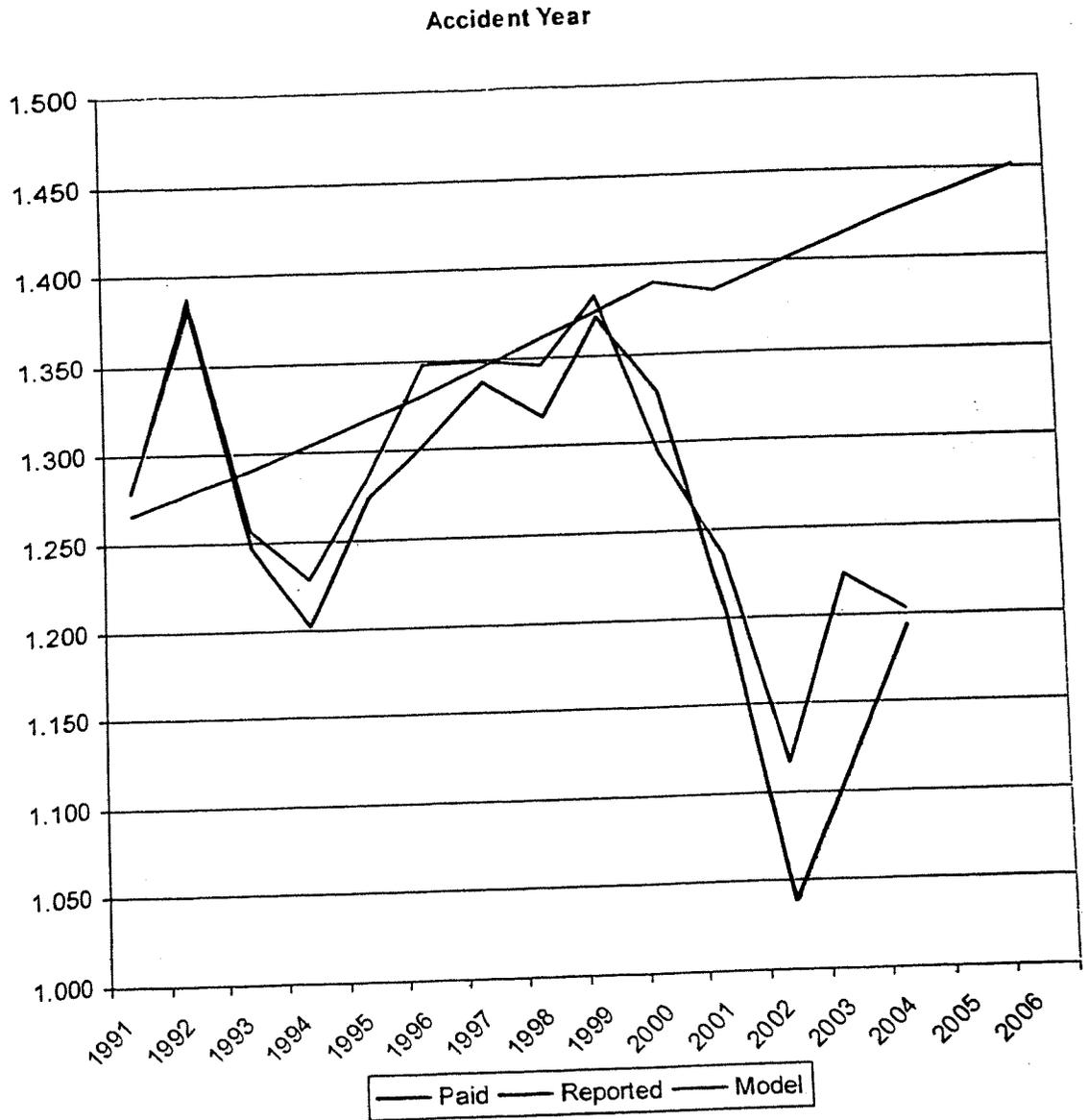


Exhibit F - \$10.0 Million ILF - Paid Basis

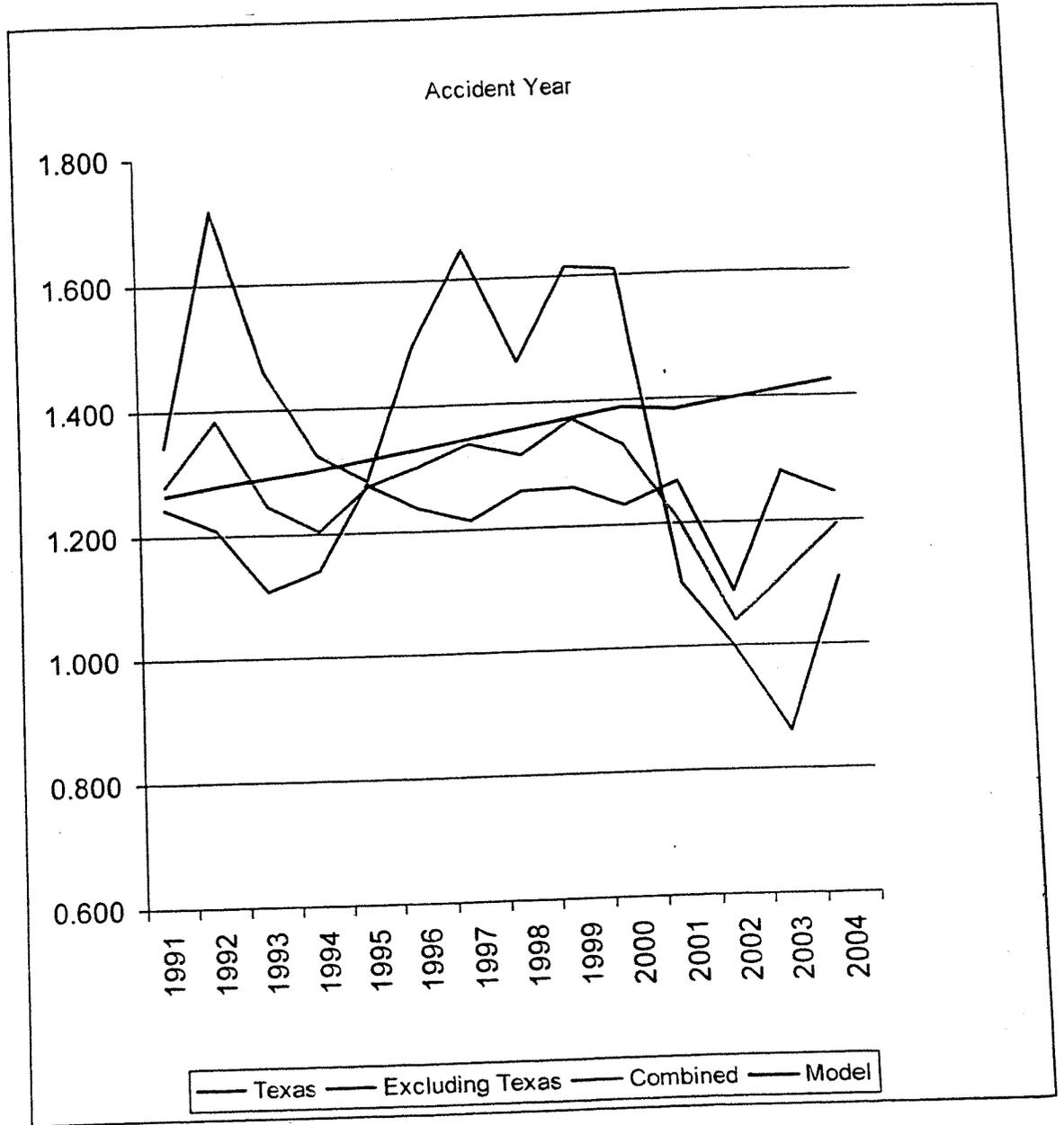
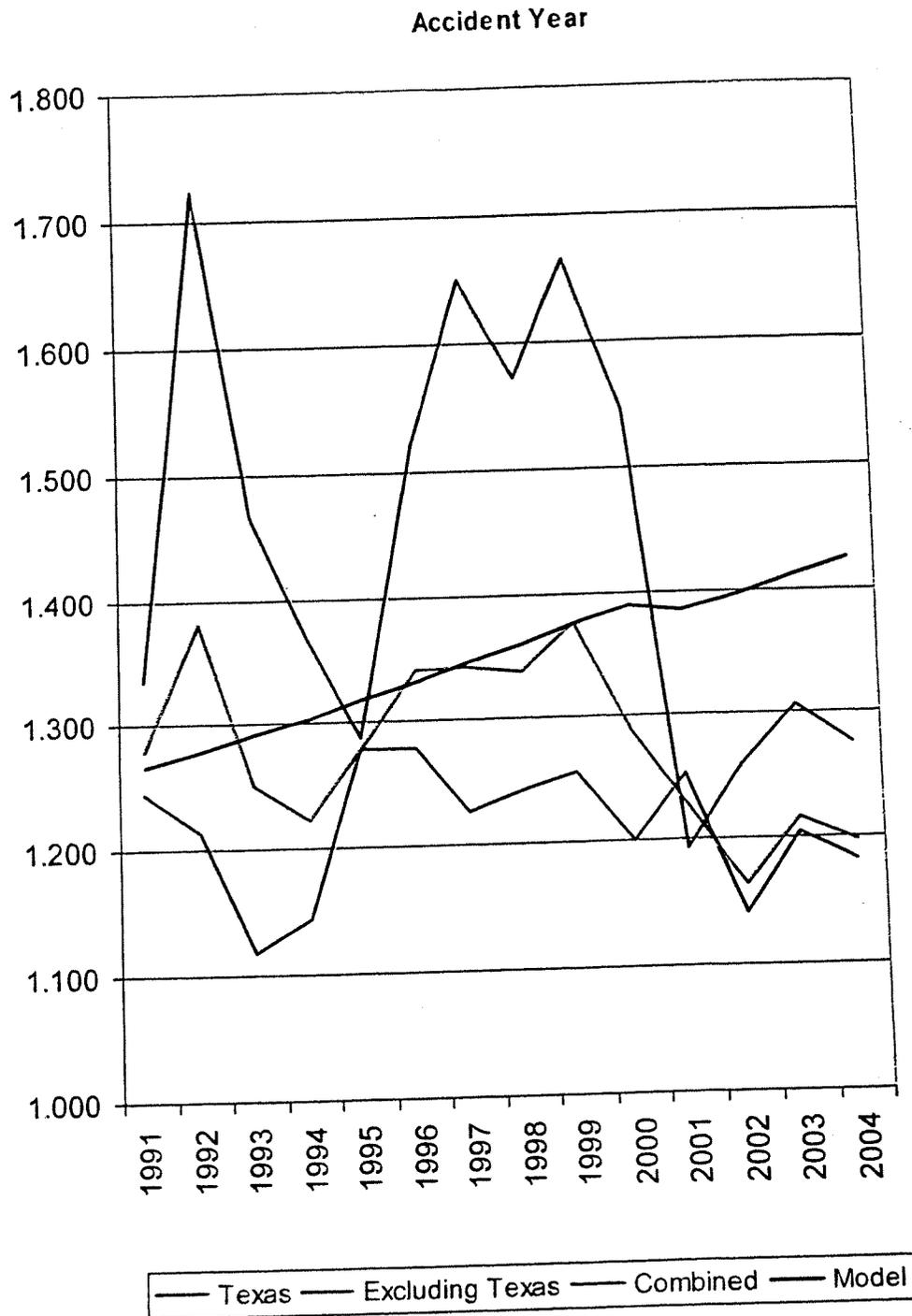


Exhibit G- \$10.0 Million ILF - Reported Basis



SOURCES OF UNCERTAINTY

Loss Reserve Estimates

It must be understood that estimates of loss and loss expense liabilities are subject to large potential errors of estimation, due to the fact that the ultimate disposition of claims incurred prior to the financial statement date, whether reported or not, are subject to the outcome of events that have not yet occurred. Examples of these events include jury decisions, court interpretations and legislative changes; changes in the medical condition of claimants; as well as public attitudes, and social and economic conditions such as inflation. Any estimate of future costs is subject to the inherent limitation on one's ability to predict the aggregate course of future events. It should therefore be expected that the actual emergence of losses and loss expenses will vary, perhaps materially, from any estimate. Thus, no assurance can be given that HCI's actual loss and loss expense liabilities will not ultimately exceed the estimates contained herein. In our judgment, we have employed techniques and assumptions that are appropriate, and the conclusions presented herein are reasonable, given the information currently available.

The uncertainty associated with loss reserve estimates is magnified in the current review due to the following:

- The change in HCI insured exposures
- Changes in claims operations
- Very high limits
- The uncertainties surrounding the Texas tort reform impact.

BACKGROUND

Ownership and Management

HCI was incorporated under the laws of Colorado. HCI is the captive insurance company for HCA – The Healthcare Company.

Underwriting

HCI underwrites medical malpractice coverage for hospitals predominantly on an occurrence basis. HCI assumes a small volume of claims under physician medical malpractice claims-made coverage.

Claim Handling

HCI's claims are handled internally. It is our understanding that the case reserving philosophy has not been explicitly changed for the last several years, although some increase in case reserve levels and average claim costs have been observed.

Reinsurance

HCI's retentions are described in Part A, Exhibit G.

DATA UTILIZATION AND RELIANCES

Data Utilization

In our analysis, we relied on the following information provided by HCI:

- MCA combined professional and general liability paid and reported loss experience as of December 31, 2004, at \$1 million, \$3 million, \$10 million, and \$25 million limits.
- HealthTrust combined professional and general liability paid and reported loss experience as of December 31, 2004, at \$250,000; \$1 million, \$3 million, \$10 million, and \$25 million limits.
- Galen professional and general liability paid and reported losses as of December 31, 2004, at \$1 million, net; and direct limits.
- Columbia combined professional and general liability paid and reported loss experience as of December 31, 2004, at \$250,000; \$1 million, \$3 million, \$5 million, \$10 million, and \$25 million limits.
- HCA combined professional and general liability paid and reported loss experience as of December 31, 2004, at \$250,000; \$1 million, \$3 million, \$10 million, and \$25 million limits.
- Net and direct paid and reported loss experience as of December 31, 2004, for all programs.
- Triad and LifePoint deductible losses.
- Exposure information for all entities.

None of the above data was audited other than for reasonableness. We also relied on Tillinghast's July 2004 report for HCA – The Healthcare Company. The statements in that report regarding data reliance apply equally to this report. Any data referenced, but not included in this report, is available upon request.

We did not review the carried reserve levels for the following programs: HCI claims-made professional liability, HCI workers compensation, HCI commercial reinsurance, a portfolio transfer to HUMANA, Inc., Bennett Physicians, St. Frances tail, Columbia (220791), contract doctors, ALAE reclass, and ULAE. Based on descriptions of these programs, the reported losses of HCI, and the maturity and/or size of these programs, we do not believe these programs or items are material to the overall reserve levels. The ULAE reserve is small because much of the normal ULAE expenses are allocated to individual claims. The paid ULAE amounts in our report exclude the reclass of ULAE that is included in ALAE which is in our loss projections. It is our understanding that none of the ALAE expenses have been reclassified.

Data Reliance

In developing this report, Tillinghast has relied, without audit or independent verification, on historical data and other quantitative and qualitative information supplied by HCI. Tillinghast did, however, review this information for reasonableness and internal consistency. The accuracy of our results is dependent upon the accuracy and completeness of this underlying data; therefore, any material discrepancies discovered in this data by HCI should be reported to us and this report amended accordingly, if warranted.

As explained in the *Analysis* section, we have supplemented this information with judgments drawn from data compiled from industry sources.

ASSUMPTIONS

Loss Development Patterns

Our projection of future claim reporting and payment was based upon the company's historical experience.

We have not anticipated any extraordinary changes to the legal, social, or economic environment which might affect the cost, frequency, or future reporting of claims. In addition, our estimates make no provision for potential future claims arising from loss causes not contained in the historical data except insofar as claims of these types are included in the reported claims and are implicitly analyzed.

Reinsurance

Loss reserves were estimated both gross and net of reinsurance. Based on inquiries made of company management, we have found no evidence that reinsurance may be uncollectible; however, we have made no attempt to evaluate the quality of security provided by HCI's reinsurers other than review of Best ratings, when available. We have assumed that all of the company's reinsurance protection is valid and collectible. Contingent liability may exist for any reinsurance recoveries which may prove to be uncollectible. Should such liabilities materialize, they would be in addition to the net liability estimates contained herein. The premium and claim emergence patterns used in our analysis are based on the assumption that business will proceed essentially "as usual," i.e., no commutation of accounts or material changes in broker or ceding company cash flow.

Underlying Assets

We have not examined the assets underlying HCI's loss reserves and we have formed no opinion as to the validity or value of these assets. We have assumed throughout our analysis that HCI's loss reserves are backed by valid assets which have suitably scheduled maturities and/or adequate liquidity to meet cash flow requirements.

Salvage and Subrogation

The loss reserves contained in this report are on a basis net of anticipated future salvage and subrogation. If an asset for anticipated salvage and subrogation is included in the balance sheet, the liability for loss reserves should be increased by an identical amount.

All figures shown in this report have been rounded to the nearest thousand dollars. Totals and calculations may not agree because of rounding.

Texas Tort Reform

We have not given explicit prospective credit for the impact of the 2003 tort reform legislation in Texas other than reflected in the underlying loss data. Payments and case reserves since September 1, 2003, should reflect the impact of this reform. Because of the lack of historical data, there is considerable uncertainty regarding the actual future impact of this legislation.

ANALYSIS

The attached exhibits are arranged from back to front in the following order:

- Appendices - Development Exhibits
- Part F - Expected Losses
- Part E - Increased Limits Factors Analysis
- Part D - Trend Analysis
- Part C - Forecast of 2005 and 2006 Losses
- Part B - Galen \$1,000,000 Limits Projections
- Part A - HCI Projections

Each section is described in the analysis section following the same order.

Appendices

The Appendices provide development data on a combined basis. In prior reports development data were based on Galen only experience.

Appendix E contains accident year data for combined entities. These include the support for the increased limits factor projections.

Appendix D contains the diagnostic data on a report year basis. Claim count ratios and average paid and reported losses are shown.

Appendix C contains the report year development data. Development factors are chosen and used to project the accident year by report year paid and reported losses to ultimate. Overall, the report year paid and reported projections are fairly close.

Appendix B contains the development of the emergence patterns. These selected emergence patterns combined with the report year development patterns yield the accident year development patterns in Appendix A.

Expected Losses

Part F contains the development of expected losses at \$1.0 million limits for all years. RIB's prior to 1995 were developed based on factors applied to the prior bed equivalents which were based on just beds and outpatient visits. Expected losses are calculated for Triad, LifePoint, HCA, and Combined for 1996 and subsequent. For prior years expected losses are developed for Galen (HCI going forward) and Combined. The expected losses are divided by the Florida, Territory 2 hospital pure premium to obtain Florida, Territory 2 equivalent exposures.

Increased Limits Factors Analysis

Part E contains the indicated increased limits factor analysis. Exhibit D contains the \$5.0 million indication based on paid and reported ILF's and a comparison with industry is shown. Exhibit C contains the \$10.0 million limit ILF's projections. On Exhibit F we compared the combined \$10.0 million limit ILF paid indication with the Texas only and excluding Texas indications. Exhibit E contains the corresponding reported indications. Exhibit B contains the \$25 million limit paid and reported results to date which are not developed because of the limited number of claims above \$10.0 million limits. On Exhibit A the pro-rata ALAE ILF's are projected.

Trend Selections

Part D contains a summary of the selected \$1.0 million limit trend rates based on combined data. The indicated and selected frequency trends are calculated on Exhibit D, while the severity indications and selections are calculated on Exhibit C. Exhibit B contains the calculation of indicated and selected EMF's. The selected EMF is used to project expected calendar year paid and reported losses by accident year on Exhibits F and G, respectively. The results are summarized on Exhibit F. Exhibit A contains a summary of the indicated and selected pure premium trend.

Forecast of 2005 and 2006 Losses

Indicated ultimate losses are calculated by insured for Combined, HCA, Triad, and LifePoint on Exhibits C through F, respectively. Indicated paid and reported EMF's are calculated on

Sheet 3. The EMF's are based on the individual program's selected development factors that are calculated on Exhibits G through J. Selected EMF's are used to project paid and reported indicated ultimate losses on Sheet 2. The indicated ultimate losses are summarized on Sheet 1 and selected ultimate losses are chosen and the physician share of business calculated on Sheet 1. The selected ultimate losses by insured are shown on Exhibit B and compared to the combined ultimates as well as the Galen ultimates for Part B. The 2005 and 2006 projections are contained on Exhibit A.

Galen \$1,000,000 Limit Projections

The \$1.0 million limit projections are contained on Part B. The EMF's are calculated and selected on Exhibit D. The paid BF ultimates are on Exhibit C and reported BF ultimates on Exhibit B. The selected \$1.0 million ultimate losses are combined on Exhibit A.

HCI Projections

Part A, Exhibit E contains the projection of the deductibles retained by LifePoint and Triad.

The miscellaneous projections are contained on Part A, Exhibit D. The pre-merger claims-made projections are contained on Sheet 4. The HCA 1976-1985 occurrence losses and Columbia 1991-1993 claims-made losses assumed by HCI are shown on Sheet 4. Because of the maturity of these programs we relied on reported losses. Sheet 2 contains the related tail liability projections. These reflect the complete tail exposure HCI covered as the various systems were merged in with HCA. Sheet 1 contains the claims-made physician programs projected losses.

Galen projections are contained on Exhibit C. Galen accident year projections include Columbia and HCA occurrences after January 1, 1993, HealthTrust after April 24, 1995, and MCA after September 30, 1994. Sheet 3 contains the direct indications, Sheet 2 contains the net indications and Sheet 1 contains the \$5.0 million and \$10.0 million limit projections needed for the reinsurance recalculations on Exhibit B. Expected excess losses are calculated on the "d" sheets while paid and reported BF projections on an excess of \$1.0 million limits basis are shown on Sheets "c" and "b", respectively. The Sheet "a" contains the selected ultimate losses. The Galen experience excess of \$1.0 million limits has been favorable. The

Louisiana projections for years that are not covered by H.C.I. are contained on Sheet 4. These losses are removed from the HCI projections. The 2002 net and direct ultimates are calculated on Sheet 5, the 2003 are on Sheet 6, and 2004 are on Sheet 7.

Exhibit B contains the projections of the retained losses under the reinsurance contracts. Sheet 1 contains the projection of the retained in 2001 on the excess program. Sheet 2 contains the projections for the 1999 and 2000 excess treaties and losses are not anticipated to exceed the aggregate limit. Sheet 3 contains the excess treaty that covers the 1997, 1998, and 1999 policy periods. Sheet 4 contains the corresponding projections for the 1994, 1995 and 1996 periods. Finally, Sheet 5 contains the actual losses retained under the excess of loss treaties.

Part A, Exhibit A summarizes the indications, with a range around the indications. Sheet 4 contains a summary of the direct medical malpractice occurrence ultimate losses, and Sheet 3 shows ultimates on a net basis. These ultimates are combined with the other lines of business and compared with prior carried ultimates; then, selected ultimate losses are chosen on a net (Sheet 1) and direct basis (Sheet 2). Actual paid losses are subtracted and a factor of .95 to 1.10 is applied to obtain a range of reserves.

2006 Rate change percentage by classification

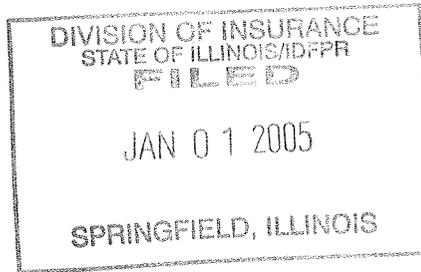
State	Territory	Territory Description	Class	2006 Rates	% Change	2005 Rates
IL	1	Remainder of State	1	14,550.18	20.00%	12,125.15
IL	1	Remainder of State	2	20,370.64	20.00%	16,975.53
IL	1	Remainder of State	3	29,100.36	20.00%	24,250.30
IL	1	Remainder of State	4	33,642.12	6.71%	31,526.68
IL	1	Remainder of State	5	45,419.64	6.47%	42,659.67
IL	1	Remainder of State	6	66,138.94	20.00%	55,115.78
IL	1	Remainder of State	7	65,052.81	7.60%	60,458.24
IL	1	Remainder of State	8	87,761.28	20.00%	73,134.40
IL	2	Cook County	1	22,045.00	20.00%	18,370.83
IL	2	Cook County	2	30,863.88	20.00%	25,719.90
IL	2	Cook County	3	44,092.20	20.00%	36,743.50
IL	2	Cook County	4	57,318.30	20.00%	47,765.25
IL	2	Cook County	5	68,253.71	20.00%	56,878.09
IL	2	Cook County	6	88,183.49	20.00%	73,486.24
IL	2	Cook County	7	109,347.04	20.00%	91,122.53
IL	2	Cook County	8	132,276.11	20.00%	110,230.09



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

October 4, 2004

Mr. John Gatlin
Illinois Insurance Department
320 West Washington Street
Springfield, IL 62767



RE: Health Care Indemnity, Inc.
Rate and Rule Filing
Company Identification HCI2005

Dear Mr. Gatlin:

Enclosed for your review are the proposed 2005 Hospital Professional and General Liability and Physician and Surgeon Professional Liability rates and rules. Included in this filing are the following:

Filing Memorandum
Actuarial Opinion
Professional and General Liability Rates and Rules

I have enclosed a duplicate copy of this letter and a self-addressed envelope for your stamp and return to my attention.

If you should have any questions, or require additional information, please do not hesitate to call me at (615) 344-1487. For additional convenience, my facsimile number is (877) 766-7099 and my e-mail address is Teresa.Stinson@hcahealthcare.com if needed.

Regards,

Teresa L. Stinson
Senior Compliance Analyst

Enclosure

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 1/1/2005.

(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1. Automobile Liability Private Passenger Commercial		
2. Automobile Physical Damage Private Passenger Commercial		
3. Liability Other Than Auto	0	-1.6
4. Burglary and Theft		
5. Glass		
6. Fidelity		
7. Surety		
8. Boiler and Machinery		
9. Fire		
10. Extended Coverage		
11. Inland Marine		
12. Homeowners		
13. Commercial Multi-Peril		
14. Crop Hail		
15. Other <i>medicalmalpractice</i>		
Life of Insurance		

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

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

*Adjusted to reflect all prior rate changes.

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

Health Care Indemnity Inc.

Name of Company

Teresa Stinson, Sr. Compliance Analyst

Official - Title





Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

Rate and Rule Filing Memorandum

Date: October 4, 2004

To: Mr. John Gatin
Illinois Department of Insurance

From: Teresa L. Stinson
Senior Compliance Analyst

RE: Health Care Indemnity, Inc.
NAIC Company Number 35904
Company Identification: HCI2005

The base rate \$1,000,000 layer decrease is -2.9%. The 1st layer, \$4,000,000 in excess of \$1,000,000, indicates a decrease of -0.3%. The 2nd layer, \$5,000,000 in excess of \$5,000,000, indicates an increase of 2.1%. The Physician and Surgeon rates reflect various changes by classification. Currently there is no business written in the state but want to stay within competitive rate range in the event new business is written.

The rules amendments include page 10 is amended to add ER physician assistant rated based on ER classification base rate, page 12 is amended to add Hospitalist in Classification 3 description and Page 15 adds 2M/6M increase limit factor.

This filing is proposed to replace existing filed rates and rules effective January 1, 2005 or as soon as possible by receipt of this filing.



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

September 25, 2003

Mr. John Gatlin
Illinois Insurance Department
320 West Washington Street
Springfield, IL 62767

RE: Health Care Indemnity, Inc.
Rate and Rule Filing
Company Identification IL2004-01R

Dear Mr. Gatlin:

Enclosed for your review are the proposed 2003 Hospital Professional and General Liability and Physician and Surgeon Professional Liability rates and rules. Included in this filing are the following:

Filing Memorandum
Actuarial Opinion
Professional and General Liability Rates (informational only) and Rules

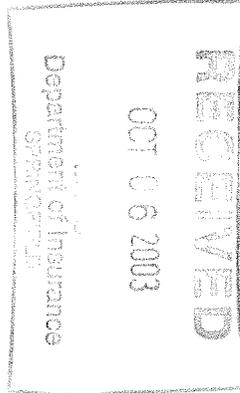
I have enclosed a duplicate copy of this letter and a self-addressed envelope for your stamp and return to my attention.

If you should have any questions, or require additional information, please do not hesitate to call me at (615) 344-1487. For additional convenience, my facsimile number is (877) 766-7099 and my e-mail address is Teresa.Stinson@hcahealthcare.com if needed.

Regards,

Teresa L. Stinson
Senior Compliance Analyst

Enclosure





Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

Rate and Rule Filing Memorandum

Date: September 25, 2003

To: Mr. John Gatin
Illinois Department of Insurance

From: Teresa L. Stinson
Senior Compliance Analyst

RE: Health Care Indemnity, Inc.
NAIC Company Number 35904
Company Identification:IL2004-01R

Attached is the proposed additional rules page 16 for 2004. There is no change to the currently filed rates.

Rule page 16 has been added to Physician and Surgeon Professional Liability section reflecting Claims Made Step Factors, Optional Extended Reporting Period and Entity Coverage.

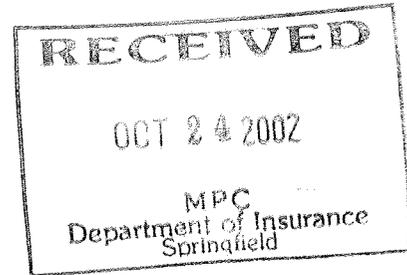
This filing is proposed to replace existing filed rules effective January 1, 2004 or as soon as possible by receipt of this filing.



Health Care Indemnity, Inc.
 One Park Plaza
 P.O. Box 555
 Nashville, TN 37202-0555

October 21, 2002

Mr. John Gatlin
 Illinois Insurance Department
 320 West Washington Street
 Springfield, IL 62767



RE: Health Care Indemnity, Inc.
 Rate and Rule Filing
 Company Identification IL2003-01R

Dear Mr. Gatlin:

Enclosed for your review are the proposed 2003 Hospital Professional and General Liability and Physician and Surgeon Professional Liability rates and rules. Included in this filing are the following:

- Form RF-3
- Filing Memorandum
- Actuarial Opinion
- Professional and General Liability Rates and Rules
- Application
- Company Profile



I have enclosed a duplicate copy of this letter and a self-addressed envelope for your stamp and return to my attention.

If you should have any questions, or require additional information, please do not hesitate to call me at (615) 344-1487. For additional convenience, my facsimile number is (877) 766-7099 and my e-mail address is Teresa.Stinson@hcahealthcare.com, if needed.

Regards,

Teresa L. Stinson
 Senior Compliance Analyst

Enclosure

Wudy Rose Boucher
 CASUALTY ACTUARY
 ILLINOIS DEPT. OF INSURANCE
 RECEIVED/APPROVED
 10/25/2002



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

Rate and Rule Filing Memorandum

Date: October 21, 2002

To: Mr. John Gatlin
Illinois Department of Insurance

From: Teresa L. Stinson
Senior Compliance Analyst

RE: Health Care Indemnity, Inc.
NAIC Company Number 35904
Company Identification: IL2003-01R

Attached are the proposed rules and rates for 2003.

There is no change to the rates.

The rules pages have been amended to reflect the addition of the proposed contracted physician and surgeons/groups sections. The relativity factors involved in the RIB calculation have been updated. Copies of the rules with highlight to clarify changes are attached along with a final draft of the rules pages 1-15.

An updated physician and surgeon application and company profile is also enclosed for reference.

This filing is proposed to replace existing filed rates and rules effective January 1, 2003 or as soon as possible by receipt of this filing.

Teresa L. Stinson, Sr. Compliance Analyst

<General Materials (GM) - References, Annotations, or Tables>

50 ILAC § 754.EXH. A

50 IL ADC 754 EXH. A
END OF DOCUMENT



HEALTH CARE INDEMNITY, INC.
Physician & Surgeon Professional Liability Application

GENERAL INFORMATION

- 1. Full last name of the practitioner
2. First name and middle initial Suffix
3. Address: Mailing Premises (if different)
4. Social Security Number 5. Date of Birth
6. Contact Name 7. Telephone No.
8. Facility Name Facility COID (If Applicable)
9. How is practice organized? Corporation Partnership Sole Proprietor Other
10. Legal name under which you practice

PROFESSIONAL INFORMATION

- 11. Degree 12. Medical License Number State
(Include all states in which practitioner holds a license)
13. Is this practitioner Employed Contracted -Submit five year loss history from previous carrier. If not submitted with application, review will be delayed until received.
14. Practitioner specialty? Board Certified? Board Eligible? Date Certified?
15. Is this a resident (including interns and fellows)?

UNDERWRITING INFORMATION

- 16. Enter start date or date medical services will begin
17. Limit of Liability requested:

Table with 6 columns and 2 rows of liability limits: 100,000/300,000, 200,000/600,000, 250,000/750,000, 1,000,000/3,000,000, 2,000,000/4,000,000



HEALTH CARE INDEMNITY, INC.
Physician & Surgeon Professional Liability Application

18. Average number of hours to be worked? _____ (e.g. 40 hours per week = 1.0 FTE's ;
 20 hours per week divided by 40 = .5 FTE's; 40 hours per month divided by 160 = .25 FTE's)

19. Will this practitioner perform Non-Invasive Invasive Surgical procedures.

20. Is prior acts coverage requested (employed physicians only)? Yes No

Prior limit of liability? _____ Retroactive Date _____

21. Present and Prior Providers of Insurance Coverage (for previous five years)

Insurance Company Name	Year

22. Explain all "yes" responses to the following. Provide claims history for items a and b.:

	YES	NO
a. Any claims pending or paid by insurer (past or present)?		
b. Any suits pending?		
c. Have you participated in continuing education in the past 12 months?		
d. Do you have established risk management practices that are followed?		
e. Any disciplinary action by hospital, associated facility, board?		
f. Any disciplinary action in regard to license?		
g. Ever had a professional liability application declined, cancelled, issued on special terms or non-renewed?		
h. Has your license to prescribe narcotics ever been limited, suspended, revoked or restricted?		
i. Have you ever been convicted of a crime (other than motor vehicle citation)?		
j. Do you presently have, or have you ever had a chronic illness or impairment, including but not limited to alcohol or drug use?		

23. List of all associated hospitals that should receive a certificate of insurance.

Comments/Other:

Completion of this application does not extend coverage.



HEALTH CARE INDEMNITY, INC.
Physician & Surgeon Professional Liability Application

I warrant the truth of any statements and answers included in the application and have not intentionally withheld any information that could influence the judgment of the company considering this application for professional liability insurance. I understand material misrepresentation could cause my insurance coverage to be cancelled or non-renewed.

I understand that the policy being applied for does not cover the liability of others that I may have assumed under any contract or agreement.

I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil claims. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the applicable division of insurance within the department of regulatory agencies.

Signature

Date of Completion

HEALTH CARE INDEMNITY, INC.

Company Profile

Company History

Health Care Indemnity, Inc. ("HCI") was incorporated under the captive insurance laws of Colorado on August 5, 1976. Initially it was a wholly owned subsidiary of Humana Inc., a leading health care services company principally engaged in the business of operating hospitals and health plans. HCI began business on August 31, 1976 writing professional and general liability coverage for its parent and affiliates. HCI's certificate of authority was converted to that of a multiple line insurance company under the laws of Colorado on October 12, 1982.

HCI has experienced numerous organizational changes in recent years. In March 1993, Humana Inc., spun off its hospital business into Galen Health Care, Inc., and retained its managed care business. As part of that reorganization, HCI became a wholly owned subsidiary of Galen. In September 1993, Galen merged with Columbia Hospital Corporation, a smaller hospital operator. A few months later, in February 1994, Columbia merged with Hospital Corporation of America (HCA), another leading operator of hospitals. The resulting entity was renamed Columbia/HCA Healthcare Corporation, which at the time operated nearly 200 hospitals. Through subsequent acquisitions and a 1995 merger with Healthtrust, Inc., yet another leading hospital operator, Columbia/HCA became by 1997 the nation's largest healthcare company with nearly 350 hospitals, over 100 surgery centers and other businesses.

As a result of a government investigation initiated in 1997 alleging Medicare fraud, Columbia/HCA's Board replaced many of its senior managers. The new management team initiated a corporate restructuring, which by 1999 had resulted in the sale of non-core businesses (more than 70 hospitals, virtually all of its home health agencies and nearly 30 surgery centers). In addition, on May 11, 1999, Columbia/HCA spun off two separate, independent businesses, Triad Hospitals, Inc. and LifePoint Hospitals, Inc., which operate smaller, more rural hospitals. In May 2000, the parent company's name was changed from Columbia/HCA Healthcare Corporation to HCA - The Healthcare Company ("HCA"). In July, 2001, the company name was subsequently changed to HCA Inc. It is still the nation's largest healthcare company operating nearly 181 hospitals and nearly 80 surgery centers.

Throughout all of these changes, HCI provided professional and general liability insurance for its parent and its affiliates.

On December 31, 1994, HCI absorbed by merger the Parthenon Insurance Company, Nashville, TN. Parthenon had been a captive insurer that underwrote professional liability insurance for affiliates of HCA.

Between 1983 and 1999, HCI became licensed to write as an admitted insurer in Kentucky, Illinois, Florida, Kansas, Indiana, Texas, Nevada, Tennessee and Ohio. In 2000, additional admitted licenses were obtained in Louisiana, Oklahoma and South Carolina.

All of the outstanding stock in HCI is currently held by Galen Holdco, LLC, the sole member of which is Healthtrust, Inc. - The Hospital Company (a wholly owned subsidiary of HCA). HCI has only one affiliated insurance company— Parthenon Insurance Company, Limited, a Bermuda captive insurer.



Willis

Overview and Description of Operations

Business review

HCI writes the primary and first excess layers of professional and general liability insurance for hospitals, surgery centers and employed physicians that are affiliated with its parent company, HCA. Since their May 1999 spin off, HCI also has provided similar coverage to LifePoint Hospitals, Inc. and Triad Hospitals, Inc. The policies issued are on the occurrence form with rates determined by independent actuaries, subject to the approval, when necessary, of the various insurance departments in the states where HCI is licensed.

Administration

HCI's headquarters is located in Nashville, TN. All financial and accounting services, risk management, underwriting and claims administration is performed by internal staff. There are no regional or divisional offices. Tillinghast performs evaluations of reserves. HCA provides HCI with certain management, data processing and administrative services in return for a management fee. Records are maintained on site.

There are three officers and directors of HCI. James D. Hinton is President and a Director. He has been President since 1994 and a Director since 1991. From 1988 to 1994 he was a Vice President and in charge of HCI operations. Mr. Hinton holds an MBA and is a Certified Public Accountant. David G. Anderson is Vice-President, Treasurer and a Director. He has been a Vice-President and Treasurer for nearly 20 years and has been a Director since 1999. Mr. Anderson is also Sr. Vice President and Treasurer of HCA. John M. Franck II is a Vice-President, Secretary and a Director. He has served in those capacities since 1997. Mr. Franck also serves as Vice-President and Secretary of HCA.

HCI's senior management team includes Mr. Hinton and five other experienced insurance professionals. Joseph S. Haase is Assistant Vice President of Risk Management and has served as both Assistant Vice President of Insurance and Director of Claims. He has been with HCI since 1983. Kenneth K. Roth has served as Assistant Vice President of Finance since 1996. He is a Certified Public Accountant with nearly 12 years of insurance accounting experience. Lorraine Gerelick has been Assistant Vice President of Claims since 1994. She has over 20 years of experience in managing claims for healthcare entities and professional liability insurers. Shirley Fuller Cooper is Director of Insurance and is responsible for HCA's insurance placements along with policy service, regulatory compliance and reinsurance. Shirley has more than 15 years of insurance experience and 4 years with HCI. Tim Portale is the Director of Environmental and Employee Safety Department. He has been with HCI for 7 years and previously served as a Director in the Risk Management Department.

Marketing and Underwriting

Due to the predominately captive nature of HCI, it historically has done no marketing. The Company does not utilize management agreements with general agents or underwriters. Premium rates are calculated by using actuarial projected losses appropriately discounted in recognition of the payment lag associated with occurrence policies. Expense loads are lower than customary for the industry because of the very low cost structure associate with HCI's business.

Claims Administration

The internal staff of 22 claims professionals, all located in Nashville, TN, oversees all claims. Either contracted vendors with extensive professional liability experience or personnel at the insured location perform investigations of all claims. Local defense counsel with demonstrated expertise in medical



Willis

liability matters are assigned to all litigated claims. The claims staff in Nashville controls all reserve setting, settlement authority and payments.

Risk Management

With an experienced staff of healthcare risk management consultants, HCI offers comprehensive educational programs as well as proactive loss control solutions to its insureds. The group makes extensive use of one of the nations largest acute care hospital claims databases to design its educational programs and risk reduction initiatives to address those healthcare liability issues facing its insureds.

Investment Management

Under the direction of its Treasurer, HCI's investments are managed by both external and internal portfolio managers. At June 30, 2002, six external portfolio managers were employed to assist with the management the of equity securities: MacKay Shields, Harris Associates, Gardner Lewis, Trust Company of the West, Lathrop Investment Management and Thomson Horstman & Bryant. External portfolio managers Fleet Bank (Stein Roe) and Deutsche Bank (Scudder) were responsible for the majority of the fixed income portfolio. Each manager operates under established written investment guidelines. Portfolios are monitored on a monthly basis for comparison to performance benchmarks established by the Treasurer.

At June 30, 2002, approximately 64% of its assets are invested in a diversified portfolio of investment-grade municipal, corporate and government fixed income securities with a duration designed to match the timing of expected claim payments; 30% of its invested assets in a diversified portfolio of exchange-traded equity securities; 3% of assets were invested in other types of investments that included limited partnerships and other investments with a stated goal of producing a long-term, consistently high rate of return with low correlation to stocks and bonds; 3% of it's invested assets were held in short-term securities for liquidity purposes.

Reinsurance

HCI writes a maximum \$25 million limit of liability. Its net retention has fluctuated from year to year. HCI currently retains the first \$1 million each claim. The following reinsurance treaties are in effect for the 2002 accident year:

- TRC reinsures 60% of the \$4 million excess of \$1 million layer (Triad placement)
- ERC reinsures 100% of the \$15 million excess of \$10 million layer.

Colorado approves all companies as reinsurers.

Future Direction

HCI does not plan to diversify into coverage beyond the current offerings of professional and general liability, except incidental surety bonds or to market those products beyond the current client list- HCA, Triad and LifePoint. Growth opportunities will derive from the normal expansion of those businesses.

September 2002



Willis

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

I. GENERAL RULES

A) Eligibility

1) Hospital - Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

2) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses with the exception of an additional premium computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

3) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures

- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.
- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91
163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	+10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	+10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	+7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	+5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	+5%
• Certificates of insurance are obtained verifying vendor liability coverage.	+5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	+3%
• Written job descriptions are established for all positions.	+3%
• Each facility has a designated, full-time safety director or safety officer.	+3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	+10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	+10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	+10%
• The quality management and risk management programs are integrated.	+7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	+5%
• Continuing risk management education requirements routinely fulfilled.	+5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	+3%
• Risk management issues are addressed in new employee orientation.	+3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	+3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	+5%
• No citations or penalties by a regulatory agency within the past 3 years.	+5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	+10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	+7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	+7%
• Emergency department physicians are board certified.	+5%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

A) Applicability

Physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

1) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

2) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

C) Definitions

Physician, surgeon and allied health professional

- Contract physician Physician under contract with a facility to provide professional medical service to or on behalf of such institution

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- Employed physician Physician providing health care services, including osteopathic physician and resident, who is considered an employee of an insured business
- Full-time employee Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE)
- Part-time employee Person employed by the facility less than 40 hours per week expressed in percentage of FTE
- Resident Postgraduate medical student (including intern and fellow)

D) Basis of premium

- Employed physician, surgeon and resident – Refer to C) Definitions above. The unit of exposure is per FTE.
 - Allied health professional – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
 - Part-time physician and surgeon – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = 75% subject to note below) Multiply the result by the class premium for each specialty
 - Contract physician, surgeon and resident – Refer to C) Definitions above. The unit of exposure is per FTE.
- Note: No FTE lower than 25%. FTE equal to 25% or less use 25%. FTE between 25% and 80% use 50%. FTE 80% or higher use 100%. More than 240 hours or 6 FTE use a surcharge of 25%

E) Calculation of premium

1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.

2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Nurse Practitioner	Charge 25% of the class 1 rate
Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY – NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE - NI

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 1 Continued

- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE – NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE – INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE – INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS – INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE – INV

CLASS 3

- FAMILY PRACTICE – SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE - SRG

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM CREDIT/DEBIT
Loss experience	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

See Addendum B

J) Physician prior acts coverage

1) Applicability

Physician's prior acts coverage may be provided only to physicians employed by insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.

2) Coverage

Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 2.1 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

4) Increased Limits

As stated under J) 2) Physician prior acts coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:

Limits of Liability	Decrease/Increased Limits Factor
\$100,000/300,000	0.46
\$200,000/600,000	0.60
\$250,000/750,000	0.61
\$1/3 million	1.00
\$2/4 million	1.24
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50

5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.



MADISON CONSULTING GROUP

Actuaries • Property/Casualty Consulting Services

October 3, 2002

Ms. Maggie Hayden Kuhlman
Director of Financial Analysis
HCA, Inc.
One Park Plaza
P. O. Box 550
Nashville, Tennessee 37202-0550

Dear Ms. Kuhlman:

At your request, we have prepared this letter setting forth a description of the procedures underlying the development of rate level indications for Healthcare Indemnity, Inc. (HCI). This overall rate level determination forms the basis of the complete rate structure underlying HCI's 2003 medical professional liability rates.

Distribution and Use

It is our understanding that it is intended for this letter to be included as part of a rate filing to be provided to the Illinois Department of Insurance. Any other use or further distribution is not permitted without our prior consent.

Conditions and Limitations

Madison Consulting Group, Inc. has developed and assisted in implementing an experience based budget system for HCA, Inc. (HCA) and some of its predecessor companies for a number of years. The first step in the process involves conducting a detailed analysis of indicated ultimate losses and allocated loss adjustment expenses (ALAE) for each historical accident year, based on an examination of actual experience of the program in total. As a part of that study, projections are made of ultimate losses and ALAE for the prospective accident year (in this instance, 2003). This projection, along with estimated exposure units, is used to develop the average loss cost, or pure premium, needed to support HCA's program for the prospective period. This pure premium and other rating variables are used to develop the rate structure set forth by HCI.

As is noted in our studies, it must be recognized that the development of medical professional liability rates and budgets involves the projection of future contingent events. Therefore, no guarantee can be made that the projected results will prove to be adequate or not excessive. However, in developing the indications, we utilize methods and assumptions that are in accord with accepted actuarial principles, and we believe the conclusions reached are reasonable.

200 North Second Street • Madison, Georgia 30650

706-342-7750

Fax: 706-342-7775

Description of Rate Level Determination

Due to its size and statistical reliability, the development of HCI's rate structure begins with a traditional ultimate loss cost study based on an examination of actual historical experience of HCI's parent. The details of that analysis are set forth in a proprietary report provided to HCA. The following discussion describes how the results of that analysis are used to develop rate level indications for the 2003 accident year.

Projected Ultimate Losses and ALAE for Accident Year 2003

HCA has accumulated a significant amount of experience on historical accident years for its medical professional liability program. This information is used in a comprehensive actuarial analysis to determine ultimate losses and ALAE by accident year for the HCA program. Various actuarial projection techniques are used to project ultimate losses and ALAE and to test various characteristics of the program (e.g., trend assumptions, underlying increased limits relationships, etc.). These indications are used to project ultimate losses and ALAE for the prospective accident year. Projections reflect assumed trends in underlying loss costs and expected changes in underlying exposure.

Development of \$1,000,000 Limits Pure Premium for Accident Year 2003

Management combines the ultimate losses and ALAE for accident year 2003 described above with other actuarial indications and projected exposure units for 2003 to produce the underlying average loss cost, or pure premium. Note that in this step, the pure premium is developed at HCI's basic limit of \$1,000,000.

Development of Accident Year 2003 Rates

The basic limit pure premium is further combined by management with other rating variables to develop rates for the 2003 accident year. These rating variables are included according to a traditional ratemaking procedure and reflect the following considerations:

- prospective investment income;
- territorial differentials;
- operational expenses, including premium taxes and profit and contingencies; and
- increased limits relationships for excess layers.

Ms. Maggie Hayden Kuhlman
October 3, 2002
Page 3

Indicated Rate Change

A comparison is made between the rates developed for the 2003 accident year and rates underlying HCI's current rate structure. The resulting rate change is indicated for \$1,000,000 basic limits; \$4,000,000 excess of \$1,000,000 limits; and \$5,000,000 excess of \$5,000,000 limits. As with the lower layers, these rates are based on underlying rating variables and an examination of historical size of loss distributions.

Conclusion

The projected rates developed by HCI reflect an examination of actual historical experience and are based on standard ratemaking principles used for similar types of risks. In our opinion, the process employed by HCI is reasonable and appropriate and follows accepted actuarial standards. We believe the approaches utilized by the company produce rates that are adequate, not excessive, and not unfairly discriminatory.

If you have any questions or require additional information, please let us know.

Sincerely,

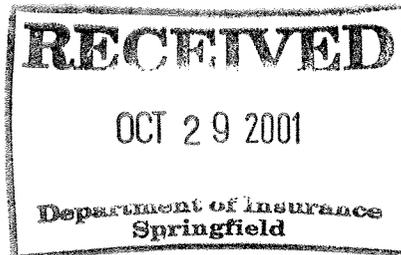


Terry J. Biscoglia, FCAS, MAAA

TJB/ms
Attachments



Health Care Indemnity, Inc.
 One Park Plaza
 P.O. Box 555
 Nashville, TN 37202-0555



October 24, 2001

Ms. Donna Raffa
 Illinois Insurance Department
 320 West Washington Street
 Springfield, IL 62767

RE: Health Care Indemnity, Inc.
 Rate and Rule Filing
 Company Identification: IL2002-01R

Dear Ms. Raffa:

Enclosed for your review are the proposed 2002 Hospital Professional Liability and Physician and Surgeon Professional Liability rates. Included in this filing are the following:

- Form RF-3
- Filing Memorandum
- Actuarial Opinion
- Professional and General Liability Rates

I have enclosed a duplicate copy of this letter and a self-addressed envelope for your stamp and return to my attention.

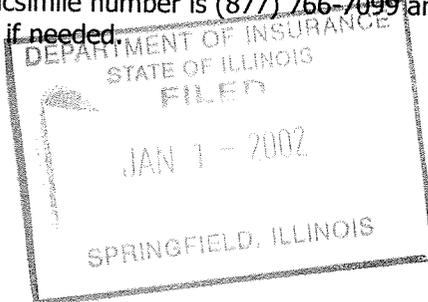
If you should have any questions, or require additional information, please do not hesitate to call me at (615) 344-1487. For additional convenience, my facsimile number is (877) 766-7099 and my e-mail address is Teresa.Stinson@hcahealthcare.com, if needed.

Regards,

Teresa Stinson

Teresa L. Stinson
 Senior Compliance Analyst

Enclosure



*Received
 Casualty Actuarial
 Section
 11/2/2001*

*+19.5%
 1-1-2002*



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

Rate and Rule Filing Memorandum

Date: October 24, 2001
To: Ms. Donna Raffa
Illinois Department of Insurance
From: Teresa L. Stinson
Senior Compliance Analyst
RE: Health Care Indemnity, Inc.
NAIC Company Number 35904

Attached are the proposed rates and rules for 2002.

The base rate \$1,000,000 layer increase is at 15.5%. The 1st layer, \$4,000,000 in excess of \$1,000,000, indicates an increase of 19.2% recognizing a surcharge that was implicit in the previous filing. The 2nd layer, \$5,000,000 in excess of \$5,000,000, indicates an increase of 70.4%. The Physician and Surgeon rates reflect various increases by classification.

This filing is proposed to replace existing filed rates with the enclosed rates effective 1/1/2002.



MADISON CONSULTING GROUP

Actuaries • Property/Casualty Consulting Services

September 5, 2001

Ms. Maggie Hayden Kuhlman
Director of Financial Analysis
HCA - The Healthcare Company
One Park Plaza
P. O. Box 550
Nashville, Tennessee 37202-0550

Dear Ms. Kuhlman:

At your request, we have prepared this letter setting forth a description of the procedures underlying the development of rate level indications for Healthcare Indemnity, Inc. (HCI). This overall rate level determination forms the basis of the complete rate structure underlying HCI's 2002 medical professional liability rates.

Distribution and Use

It is our understanding that it is intended for this letter to be included as part of a rate filing to be provided to the Department of Insurance. Any other use or further distribution is not permitted without our prior consent.

Conditions and Limitations

Madison Consulting Group, Inc. has developed and assisted in implementing an experience based budget system for HCA – The Healthcare Company (HCA) and some of its predecessor companies for a number of years. The first step in the process involves conducting a detailed analysis of indicated ultimate losses and allocated loss adjustment expenses (ALAE) for each historical accident year, based on an examination of actual experience of the program in total. As a part of that study, projections are made of ultimate losses and ALAE for the prospective accident year (in this instance, 2002). This projection, along with estimated exposure units, is used to develop the average loss cost, or pure premium, needed to support HCA's program for the prospective period. This pure premium and other rating variables are used to develop the rate structure set forth by HCI.

As is noted in our studies, it must be recognized that the development of medical professional liability rates and budgets involves the projection of future contingent events. Therefore, no guarantee can be made that the projected results will prove to be adequate or not excessive. However, in developing the indications, we utilize methods and assumptions that are in accord with accepted actuarial principles, and we believe the conclusions reached are reasonable.

200 North Second Street • Madison, Georgia 30650

706-342-7750

madisoninc@mindspring.com

Fax: 706-342-7775

Description of Rate Level Determination

Due to its size and statistical reliability, the development of HCI's rate structure begins with a traditional ultimate loss cost study based on an examination of actual historical experience of HCI's parent. The details of that analysis are set forth in a proprietary report provided to HCA. The following discussion describes how the results of that analysis are used to develop rate level indications for the 2002 accident year.

Projected Ultimate Losses and ALAE for Accident Year 2002

HCA has accumulated a significant amount of experience on historical accident years for its medical professional liability program. This information is used in a comprehensive actuarial analysis to determine ultimate losses and ALAE by accident year for the HCA program. Various actuarial projection techniques are used to project ultimate losses and ALAE and to test various characteristics of the program (e.g., trend assumptions, underlying increased limits relationships, etc.). These indications are used to project ultimate losses and ALAE for the prospective accident year. Projections reflect assumed trends in underlying loss costs and expected changes in underlying exposure.

Development of \$1,000,000 Limits Pure Premium for Accident Year 2002

Management combines the ultimate losses and ALAE for accident year 2002 described above with other actuarial indications and projected exposure units for 2002 to produce the underlying average loss cost, or pure premium. Note that in this step, the pure premium is developed at HCI's basic limit of \$1,000,000.

Development of Accident Year 2002 Rates

The basic limit pure premium is further combined by management with other rating variables to develop rates for the 2002 accident year. These rating variables are included according to a traditional ratemaking procedure and reflect the following considerations:

- prospective investment income;
- territorial differentials;
- operational expenses, including premium taxes and profit and contingencies; and
- increased limits relationships for excess layers.

Ms. Maggie Hayden Kuhlman
September 5, 2001
Page 3

Indicated Rate Change

A comparison is made between the rates developed for the 2002 accident year and rates underlying HCI's current rate structure. The resulting rate change is indicated for \$1,000,000 basic limits; \$4,000,000 excess of \$1,000,000 limits; and \$5,000,000 excess of \$5,000,000 limits. As with the lower layers, these rates are based on underlying rating variables and an examination of historical size of loss distributions.

Conclusion

The projected rates developed by HCI reflect an examination of actual historical experience and are based on standard ratemaking principles used for similar types of risks. In our opinion, the process employed by HCI is reasonable and appropriate and follows accepted actuarial standards. We believe the approaches utilized by the company produce rates that are adequate, not excessive, and not unfairly discriminatory.

If you have any questions or require additional information, please let us know.

Sincerely,

A handwritten signature in black ink, appearing to read "Terry J. Biscoglia". The signature is fluid and cursive, with a large initial "T" and "B".

Terry J. Biscoglia, FCAS, MAAA

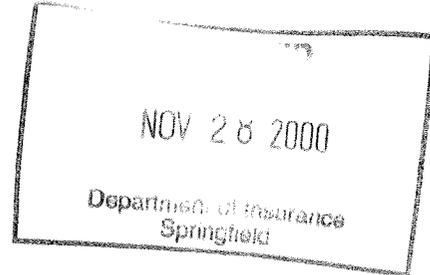
TJB/hst
Attachments



Health Care Indemnity, Inc.
 One Park Plaza
 P.O. Box 555
 Nashville, TN 37202-0555

November 21, 2000

Ms. Donna Raffa
 Illinois Department of Insurance
 320 W. Washington Street
 Springfield, IL 62762-0001



RE: Health Care Indemnity, Inc.
 Rate and Rule Filing
 Company Identification: IL2001-02

Dear Ms. Raffa: *61-0907881*

Enclosed for your review are the proposed 2001 Hospital Professional Liability and Physician and Surgeon Professional Liability rules and rates. Included in this filing are the following:

- Filing Memorandum
- Summary Sheet (Form RF-3)
- Actuarial Opinion
- Professional and General Liability Rules and Rates
- Plan of Operation

I have enclosed a duplicate copy of this letter and a self-addressed envelope for your stamp and return to my attention.

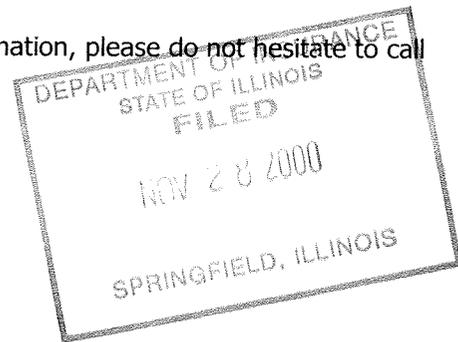
If you should have any questions, or require additional information, please do not hesitate to call me at (615) 344-1487.

Regards,

Teresa L. Stinson

Teresa L. Stinson
 Senior Compliance Analyst

Enclosure



Received Sarah Dale, ACS, MAAA 12/11/2000



Health Care Indemnity, Inc.
One Park Plaza
P.O. Box 555
Nashville, TN 37202-0555

Rate and Rule Filing Memorandum

Date: November 21, 2000

To: Ms. Donna Raffa
Illinois Department of Insurance

From: Teresa L. Stinson
Senior Compliance Analyst

RE: Health Care Indemnity, Inc.
NAIC Company Number 35904

Attached are the proposed rates and rules for 2001. The base \$1,000,000 layer increase is 22.5%. However, the increase represents only 11.25% over a 2-year period. The 1st layer, \$4,000,000 X \$1,000,000, indicates an increase of 10.6% recognizing a surcharge that was implicit in the previous filing. The proposed 2-year annualized increase is 19.1% weighted. We also reflect the addition of the 2nd layer, \$5,000,000 X \$5,000,000. The Physician and Surgeon rates reflect an increase of 12.5%.



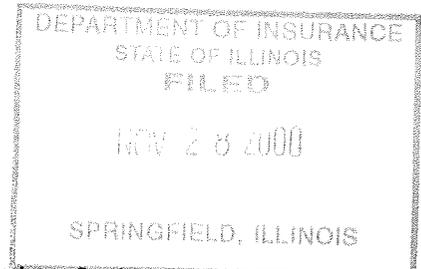


MADISON CONSULTING GROUP

Actuaries • Property/Casualty Consulting Services

November 16, 2000

Ms. Maggie Hayden Kuhlman
Director of Financial Analysis
HCA - The Healthcare Company
One Park Plaza
P. O. Box 550
Nashville, Tennessee 37202-0550



Dear Ms. Kuhlman:

At your request, we have prepared this letter setting forth a description of the procedures underlying the development of rate level indications for Healthcare Indemnity, Inc. (HCI). This overall rate level determination forms the basis of the complete rate structure underlying HCI's 2001 medical professional liability rates.

Distribution and Use

It is our understanding that it is intended for this letter to be included as part of a rate filing to be provided to the Department of Insurance. Any other use or further distribution is not permitted without our prior consent.

Conditions and Limitations

Madison Consulting Group, Inc. has developed and assisted in implementing an experience based budget system for HCA – The Healthcare Company (HCA) and some of its predecessor companies for a number of years. The first step in the process involves conducting a detailed analysis of indicated ultimate losses and allocated loss adjustment expenses (ALAE) for each historical accident year, based on an examination of actual experience of the program in total. As a part of that study, projections are made of ultimate losses and ALAE for the prospective accident year (in this instance, 2001). This projection, along with estimated exposure units, is used to develop the average loss cost, or pure premium, needed to support HCA's program for the prospective period. This pure premium and other rating variables are used to develop the rate structure set forth by HCI.

As is noted in our studies, it must be recognized that the development of medical professional liability rates and budgets involves the projection of future contingent events. Therefore, no guarantee can be made that the projected results will prove to be adequate or not excessive. However, in developing the indications, we utilize methods and assumptions that are in accord with accepted actuarial principles, and we believe the conclusions reached are reasonable.

200 North Second Street • Madison, Georgia 30650

706-342-7750

madisoninc@mindspring.com

Fax: 706-342-7775

Description of Rate Level Determination

As noted above, the development of HCI's rate structure begins with a traditional ultimate loss cost study for the program, based on an examination of actual historical experience. Since HCI's sole policyholder through 2000 is its parent, this first step is conducted on behalf of and for the exclusive use of HCA – The Healthcare Company. The details of that analysis are set forth in a proprietary report provided to HCA. The following discussion describes how the results of that analysis are used to develop rate level indications for the 2001 accident year.

Projected Ultimate Losses and ALAE for Accident Year 2001

HCA has accumulated a significant amount of experience on historical accident years for its medical professional liability program. This information is used in a comprehensive actuarial analysis to determine ultimate losses and ALAE by accident year for the HCA program. Various actuarial projection techniques are used to project ultimate losses and ALAE and to test various characteristics of the program (e.g., trend assumptions, underlying increased limits relationships, etc.). These indications are used to project ultimate losses and ALAE for the prospective accident year. Projections reflect assumed trends in underlying loss costs and expected changes in underlying exposure.

Development of \$1,000,000 Limits Pure Premium for Accident Year 2001

Management combines the ultimate losses and ALAE for accident year 2001 described above with projected exposure units for 2001 to produce the underlying average loss cost, or pure premium. Note that in this step, the pure premium is developed at HCI's basic limit of \$1,000,000.

Development of Accident Year 2001 Rates

The basic limit pure premium is further combined by management with other rating variables to develop rates for the 2001 accident year. These rating variables are included according to a traditional ratemaking procedure and reflect the following considerations:

- prospective investment income;
- territorial differentials;
- operational expenses, including premium taxes and profit and contingencies; and
- increased limits relationships for excess layers.

Ms. Maggie Hayden Kuhlman
November 16, 2000
Page 3

Indicated Rate Change

A comparison is made between the rates developed for the 2001 accident year and rates underlying HCI's current rate structure. The resulting rate change is indicated for both \$1,000,000 basic limits and \$4,000,000 excess of \$1,000,000 limits. It is our understanding that in the current filing, HCI is introducing rates for the \$5,000,000 excess of \$5,000,000 layer. As with the lower layers, these rates are based on underlying rating variables and an examination of historical size of loss distributions.

Conclusion

The projected rates developed by HCI reflect an examination of actual historical experience and are based on standard ratemaking principles used for similar types of risks. In our opinion, the process employed by HCI is reasonable and appropriate and follows accepted actuarial standards. We believe the approaches utilized by the company produce rates that are adequate, not excessive, and not unfairly discriminatory.

If you have any questions or require additional information, please let us know.

Sincerely,



Terry J. Biscoglia, FCAS, MAAA

TJB/hst
Attachments

EXHIBIT A

Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

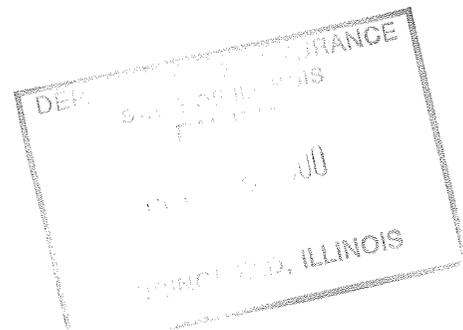
Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY – NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE - NI
- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE - NI
- ONCOLOGY - NI
- OSTEOPATHY



- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE - INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE - INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS - INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE - INV

CLASS 3

- FAMILY PRACTICE - SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE - SRG

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE
- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- EMERGENCY MEDICINE
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY



CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY
- NEUROLOGICAL SURGERY

HEALTH CARE INDEMNITY, INC.

Plan of Operation

Company History

Health Care Indemnity, Inc. ("HCI") was incorporated under the captive insurance laws of Colorado on August 5, 1976. Initially it was a wholly owned subsidiary of Humana Inc., a leading health care services company principally engaged in the business of operating hospitals and health plans. HCI began business on August 31, 1976 writing professional and general liability coverage for its parent and affiliates. HCI's certificate of authority was converted to that of a multiple line insurance company under the laws of Colorado on October 12, 1982.

HCI has experienced numerous organizational changes in recent years. In March 1993, Humana Inc., spun off its hospital business into Galen Health Care, Inc., and retained its managed care business. As part of that reorganization, HCI became a wholly owned subsidiary of Galen. In September 1993, Galen merged with Columbia Hospital Corporation, a smaller hospital operator. A few months later, in February 1994, Columbia merged with Hospital Corporation of America (HCA), another leading operator of hospitals. The resulting entity was renamed Columbia/HCA Healthcare Corporation, which at the time operated nearly 200 hospitals. Through subsequent acquisitions and a 1995 merger with Healthtrust, Inc., yet another leading hospital operator, Columbia/HCA became by 1997 the nation's largest healthcare company with nearly 350 hospitals, over 100 surgery centers and other businesses.

As a result of a government investigation initiated in 1997 alleging Medicare fraud, Columbia/HCA's Board replaced many of its senior managers. The new management team initiated a corporate restructuring which by 1999 had resulted in the sale of non-core businesses (more than 70 hospitals, virtually all of its home health agencies and nearly 30 surgery centers). In addition, on May 11, 1999, Columbia/HCA spun off two separate, independent businesses, Triad Hospitals, Inc. and LifePoint Hospitals, Inc., which operate smaller, more rural hospitals. In May 2000, the parent company's name was changed from Columbia/HCA Healthcare Corporation to HCA – The Healthcare Company ("HCA"). It is still the nation's largest healthcare company operating nearly 210 hospitals and nearly 100 surgery centers.

Throughout all of these changes, HCI provided professional and general liability insurance for its parent and its affiliates.

On December 31, 1994, HCI absorbed by merger the Parthenon Insurance Company, Nashville, TN. Parthenon had been a captive insurer that underwrote professional liability insurance for affiliates of HCA.

Between 1983 and 1999, HCI became licensed to write as an admitted insurer in Kentucky, Illinois, Florida, Kansas, Indiana, Texas, Nevada, Tennessee and Ohio. In early 2000, additional admitted licenses were obtained in Louisiana and Oklahoma.

All of the outstanding stock in HCI is currently held by Galen Holdco, LLC, the sole member of which is Healthtrust, Inc. – The Hospital Company (a wholly owned subsidiary of HCA). HCI has only one affiliated insurance company—Parthenon Insurance Company, Limited, a Bermuda captive insurer.

Overview and Description of Operations

Business review

HCI writes the primary and first excess layers of professional and general liability insurance for hospitals, surgery centers and employed physicians that are affiliated with its parent company, HCA. Since their May 1999 spin off, HCI also has provided similar coverage to LifePoint Hospitals Inc. and Triad Hospitals, Inc. The policies issued are on the occurrence form with rates determined by independent actuaries, subject to the approval, when necessary, of the various insurance departments in the states where HCI is licensed.

Administration

HCI's headquarters is located in Nashville, TN. All financial and accounting services, risk management, underwriting and claims administration is performed by internal staff. There are no regional or divisional offices. Tillinghast performs evaluations of reserves. HCA provides HCI with certain management, data processing and administrative services in return for a management fee. Records are maintained on site.

There are three officers and directors of HCI. James D. Hinton is President and a Director. He has been President since 1994 and a Director since 1991. From 1988 to 1994 he was a Vice-President and in charge of HCI operations. Mr. Hinton holds an MBA and is a Certified Public Accountant. David G. Anderson is Vice-President, Treasurer and a Director. He has been a Vice-President and Treasurer for nearly 20 years and has been a Director since 1999. Mr. Anderson is also Sr. Vice-President and Treasurer of HCA. John M. Franck II is a Vice-President, Secretary and a Director. He has served in those capacities since 1997. Mr. Franck also serves as Vice-President and Secretary of HCA.

HCI's senior management team includes Mr. Hinton and four other experienced insurance professionals. Gerald M. Rakes is Asst. Vice-President of Risk Management, a position he has held with Parthenon and HCI since the mid-1980's. He has more than 20 years experience in healthcare risk management. Kenneth K. Roth has served as Asst. Vice-President of Finance since 1996. He

is a Certified Public Accountant with nearly 10 years of insurance accounting experience. Lorraine Gerelick has been Asst. Vice-President of Claims since 1994. She has over 20 years of experience in managing claims for healthcare entities and professional liability insurers. Joseph S. Haase has been the Asst. Vice-President of Insurance with responsibilities for policy servicing, regulatory compliance and reinsurance since 1993. Prior to that he had been HCI's Director of Claims since 1983.

Marketing and Underwriting

Due to the predominately captive nature of HCI, it historically has done no marketing. The Company does not utilize management agreements with general agents or underwriters. Premium rates are calculated by using actuarial projected losses appropriately discounted in recognition of the payment lag associated with occurrence policies. Expense loads are lower than customary for the industry because of the very low cost structure associate with HCI's business.

Claims Administration

The internal staff of 18 claims professionals, all located in Nashville, TN, oversees all claims. Either contracted vendors with extensive professional liability experience or personnel at the insured location perform investigations of all claims. Local defense counsel with demonstrated expertise in medical liability matters are assigned to all litigated claims. The claims staff in Nashville controls all reserve setting, settlement authority and payments.

Risk Management

With an experienced staff of healthcare risk management consultants, HCI offers comprehensive educational programs as well as proactive loss control solutions to its insureds. The group makes extensive use of one of the nation's largest acute care hospital claims databases to design its educational programs and risk reduction initiatives to address those healthcare liability issues facing its insureds.

Investment Management

Under the direction of its Treasurer, HCI's investments are managed by seven external professional portfolio managers. Stein Roe and Scudder each manage half of the fixed income portfolio. Five firms manage the equity portfolio: MacKay Shields, Harris Associates, Gardner Lewis, Thomson Horstman & Bryant and Vinick Asset Management. Each manager operates under established written investment guidelines. Also, each is monitored monthly against predetermined benchmarks established by the Treasurer. Generally, HCI's investment philosophy is to invest all or a substantial portion of its surplus dollars in a diversified portfolio of blue chip equity securities. The balance of its funds are invested in a well diversified portfolio of high quality corporate and government fixed income securities with a duration that correlates to the timing of expected claim payments.

Reinsurance

HCI writes a maximum \$25 million limit of liability. Its net retention has fluctuated from year to year. HCI currently retains the first \$1 million each claim. The following reinsurance treaties are in effect for the 2000 accident year:

- Transportation Insurance Company (of the CNA Group) reinsures 50% of the layer \$4 million excess of \$1 million. Lawrenceville Property and Casualty Company (MIIX Group) reinsures 30%. HCI retains the remaining 20%.
- Employers Reinsurance Corporation (ERC) reinsures 65% of the \$5 million excess of \$5 million layer. Swiss Reinsurance America Corporation reinsures the remaining 35%.
- ERC reinsures the entire \$15 million excess of \$10 million layer.

Colorado approves all companies as reinsurers.

Operational Changes

Target Markets

HCI wishes to pursue professional and general liability insurance business from healthcare entities other than those of its parent company. Target markets includes the relatively few, usually for-profit, multi-hospital healthcare systems. These companies typically have operations that include between 5-50 hospital facilities, located in sun-belt states, and customarily buy coverage with a significant deductible or self-insured retention. They usually do not have significant internal corporate risk or claims management resources. Existing insurance markets for these target customers would include CNA-HealthPro, Zurich, Swiss Re, St. Paul, ERC, etc.

HCI believes that its comprehensive risk management and loss control programs, and claims and litigation management expertise, specific to the hospital industry, distinguishes HCI from the competitive markets. HCI believes that it can write this new business at competitive rates and continue to provide specific, focused risk management service that healthcare clients value.

Marketing and Underwriting

Because of the limited number of potential customers, HCI plans to market primarily on a direct basis and accept risk from a licensed surplus lines broker when appropriate. Marketing costs will be minimal and limited to the publication of a small brochure describing HCI and its services.

HCI does not plan to diversify into coverage beyond the current offerings of professional and general liability. In addition to the use of the current occurrence form, HCI may also offer a claims-made form. Underwriting for these new

healthcare systems will be conducted in a manner similar to the practices currently in use.

Start-up Costs

Because the expansion is so closely related to the current business of the Company, initial start-up costs will not be material. Current offices, systems and staffing are deemed to be adequate in the short term. HCI will continue to use external actuarial support to evaluate each proposal, as needed. Additional staffing (all in Nashville) will be added in claims and risk management as new business is generated. The most significant one-time expenditure will be the costs of outside attorneys to assist in preparing surplus lines license applications in the 12-14 sun-belt states where HCI is not currently licensed.

Projected Financial Statements

Actual and projected financial statements for the years 1997-2003, along with a statement of assumptions are attached as Exhibit A. These statement show both the base premium from HCI's parent company and expected new premium as a result of the new marketing effort.

July 2000

Health Care Indemnity, Inc.
Balance Sheets--Statutory-Basis
(Dollars in Thousands)

	Actual			Projected			
	12/31/97	12/31/98	12/31/99	12/31/00	12/31/01	12/31/02	12/31/03
Admitted assets							
Cash and invested assets:							
Bonds.....	\$ 870,494	\$ 1,041,931	\$ 1,017,074	\$ 1,005,810	\$ 950,510	\$ 973,610	\$ 1,025,110
Preferred and common stocks.....	498,423	442,434	454,884	500,000	500,000	500,000	500,000
Cash and short-term investments....	45,658	200,808	63,438	63,400	63,400	63,400	63,400
Other invested assets.....	22,251	22,326	84,636	84,600	84,600	84,600	84,600
Total cash and invested assets.....	1,436,826	1,707,499	1,620,032	1,653,810	1,598,510	1,621,610	1,673,110
Other admitted assets.....	74,642	26,448	62,021	62,021	62,021	62,021	62,021
Total admitted assets.....	<u>\$ 1,511,468</u>	<u>\$ 1,733,947</u>	<u>\$ 1,682,053</u>	<u>\$ 1,715,831</u>	<u>\$ 1,660,531</u>	<u>\$ 1,683,631</u>	<u>\$ 1,735,131</u>
Liabilities and capital and surplus							
Liabilities:							
Total reserves.....	\$ 1,048,695	\$ 1,202,394	\$ 1,127,439	1,089,739	1,078,339	1,093,539	1,129,739
Other liabilities.....	87,935	95,942	42,681	42,681	42,681	42,681	42,681
Total liabilities.....	1,136,630	1,298,336	1,170,120	1,132,420	1,121,020	1,136,220	1,172,420
Capital and surplus:							
Preferred stock.....	250	250	250	250	250	250	250
Common stock.....	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Paid-in surplus.....	1,324	1,324	1,324	1,324	1,324	1,324	1,324
Segregated surplus.....	-	-	20,427	20,427	20,427	20,427	20,427
Unassigned surplus.....	372,264	433,037	488,932	560,410	516,510	524,410	539,710
Total capital and surplus.....	374,838	435,611	511,933	583,411	539,511	547,411	562,711
Total liabilities and capital and surplus....	<u>\$ 1,511,468</u>	<u>\$ 1,733,947</u>	<u>\$ 1,682,053</u>	<u>\$ 1,715,831</u>	<u>\$ 1,660,531</u>	<u>\$ 1,683,631</u>	<u>\$ 1,735,131</u>
Net asset activity:							
Collection of net/earned premiums.....	\$ 199,900	\$ 209,600	\$ 229,300	\$ 250,400			
Claims payments based on historical payout pattern.....	(249,700)	(243,400)	(237,800)	(238,800)			
Payment of other underwriting expenses.....	(11,800)	(12,800)	(13,800)	(14,900)			
Collection of investment income.....	108,878	57,700	54,900	56,100			
Collection of other income.....	2,000	2,000	2,000	2,000			
Payment of federal income taxes.....	(15,500)	(4,400)	(3,500)	(3,300)			
Dividend payment to shareholder.....	-	(64,000)	(8,000)	-			
	<u>\$ 33,778</u>	<u>\$ (55,300)</u>	<u>\$ 23,100</u>	<u>\$ 51,500</u>			
Surplus activity:							
Net income.....	\$ 71,478	\$ 20,100	\$ 15,900	\$ 15,300			
Dividend payment to shareholder.....	-	(64,000)	(8,000)	-			
	<u>\$ 71,478</u>	<u>\$ (43,900)</u>	<u>\$ 7,900</u>	<u>\$ 15,300</u>			

Health Care Indemnity, Inc.
 Statements of Income--Statutory-Basis
 (Dollars in Thousands)

	Actual			Budget	Projected		
	1997	1998	1999	2000	2001	2002	2003
Premiums earned.....	\$ 254,872	\$ 270,804	\$ 204,151	\$ 199,900	\$ 209,600	\$ 229,300	\$ 250,400
Losses and loss expenses incurred.....	278,645	294,213	221,490	212,000	232,000	253,000	275,000
Other underwriting expenses incurred...	13,391	11,280	10,941	11,800	12,800	13,800	14,900
Underwriting loss.....	(37,164)	(34,689)	(28,280)	(23,900)	(35,200)	(37,500)	(39,500)
Net investment income.....	46,544	57,001	61,783	58,300	57,700	54,900	56,100
Net realized capital gains.....	91,261	63,789	55,328	50,578	-	-	-
Other income.....	2,230	2,357	1,917	2,000	2,000	2,000	2,000
Income before federal income taxes.....	102,871	88,458	90,748	86,978	24,500	19,400	18,600
Federal income taxes.....	26,671	17,041	16,203	15,500	4,400	3,500	3,300
Net income.....	\$ 76,200	\$ 71,417	\$ 74,545	\$ 71,478	\$ 20,100	\$ 15,900	\$ 15,300

Detail of written premiums:

Direct & assumed:

Affiliated premiums	\$ 268,349	\$ 282,342	\$ 237,252	\$ 235,280	\$ 251,700	\$ 269,300	\$ 288,200
Non-affiliated premiums	-	-	14,756	11,083	16,900	23,100	29,700
	268,349	282,342	252,008	246,363	268,600	292,400	317,900

Ceded:

Affiliated premiums	13,477	11,538	45,059	41,613	52,800	56,500	60,400
Non-affiliated premiums	-	-	2,798	4,850	6,200	6,600	7,100
	13,477	11,538	47,857	46,463	59,000	63,100	67,500

Net:

Affiliated premiums	254,872	270,804	192,193	193,667	198,900	212,800	227,800
Non-affiliated premiums	-	-	11,958	6,233	10,700	16,500	22,600
	\$ 254,872	\$ 270,804	\$ 204,151	\$ 199,900	\$ 209,600	\$ 229,300	\$ 250,400

Assumptions used in 2001-2003 projections:

Annual growth in affiliated & existing unaffiliated premiums:

Attributable to increased volumes.....	2.0%	2.0%	2.0%
Attributable to increased rate.....	5.0%	5.0%	5.0%
	7.0%	7.0%	7.0%

Estimates of new unaffiliated premiums..... \$ 5,000 \$ 5,000 \$ 5,000

Loss and loss expense ratio for affiliated business..... 111.4% 111.4% 111.4%

Loss and loss expense ratio for unaffiliated business..... 95.0% 95.0% 95.0%

Other underwriting expenses:

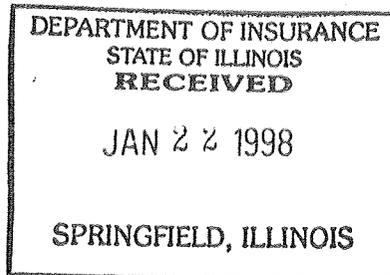
Annual growth rate estimate for general & administrative expenses.....	3.5%	3.5%	3.5%
Additional G&A exp. to support new business (6% of new unaffiliated premiums).....	\$ 300	\$ 300	\$ 300
Administrative & general expenses.....	\$ 5,425	\$ 6,100	\$ 6,600
Premium taxes.....	5,516	5,700	6,200
	\$ 10,941	\$ 11,800	\$ 12,800
		\$ 13,800	\$ 14,900

Yield assumption for net investment income..... 5.0% 5.0% 5.0%

Note that there are no projections for realized gains or changes in unrealized gains on preferred & common stocks subsequent to actual activity recorded through May 2000.

One Park Plaza
Nashville, Tennessee 37203
Telephone 615/344-9551
FAX 615/344-5889

January 22, 1998



Mr. John Gatlin
Insurance Analyst, P & C Compliance Unit
State of Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

Re: FEIN 61-0904881
Filing Number: ILL-1998
Medical Malpractice Rate Filing
Number of Pages: 10

Dear Mr. Gatlin:

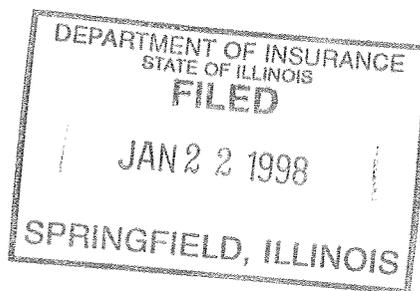
Enclosed is our revised rate filing. The main changes in the rules are the layers of coverage to which rates are applied in the hospital section and the deletion of the deductible credit in the physicians section.

I have enclosed a duplicate copy of this letter and a self-addressed, stamped envelope for your stamp and return.

Sincerely,

A handwritten signature in cursive script that reads "M. Imogene Caldwell".

M. Imogene Caldwell
Senior Underwriting Supervisor



Enclosures
cc: Kevin Gabhart

HEALTH CARE INDEMNITY, INC.

Your One Source for Quality Healthcare.

P.O. Box 555
Nashville, Tennessee 37202-0555
Telephone 615/327-9551
FAX 615/344-5889

August 28, 1997



Mr. John Gatlin
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767

Re: Medical Malpractice Rate Filing
No. of Filing: ILL-1997
No. Pages - 10
Fed. I.D. No. 61-0904881

Dear Mr. Gatlin:

As you requested, enclosed is the rate filing for Health Care Indemnity, Inc. I have also enclosed a duplicate copy of this letter for the DOI stamp and a self-addressed envelope. The faxed actuary approval letter is also included.

Let me know if you have any questions or need further information. I can be reached at 615-344-5841.

Sincerely,

A handwritten signature in cursive script that reads "Imogene Caldwell".

M. Imogene Caldwell
Senior Underwriting Supervisor

Enclosures

Handwritten notes in the bottom right corner. It includes a circular stamp with the word "RECEIVED" inside, and the date "9/3/97" written below it. There are some faint, illegible handwritten notes above the stamp.



WAKELY AND ASSOCIATES, INC.
ACTUARIES • CONSULTANTS • ADMINISTRATORS

August 28, 1997

Ms. Maggie Hayden Kuhlman
Director of Financial Analysis
Columbia/HCA Healthcare Corporation
One Park Plaza
P. O. Box 550
Nashville, Tennessee 37202-0550

Dear Ms. Kuhlman:

At your request, we have prepared this letter setting forth a description of the rating methodology underlying premiums of Healthcare Indemnity, Inc. (HCI). Since HCI's only insured is the risks of its parent, this description is essentially that of the methodology underlying Wakely and Associates' development of rates and budget recommendations for the Columbia/HCA Healthcare Corporation.

Distribution and Use

It is our understanding that it is intended for this letter to be included as part of a rate filing to be provided to the Illinois Department of Insurance. Any other use or further distribution is not permitted without our prior consent.

Conditions and Limitations

Wakely and Associates has developed an experience based budget system and conducted such analyses on behalf of Columbia/HCA and some of its predecessor companies for a number of years. These analyses reflect actual experience of the company in total, the experience of individual facilities, and other relevant industry relationships (primarily to enhance company experience in the areas of increased limits relationships, and state/territory relativities). The results of our analyses are annually presented to Columbia/HCA in a written report that summarizes the indications for all facilities. This letter provides a general description of the approach and methodology those studies.

As is noted in our studies, it must be recognized that the development of professional and general liability rates and budgets involves the projection of future contingent events. Therefore, no guarantee can be made that the results for individual facilities, or in total, will prove to be adequate or not excessive. However, in developing the indications, we utilize methods and assumptions that are in accord with accepted actuarial principles, and we believe the conclusions reached are reasonable.

2046 WEST PARK PLACE, SUITE H • STONE MOUNTAIN, GEORGIA 30087
(770) 469-6702

** TOTAL PAGE.002 **

AUG 28 1997

Ms. Maggie Hayden Kuhlman
August 28, 1997
Page 2

Description of Methodology

The rating and budget systems for Columbia/HCA are separated into two components, one for Hospital Based Exposure, and the other for Employed Physician Exposure. These two systems are described below.

Hospital Based Exposure

Columbia/HCA separates its hospital professional and general liability exposure into the following layers:

- \$200,000 deductible layer;
- \$800,000 excess of \$200,000;
- \$2,000,000 excess of \$1,000,000; and
- \$7,000,000 excess of \$3,000,000.

The company utilizes an experience rating approach for the first three layers and determines the fourth layer as a function of actual costs for commercial coverage. In our opinion, given the increasingly random nature of each successive layer, this approach is reasonable and appropriate.

Rates and budget amounts for the first three layers reflect the following components:

- i. determination of aggregate needed contribution level for the calendar/accident year;
- ii. comparison of actual and expected reported losses and allocated loss adjustment expenses by individual facility; and
- iii. development of experience based rates and budgets reflecting both the aggregate amount in i., and the individual experience in ii.

In our opinion, this approach is reasonable and appropriate for the following reasons:

- i. It takes into account the overall aggregate budget requirements for the company as a whole for each layer of coverage.

Ms. Maggie Hayden Kuhlman
August 28, 1997
Page 3

- ii. It reflects the actual experience of each facility, including size of the facility, territory, and actual loss history.
- iii. The experience rating characteristics of the system provide an incentive to management at the facility level to improve loss experience.

Columbia/HCA utilizes a unique exposure base for determining rates for individual facilities referred to as Risk Index Beds, or RIB's. In our opinion, the RIB system is an improvement over the more traditional bed equivalent approach because it more accurately accounts for shifts in malpractice exposure resulting from changes in the delivery of health care. As an example, recent increases in home health visits has resulted in a reduction in more traditional outpatient visits. The RIB system recognizes the professional liability exposure associated with such shifts in health care activity, while the more traditional bed equivalent system does not.

Employed Physician Exposure

Due to the difference in the category of risk, professional liability for employed physicians is not included in the RIB system. In our opinion, this is reasonable and appropriate because physicians and surgeons exposures do not represent a credible class of risks for individual experience rating. That is, the experience of an individual physician for a given historical period is not statistically reliable enough for projection into a future period. Accordingly, rates for Columbia/HCA's employed physicians are determined on the basis of the estimated total expected losses and allocated loss adjustment expenses and a distribution that reflects state/territorial relativities. These relativities are based on an examination of Columbia/HCA's actual experience and other relevant industry experience.

Conclusion

The Columbia/HCA rating and budget system generally follows accepted actuarial techniques that are used in the industry for rating similar types of risks. For hospital based exposures, it is an experience based system that takes into account the needs of the program and the aggregate and distributes the total on the basis of layer, geographic territory and actual historical experience. For physician based exposures, due to the lack of statistical credibility, final rates do not reflect individual actual historical experience.

In our opinion, these approaches for these categories of risk are reasonable and appropriate and follow accepted actuarial standards. Further, Columbia/HCA's enhancement to reflect Risk Index Beds as opposed to more traditional bed equivalent exposures is an improvement over industry standards.

Ms. Maggie Hayden Kuhlman
August 28, 1997
Page 4

If you have any questions or require additional information, please let us know.

Sincerely,



Terry J. Biscoglia, FCAS, MAAA

TJB/kch

WSA

WAKELY AND ASSOCIATES, INC.

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Friday, January 12, 2007 12:21 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006
Attachments: 07 0108 IL Rules.doc

Ms. Neuman, I have attached a complete copy of the rules manual showing changed areas with a highlight. Pages with changes to comply with items listed below are located on pages 2, 3, 6, 13 and 16 of the manual. Please allow an opportunity to address any additional information prior to a disapproval. Thank you again for your help.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, January 02, 2007 8:27 AM
To: Stinson Teresa
Subject: FW: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

We request your immediate attention on this filing. We are additionally holding up filing #HC12007 with this filing. As both filings have past their effective dates, we would appreciate the attention that is required.

From: Neuman, Gayle
Sent: Monday, December 18, 2006 10:41 AM
To: 'Stinson Teresa'
Subject: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

This filing is still pending and under review. Although Health Care Indemnity currently has no insureds in Illinois, we require the manual be updated/corrected as follows to continue the processing of this filing:

1. We note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements. You must address each issue in the manual pages.

All companies writing medical liability insurance shall file with the Secretary or Director a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than \$500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

- i) An initial payment of no more than 40% of the estimated total premium due at policy inception;
- ii) The remaining premium spread equally among the second, third, and fourth installments, with the

maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

iii) No interest charges;

iv) Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;

v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

2. We note that your extended reporting period requirements do not meet and/or address some or all of the following prescribed requirements. You must address each issue in the manual pages.

The extended reporting period (e.r.p.) must meet requirements set forth for both general liability and professional liability. Therefore, the company must offer an e.r.p. of five years or an unlimited period. The insured must be allowed 60 days after the end of the policy period to purchase the e.r.p. The insured must be offered (a) a free 5 year tail or (b) an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration) and premium capped (e.r.p. is limited to a 200% cap of the annual premium of the expiring policy). The company must inform the insured of the e.r.p. premium at the time the last policy is purchased. The premium will be priced as a factor of (a) the last 12 months' premium, (b) the premium in effect at policy issuance, or (c) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium.

We request receipt of your response by December 22, 2006. If you cannot have the response by such date, we require you send a response indicating the date it will be submitted. We appreciate your cooperation in addressing these issues.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

F) Premium Remittance

- The insured premium payment plan may be annual, quarterly or monthly.
 - Quarterly premium installment plans are available to insureds whose annual premiums are less than \$500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

plan at a later date, the insurer must make it available. Quarterly installment premium payment plans shall include the minimum standards listed below.

- i) An initial payment of no more than 40% of the estimated total premium due at policy inception;
- ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;
- iii) No interest charges;
- iv) Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;
- v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

The premium for the \$1,000,000 base layer is developed using the following formula:

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM 25% CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	±10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	±10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	±7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	±5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	±5%
• Certificates of insurance are obtained verifying vendor liability coverage.	±5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	±3%
• Written job descriptions are established for all positions.	±3%
• Each facility has a designated, full-time safety director or safety officer.	±3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	±10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	±10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	±10%
• The quality management and risk management programs are integrated.	±7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	±5%
• Continuing risk management education requirements routinely fulfilled.	±5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	±3%
• Risk management issues are addressed in new employee orientation.	±3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	±3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	±5%
• No citations or penalties by a regulatory agency within the past 3 years.	±5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	±10%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM +25% CREDIT/DEBIT
Loss experience(not available in Kansas)	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

L) Optional Extended Reporting Period

Unlimited extended reporting period is available upon termination of the policy. The premium is determined by multiplying 200% by the mature claims made annual premium in effect at expiration of the policy. Premium is due within 60 days of quote made after end of policy and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy. The insured must be informed of the extended reporting period premium at the time the last policy is purchased.

The extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company ; or permanently retires from the practice of medicine at age 60 or older after three continuous years of coverage with the company; or, 3) to his or her estate if such medical professional dies during the policy period. An exception to the 5 year requirement for free tail at retirement may be considered by underwriting discretion.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Monday, January 08, 2007 2:34 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Neuman, thank you for the opportunity to address the outstanding issues. I will need to alter the manual substantially from the format that we use in all other states and this will require management approval so I am working on the items you have listed below and will provide as soon as I can obtain authorization to release. Please extend date to respond to January 19. Thank you again for your consideration.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, January 02, 2007 8:27 AM
To: Stinson Teresa
Subject: FW: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

We request your immediate attention on this filing. We are additionally holding up filing #HC12007 with this filing. As both filings have past their effective dates, we would appreciate the attention that is required.

From: Neuman, Gayle
Sent: Monday, December 18, 2006 10:41 AM
To: 'Stinson Teresa'
Subject: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

This filing is still pending and under review. Although Health Care Indemnity currently has no insureds in Illinois, we require the manual be updated/corrected as follows to continue the processing of this filing:

1. We note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements. You must address each issue in the manual pages.

All companies writing medical liability insurance shall file with the Secretary or Director a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than \$500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

- i) An initial payment of no more than 40% of the estimated total premium due at policy inception;
- ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months

from policy inception, respectively;

iii) No interest charges;

iv) Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;

v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

2. We note that your extended reporting period requirements do not meet and/or address some or all of the following prescribed requirements. You must address each issue in the manual pages.

The extended reporting period (e.r.p.) must meet requirements set forth for both general liability and professional liability. Therefore, the company must offer an e.r.p. of five years or an unlimited period. The insured must be allowed 60 days after the end of the policy period to purchase the e.r.p. The insured must be offered (a) a free 5 year tail or (b) an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration) and premium capped (e.r.p. is limited to a 200% cap of the annual premium of the expiring policy). The company must inform the insured of the e.r.p. premium at the time the last policy is purchased. The premium will be priced as a factor of (a) the last 12 months' premium, (b) the premium in effect at policy issuance, or (c) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium.

We request receipt of your response by December 22, 2006. If you cannot have the response by such date, we require you send a response indicating the date it will be submitted. We appreciate your cooperation in addressing these issues.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, January 02, 2007 8:35 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

I will address it immediately. My apologies, I got sick and had grandbaby in hospital so didn't get opportunity to finish last week as planned. I appreciate your patience with me on this.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, January 02, 2007 8:27 AM
To: Stinson Teresa
Subject: FW: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

We request your immediate attention on this filing. We are additionally holding up filing #HC12007 with this filing. As both filings have past their effective dates, we would appreciate the attention that is required.

From: Neuman, Gayle
Sent: Monday, December 18, 2006 10:41 AM
To: 'Stinson Teresa'
Subject: Rate/Rule Filing #HCI2006-R Effective January 1, 2006

Ms. Stinson,

This filing is still pending and under review. Although Health Care Indemnity currently has no insureds in Illinois, we require the manual be updated/corrected as follows to continue the processing of this filing:

1. We note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements. You must address each issue in the manual pages.

All companies writing medical liability insurance shall file with the Secretary or Director a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than \$500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

- i) An initial payment of no more than 40% of the estimated total premium due at policy inception;
- ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

- iii) No interest charges;
 - iv) Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;
 - v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.
2. We note that your extended reporting period requirements do not meet and/or address some or all of the following prescribed requirements. You must address each issue in the manual pages.

The extended reporting period (e.r.p.) must meet requirements set forth for both general liability and professional liability. Therefore, the company must offer an e.r.p. of five years or an unlimited period. The insured must be allowed 60 days after the end of the policy period to purchase the e.r.p. The insured must be offered (a) a free 5 year tail or (b) an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration) and premium capped (e.r.p. is limited to a 200% cap of the annual premium of the expiring policy). The company must inform the insured of the e.r.p. premium at the time the last policy is purchased. The premium will be priced as a factor of (a) the last 12 months' premium, (b) the premium in effect at policy issuance, or (c) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium.

We request receipt of your response by December 22, 2006. If you cannot have the response by such date, we require you send a response indicating the date it will be submitted. We appreciate your cooperation in addressing these issues.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Stinson Teresa [Teresa.Stinson@HCAHealthcare.com]
Sent: Tuesday, June 06, 2006 4:04 PM
To: Neuman, Gayle
Subject: RE: Hospital - Rate/Rule Filing #HCI2006-R

Please find attached the amended Page 2 of the rules that reflects the addition of Item F showing annual, quarterly or monthly remittance of premium available to insured. Please advise approval of filing. If any additional information is necessary, please allow an opportunity to respond rather than issue a disapproval. I appreciate your time and consideration. Thank you.

From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Thursday, May 25, 2006 8:40 AM
To: Stinson Teresa
Subject: RE: Hospital - Rate/Rule Filing #HCI2006-R

The extension until June 16, 2006 is granted. In answer to your question, at least a quarterly payment plan must be offered - you may additionally offer a monthly or other payment plan.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, May 24, 2006 9:57 AM
To: Neuman, Gayle
Subject: RE: Hospital - Rate/Rule Filing #HCI2006-R

I am working on the request below. My approving manager is out of the country on a mission trip and I am out of the office until 6/5 after today. May we have until to at least the week end of 6/16 to prepare changes and response required? One additional item, the company currently offers an option to pay monthly in lieu of annual if preferred. A specific quarterly billing is not referenced but is available to combine the monthly billings if preferred. Is this adequate to meet the need? I am researching the SB to get a more complete understanding but it always helps to get the clear explanation from the ones in the know. I do appreciate your help. Thank you.

From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Monday, May 22, 2006 12:57 PM
To: Stinson Teresa
Subject: Hospital - Rate/Rule Filing #HCI2006-R

Ms. Stinson,

In regard to your 3/30/06 response regarding the installment payment plan, we request such information be added to the manual for review at this time even though there is currently no Illinois business.

Additionally, there is current legislation pending in regard to the installment payment plan. Upon such legislation being finalized, we will advise you if the manual would require additional information or changes.

Your prompt attention is appreciated.

Gayle Neuman

6/7/2006

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

Neuman, Gayle

From: Neuman, Gayle
Sent: Thursday, May 25, 2006 8:40 AM
To: 'Stinson Teresa'
Subject: RE: Hospital - Rate/Rule Filing #HCI2006-R

The extension until June 16, 2006 is granted. In answer to your question, at least a quarterly payment plan must be offered - you may additionally offer a monthly or other payment plan.

From: Stinson Teresa [mailto:Teresa.Stinson@HCAHealthcare.com]
Sent: Wednesday, May 24, 2006 9:57 AM
To: Neuman, Gayle
Subject: RE: Hospital - Rate/Rule Filing #HCI2006-R

I am working on the request below. My approving manager is out of the country on a mission trip and I am out of the office until 6/5 after today. May we have until to at least the week end of 6/16 to prepare changes and response required? One additional item, the company currently offers an option to pay monthly in lieu of annual if preferred. A specific quarterly billing is not referenced but is available to combine the monthly billings if preferred. Is this adequate to meet the need? I am researching the SB to get a more complete understanding but it always helps to get the clear explanation from the ones in the know. I do appreciate your help. Thank you.

From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Monday, May 22, 2006 12:57 PM
To: Stinson Teresa
Subject: Hospital - Rate/Rule Filing #HCI2006-R

Ms. Stinson,

In regard to your 3/30/06 response regarding the installment payment plan, we request such information be added to the manual for review at this time even though there is currently no Illinois business.

Additionally, there is current legislation pending in regard to the installment payment plan. Upon such legislation being finalized, we will advise you if the manual would require additional information or changes.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through our website at http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm.

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



"Stinson Teresa"
<Teresa.Stinson@HCAHealth
care.com>
04/14/2006 12:41 PM

To <Gayle_Neuman@ins.state.il.us>
cc
bcc
Subject RE: Hospital General and Physician/Surgeon Professional
Liability - Filing #HCI2006-R

In response to your inquiries. Please keep in mind we do not currently have any business in your state. :

1. We maintain any required filings as a company but do not use or participate in any statistical agencies such as ISO, etc. If this is not your intent of the question, please advise.
2. Primarily the general liability and professional liability coverage written in other states is occurrence. We currently have one claims made product we write business in other states but that program is a pre-paid tail policy so there is no need for ERP. The ERP option was included in our rules as an emergency option for a staff physician program in case ever needed but it has no business in any state. We prefer not to remove the option in case it is ever needed but additional filings for rates and forms would be necessary if it was ever rolled out to the customer.

I hope this answers your questions but if you need to discuss further, please do not hesitate to give me a call or send email. I do appreciate your time and consideration.

From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Wednesday, April 05, 2006 10:19 AM
To: Stinson Teresa
Subject: Hospital General and Physician/Surgeon Professional Liability - Filing #HCI2006-R

Ms. Stinson,

Please address the following issues:

1. Indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?
2. Your response to the extended reporting period (e.r.p.) is unclear. Is the general liability coverage written on an occurrence basis with the professional liability coverage written on a claims-made basis?

Your 3/30/06 response stated "it is a pre-paid tail policy", yet the manual describes how the premium is determined. Please explain.

Your response is requested by no later than April 14, 2006.

Gayle Neuman
Property & Casualty Compliance Unit, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497



"Stinson Teresa"
<Teresa.Stinson@HCAHealth
care.com>
03/30/2006 09:22 AM

To <Gayle_Neuman@ins.state.il.us>
cc
bcc
Subject RE: Hospital General and Physician/Surgeon Professional
Liability - Filing #HCI2006-R

In response to your requests listed below. Please note that Health Care Indemnity, Inc. does not have any insured in your state at this time. We maintain our authority and the rate filings are only made to assure that we are in step with the marketplace so if business is ever written. We historically have written primarily the medical malpractice insurance for our parent company and do not market our product.

1. If a 3 year policy was written, we would use the rates in effect at inception of each term. Currently there are no 3 year policies written.
2. Currently the company only offers one claims made product and it is a pre-paid tail policy so the extended reporting period is addressed at onset of coverage eliminating the need when coverage terminates by request of insured or cancellation by the company. Also, the General Liability coverage is provided at no additional charge.
3. The class rates that are shown are for classes as listed in pages 11-13 of the manual. The extender rates (oral surgeons, nurse practioners, etc.) are as listed and based on calculations as notes in Item E on page 10. There is no connection of Class 1 to Oral Surgeon rates shown.
4. As noted previously, we historically have provided insurance coverage to our parent company. The current billing process is monthly. Due to no insured at this time I will make our finance department aware of the installment options that should be available should the parent company obtain any facility in the future.
5. a. As noted previously, we do not currently have any insured in your state. I have advised the underwriters that this is an item I would require detail on if business ever written.
b. Schedule rating would be reviewed for application for any contracted physician program participant. Employed physicians are automatically included in coverage and only provide an application as a way to track applicable premium charge and for claims reference.
c. All insured are treated and reviewed same. At each renewal, the insured is reviewed as applicable to program.
d. Our physician programs are a very small percentage of the overall program. Due to this, historically there has not been enough physician information for our data to be credible so reference to other carriers are the basis of our review. Each year this review is performed to better identify the marketplace for each state. We do include this rate review for your state even though we do not currently have any business there.
e. I have attached a copy of the underwriting review form that includes area for schedule credit/debit justification notes and is included in file for each contracted physician that applies for our program in other states. Please note this is an internal documentation form and is not filed in any state. Again this is a program that would be associated with the parent company facilities and is not a marketed program.

I trust this will address your concerns and I appreciate the opportunity to clear up any further questions you may have rather than receive a disapproval. Please do not hesitate to contact me if needed. I can be reached at (615) 344-1487 or by mail at PO Box 555, Nashville, TN 37202-0555. Thank you for your consideration and time.

From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Monday, March 20, 2006 1:48 PM
To: Stinson Teresa
Subject: Hospital General and Physician/Surgeon Professional Liability - Filing #HCI2006-R

Ms. Stinson,

As of March 20, 2006, no response to the 1/18/06 e-mail has been received. Do you wish to withdraw this filing? **YOUR IMMEDIATE ATTENTION IS REQUIRED.**

----- Forwarded by Gayle Neuman/INS on 03/20/2006 01:46 PM -----

Gayle Neuman/INS

01/18/2006 11:54 AM

To Teresa.Stinson@HCAHealthcare.com

cc

Subject Hospital General and Physician/Surgeon Professional Liability - Filing #HCI2006-R

Ms. Stinson,

Please provide the additional information required to review the above referenced filing:

1. On page 2 of the manual, paragraph C indicates a policy can be written for a period up to three years. Then in paragraph D, it states the rules and rates in effect at inception will be used to compute the premium. We assume a three year policy would still provide annual billing periods. If there was a rate change effective at the second year of a three year policy, would you continue using the previous rates in effect at the policy inception? We assume you need to provide a change in wording to clarify your position.
2. On page 16 of the manual, paragraph L references the optional extended reporting period. Because the policy also provides general liability, the manual will have to meet the requirements of both lines of coverage. Because this policy provides both professional liability and general liability, the policy must provide the requirements for both. Therefore, the company must offer an e.r.p. of five years or an unlimited period. The insured must be allowed 60 days after the end of the policy period to purchase the e.r.p. The insured must be offered (a) a free 5 year tail or (b) an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration) and premium capped (e.r.p. is limited to a 200% cap of the annual premium of the expiring policy). The company must inform the insured of the e.r.p. premium at the time the last policy is purchased. The premium will be priced as a factor of (a) the last 12 months' premium, (b) the premium in effect at policy issuance, or (c) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium.
3. On page 18 of the manual, please explain this format. Class 1 and Oral Surgeons have different dollar figures - but being on the same page line, do they have any connection?
4. SB 475 requires insurers that issue a medical malpractice policy offer the insured a quarterly premium payment installment plan. The premium payment installment plan must be filed in the rate/rule manual. Please provide us with information, not limited to:
 - a. Are these quarterly payments each 25% of the premium?
 - b. Is this identical for the extended reporting period premium?
 - c. Do you charge the insured anything for the payment plan, i.e. installment fees, etc.? Are any

other payment installment plans offered?

d. Will you offer every new insured and every renewal insured such plan(s) after January 1, 2006?

5. In regard to the pending rate/rule filing referenced above, please provide additional information about the filed scheduled rating plan, including the following information:

a. Specific breakdowns of actual debits/credits and detailed descriptions of criteria for applying scheduled debits/credits. For example, if the manual indicates a credit/debit of 0-20% will be applied depending on the existence/quality of a loss control program, provide specific descriptions of criteria used to judge the existence and quality of such loss control program, as well as the specific amount of debit/credit that will be applied to such criteria.

b. Whether the scheduled rating plan will be applied to all applicants/insureds. If not, provide a specific explanation of which applicants/insureds will be considered.

c. Whether the schedule debits/credits are reviewed periodically to ensure that they are still justified and added/removed accordingly. If the scheduled debits/credits are reviewed periodically, provide the time intervals for such reviews. If not all insureds are reviewed, provide a specific explanation of which insureds will be reviewed and how often.

d. All actuarial justification for determining the amount of any scheduled credit/debit.

e. A blank sample of the scheduled rating form that is kept in each applicant/insured's file to track the justification for receiving any debits/credits.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through the Department's website (<http://www.idfpr.com/>) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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



Physician Application Worksheet.doc

Physician Application Worksheet

Effective Date _____

Contracted _____

HCA or Triad

Employed _____

Staff _____

Physician Name _____

Degree _____

License # _____

Board Certified Yes No

Specialty _____

Date of Birth _____

Group Name _____

Facility _____ Coid _____

Address _____

Limits Requested \$100/300

\$1M/3M

\$200/600

\$2M/6M

\$250/750

PCF Request to Joy: Yes No

Date: _____

Prior Acts requested: Yes No

Retroactive Date: _____

Premium Financing: Yes No

Claims Summary

Total Number of Losses _____

Date of Loss/ Reported	Claimant	Death (Y/N)	Open/ Closed	Paid	Reserve	HCI Reserve
Description						
Description						
Description						
Description						
Totals						

Rating Worksheet

Rate	x	ILF/ DLF	x	Schedule Credit/Debit	x	FTE	x	Extender Factor	x	Annual Premium	x	Prorata Factor	=	Prorata Premium
	x		x		x		x		x		x		=	

Surplus Lines?		Or		Self Procurement?		Tax				Tax Amount	+	Premium	=	Total
						%					+		=	

Justification of Scheduled/Experience Debits/Credits

Claims Statement:

No known claims between last date of employment / / and
 anticipated new employment start date of / /

Or

Exception approval if there are claims: _____

Formula

Prior Acts Premium = Occurrence-based Annual Premium X 2.1 X A X B

Premium	=	Occ Annual	X	Rate	2.1	X	A	X	B
---------	---	------------	---	------	-----	---	---	---	---

Approve Decline

Referral

HCI Staff _____

Date _____

Manager of Physician Programs _____

Date _____

AVP of Insurance _____

Date _____



"Stinson Teresa"
<Teresa.Stinson@HCAHealth
care.com>
03/20/2006 01:51 PM

To <Gayle_Neuman@ins.state.il.us>
cc
bcc
Subject RE: Hospital General and Physician/Surgeon Professional
Liability - Filing #HCI2006-R

Thank you so much for the reminder and opportunity to complete this item. I do wish to respond and apologize for my oversight that this item was not promptly attended to. I will provide answers asap.

From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Monday, March 20, 2006 1:48 PM
To: Stinson Teresa
Subject: Hospital General and Physician/Surgeon Professional Liability - Filing #HCI2006-R

Ms. Stinson,

As of March 20, 2006, no response to the 1/18/06 e-mail has been received. Do you wish to withdraw this filing? **YOUR IMMEDIATE ATTENTION IS REQUIRED.**

----- Forwarded by Gayle Neuman/INS on 03/20/2006 01:46 PM -----

Gayle Neuman/INS

01/18/2006 11:54 AM
To Teresa.Stinson@HCAHealthcare.com
cc
Subject Hospital General and Physician/Surgeon Professional Liability - Filing #HCI2006-R

Ms. Stinson,

Please provide the additional information required to review the above referenced filing:

1. On page 2 of the manual, paragraph C indicates a policy can be written for a period up to three years. Then in paragraph D, it states the rules and rates in effect at inception will be used to compute the premium. We assume a three year policy would still provide annual billing periods. If there was a rate change effective at the second year of a three year policy, would you continue using the previous rates in effect at the policy inception? We assume you need to provide a change in wording to clarify your position.

2. On page 16 of the manual, paragraph L references the optional extended reporting period. Because the policy also provides general liability, the manual will have to meet the requirements of both lines of coverage. Because this policy provides both professional liability and general liability, the policy must provide the requirements for both. Therefore, the company must offer an e.r.p. of five years or an unlimited period. The insured must be allowed 60 days after the end of the policy period to purchase the e.r.p. The insured must be offered (a) a free 5 year tail or (b) an unlimited tail with limits reinstated (100% of aggregate expiring limits for the duration) and

premium capped (e.r.p. is limited to a 200% cap of the annual premium of the expiring policy). The company must inform the insured of the e.r.p. premium at the time the last policy is purchased. The premium will be priced as a factor of (a) the last 12 months' premium, (b) the premium in effect at policy issuance, or (c) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium.

3. On page 18 of the manual, please explain this format. Class 1 and Oral Surgeons have different dollar figures - but being on the same page line, do they have any connection?

4. SB 475 requires insurers that issue a medical malpractice policy offer the insured a quarterly premium payment installment plan. The premium payment installment plan must be filed in the rate/rule manual. Please provide us with information, not limited to:

- a. Are these quarterly payments each 25% of the premium?
- b. Is this identical for the extended reporting period premium?
- c. Do you charge the insured anything for the payment plan, i.e. installment fees, etc.? Are any other payment installment plans offered?
- d. Will you offer every new insured and every renewal insured such plan(s) after January 1, 2006?

5. In regard to the pending rate/rule filing referenced above, please provide additional information about the filed scheduled rating plan, including the following information:

a. Specific breakdowns of actual debits/credits and detailed descriptions of criteria for applying scheduled debits/credits. For example, if the manual indicates a credit/debit of 0-20% will be applied depending on the existence/quality of a loss control program, provide specific descriptions of criteria used to judge the existence and quality of such loss control program, as well as the specific amount of debit/credit that will be applied to such criteria.

b. Whether the scheduled rating plan will be applied to all applicants/insureds. If not, provide a specific explanation of which applicants/insureds will be considered.

c. Whether the schedule debits/credits are reviewed periodically to ensure that they are still justified and added/removed accordingly. If the scheduled debits/credits are reviewed periodically, provide the time intervals for such reviews. If not all insureds are reviewed, provide a specific explanation of which insureds will be reviewed and how often.

d. All actuarial justification for determining the amount of any scheduled credit/debit.

e. A blank sample of the scheduled rating form that is kept in each applicant/insured's file to track the justification for receiving any debits/credits.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a

paper filing or an electronic filing (SERFF). The checklists can be accessed through the Department's website (<http://www.idfpr.com/>) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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



"Stinson Teresa"
<Teresa.Stinson@HCAHealth
care.com>

10/26/2005 12:06 PM

To <Gayle_Neuman@ins.state.il.us>
cc
bcc
Subject RE: Rate/Rule Filing HCI2006-R

Please see attached rules and rate pages with changes highlighted. Changes include edition date from 0105 to 0106 and on page 10, in a previous submission a classification was added and then was determined to be not applicable for our program. Health Care Indemnity, Inc. does not currently write any business in Illinois. We try to maintain filings due to admitted authority and possible future need so we will remain standard with the industry. Thank you for your consideration and please advise if I can provide any information to assist with filing approval.

From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Tuesday, October 18, 2005 9:58 AM
To: Stinson Teresa
Subject: Rate/Rule Filing HCI2006-R

Ms. Stinson,

We are in receipt of the above referenced filing submitted by letter dated September 29, 2005.

50 Ill. Adm. Code 929.30 requires identification of all changes from superseding filings. Please provide a copy of the manual showing the exact changes that are being made in this filing.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through the Department's website (<http://www.idfpr.com/>) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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



010106 Rules with changes noted.doc 05 0929 IL 2006 Addendum A Page 17 Liability Rates.doc



05 0929 IL 2006 Addendum B Page 18 Physician Extender Rates.doc

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

I. GENERAL RULES

A) Eligibility

1) Hospital - Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

2) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses with the exception of an additional premium computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

3) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures

- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.
- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91
163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

CRITERIA	MAXIMUM CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	±10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	±10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	±7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	±5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	±5%
• Certificates of insurance are obtained verifying vendor liability coverage.	±5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	±3%
• Written job descriptions are established for all positions.	±3%
• Each facility has a designated, full-time safety director or safety officer.	±3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	±10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	±10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	±10%
• The quality management and risk management programs are integrated.	±7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	±5%
• Continuing risk management education requirements routinely fulfilled.	±5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	±3%
• Risk management issues are addressed in new employee orientation.	±3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	±3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	±5%
• No citations or penalties by a regulatory agency within the past 3 years.	±5%
Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	±10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	±7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	±7%
• Emergency department physicians are board certified.	±5%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

A) Applicability

Physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

1) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

2) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

C) Definitions

Physician, surgeon and allied health professional

- Contract physician Physician under contract with a facility to provide professional medical service to or on behalf of such institution

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- **Employed physician** Physician providing health care services, including osteopathic physician and resident, who is considered an employee of an insured business
- **Full-time employee** Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE)
- **Part-time employee** Person employed by the facility less than 40 hours per week expressed in percentage of FTE
- **Resident** Postgraduate medical student (including intern and fellow)

D) Basis of premium

- **Employed physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Allied health professional** – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
- **Part-time physician and surgeon** – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = 75% subject to note below) Multiply the result by the class premium for each specialty
- **Contract physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Note:** No FTE lower than 25%. FTE equal to 25% or less use 25%. FTE between 25% and 80% use 50%. FTE 80% or higher use 100%. More than 240 hours or 6 FTE use a surcharge of 25%

E) Calculation of premium

1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.

2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate
ER Physician Assistant	Charge 25% of the class 4 rate

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Nurse Practitioner	Charge 25% of the class 1 rate
Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY – NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE – NI

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

•
CLASS 1 Continued

- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE – NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE – INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE – INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS – INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE – INV

CLASS 3

- FAMILY PRACTICE – SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE – SRG
- HOSPITALIST

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- EMERGENCY MEDICINE

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY

F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM CREDIT/DEBIT
Loss experience(not available in Kansas)	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

See Addendum B

J) Physician prior acts coverage

1) Applicability

Physician's prior acts coverage may be provided only to physicians employed by insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.

2) Coverage

Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 2.1 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

4) Increased Limits

As stated under J) 2) Physician prior acts coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:

Limits of Liability	Decrease/Increased Limits Factor
\$100,000/300,000	0.46
\$200,000/600,000	0.60
\$250,000/750,000	0.61
\$500,000/1 million	0.84
\$500,000/1.5 million	0.87
\$1/3 million	1.00
\$2/4 million	1.24
\$2/6 million	1.27
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50

5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

L) Optional Extended Reporting Period

Unlimited extended reporting period is available upon termination of the policy. The premium is determined by multiplying 210% by the mature claims made premium in effect at expiration of the policy. Premium is due within 30 days of quote and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy.

The extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company; or 3) to his or her estate if such medical professional dies during the policy period. An exception to the 5 year requirement for free tail at retirement may be considered by underwriting discretion.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.

**HEALTH CARE INDEMNITY, INC.
PHYSICIAN AND SURGEON PROFESSIONAL LIABILITY**

Addendum B

Premium Rate Schedule

ILLINOIS

Limits: \$1,000,000/\$3,000,000

Territory: Rest of State

Class 1	14,550.18	Oral Surgeons	16,821.06
Class 2	20,370.64	Nurse Midwives	16,263.20
Class 3	29,100.36	CRNA	8,410.53
Class 4	33,642.12	NP/PA	3,637.55
Class 5	45,419.64	Optometrists	1,455.02
Class 6	66,138.94	Dentists	3,364.21
Class 7	65,052.81	Chiropractors	6,505.28
Class 8	87,761.28		

Class 1	42,125.45	Oral Surgeons	15,763.34
Class 2	46,975.53	Nurse Midwives	15,114.56
Class 3	24,250.30	CRNA	7,881.67
Class 4	31,526.68	NP/PA	3,031.29
Class 5	42,659.67	Optometrists	1,212.52
Class 6	55,115.78	Dentists	3,152.67
Class 7	60,458.24	Chiropractors	6,045.82
Class 8	73,134.40		

Territory: Cook County

Class 1	22,045.00	Oral Surgeons	28,659.15
Class 2	30,863.88	Nurse Midwives	27,336.76
Class 3	44,092.20	CRNA	14,329.58
Class 4	57,318.30	NP/PA	5,511.25
Class 5	68,253.71	Optometrists	2,204.50
Class 6	88,183.49	Dentists	5,731.83
Class 7	109,347.04	Chiropractors	10,934.70
Class 8	132,276.11		

Class 1	48,370.83	Oral Surgeons	23,882.63
Class 2	25,749.90	Nurse Midwives	22,780.63
Class 3	36,743.50	CRNA	11,941.31
Class 4	47,765.25	NP/PA	4,592.71
Class 5	56,878.09	Optometrists	1,837.08
Class 6	73,486.24	Dentists	4,776.53
Class 7	91,122.53	Chiropractors	9,112.25
Class 8	110,230.09		

Health Care Indemnity, Inc.
Pure premium costs - 2003 (new relativities)

	<u>\$1million</u>	<u>\$4M x \$1M</u>	<u>\$5M x \$5M</u>	<u>\$9M x \$1M</u>
Projected ultimate valuations	\$258,088,000	\$100,929,000	\$26,425,000	\$127,354,000
Projected Ribs	73,351	73,351	73,351	73,351
Projected state adjusted Ribs	73,804	84,337	84,337	84,337
Rate per state adjusted Rib	\$ 3,497	\$ 1,197	\$ 313	\$ 1,510
Credit for Reinsurance	-	-	-	
Pure premium	\$ 3,497	\$ 1,197	\$ 313	
Rate per rib	3,519	1,376	360	
2002 filed rates - pure premium restated	3,300	1,093	258	
2002 filed rates - per rib	3,388	1,312	310	
Pure premium-change	6%	10%	21%	
Rate per rib-change	4%	5%	16%	

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

I. GENERAL RULES

A) Eligibility

1) Hospital - Coverage is available to hospital systems that own, operate or manage, as their principal business, acute care hospitals or psychiatric hospitals, but which may also include incidental healthcare risks such as:

- Rehabilitation hospitals
- Alcoholism or chemical dependency hospitals
- Skilled nursing facilities
- Clinics, dispensaries, infirmaries, surgery centers
- Home health facilities

All applicants are required to submit a completed application including:

- Patient volume data including a schedule of employed physicians, surgeons and allied health professionals;
- Minimum of five up to a maximum of ten full years currently valued prior carrier loss experience in triangulate format, if available; and,
- Copy of the most recent audited financial statement and annual report, if available.

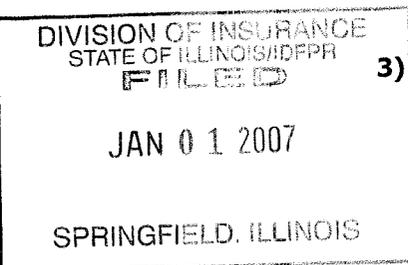
2) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses with the exception of an additional premium computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist

All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

3) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

Coverage may be declined based on loss history, financial history, or risk management issues.

B) Entity Prior Acts Coverage

At the Company's discretion, prior acts coverage may be offered to insured entities to cover occurrences that took place prior to the entity becoming insured with the Company but which are unknown at the time. The premium for this coverage will be (a)-rated to reflect the number of months or years of prior acts, the deductible, the exposure base for the prior acts period, limits of liability, etc.

The limits of liability offered under this prior act coverage should not exceed the limits of liability for the coverage in place during the prior acts period.

Rules for Prior Acts Coverage

- A completed application that indicates satisfactory previous insurance coverage must be received. (See Application Section.)
- The premium for this coverage is "fully earned" at inception.

C) Policy Term

- Policies may be written for a specified period up to three years.

D) Premium Computation

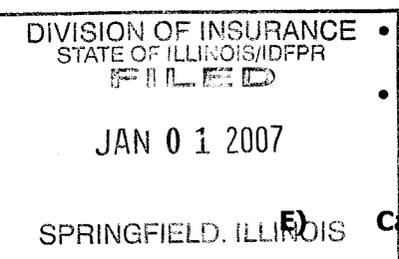
- The rules and rates in effect at the inception of the policy will be used to compute the policy premium.
- The factors or multipliers used to compute the premium will be applied consecutively and not added together.
- Dollar figures used for rates, factors, and multipliers will be rounded to two decimal places. Premiums will be rounded to the nearest whole dollar.
- All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$25 or less will be waived unless specifically requested by the insured.

E) Cancellation

- The return premium will be computed pro-rata and rounded to the next higher whole dollar when a policy is cancelled.

F) Premium Remittance

- The insured premium payment plan may be annual, quarterly or monthly.
 - Quarterly premium installment plans are available to insured whose annual premiums are less than \$500, or for premium for any extension of a reporting period. Quarterly premium installment plans are also available to insured with premium exceeding \$500. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy. Thereafter, the



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. Quarterly installment premium payment plans shall include the minimum standards listed below.

- i) An initial payment of no more than 40% of the estimated total premium due at policy inception;
- ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;
- iii) No interest charges;
- iv) Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;
- v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

II. HOSPITAL PROFESSIONAL LIABILITY RULES

A) Occurrence Rates

Risk Index Beds (RIB) - An occupied bed equivalency system shall be used as the basis for measuring the exposure. That system is referred to as the Risk Index Bed (RIB). The exposure related to physicians, surgeons and allied health professionals, as described in Section I, A) Eligibility, shall be considered separately.

The following table displays the eight statistics and how many patient "encounters" in each category equals one RIB. The relativity factor expresses the relation between each patient statistic and one occupied bed.

Statistic	Equals 1 RIB	Relativity
Occupied Bed	1	1.00000
Emergency Room Visits	500	0.00200
In-patient Surgeries	45	0.02200
Out-patient Surgeries	500	0.00200
Out-patient Visits	5,000	0.00020
Home Health Visits	8,333	0.00012
Births	10	0.10000
Clinic Visits	5,000	0.00020

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDPPR
FILED

JAN 01 2007

SPRINGFIELD, ILLINOIS

A facility's total RIBS are a measure of its malpractice risk exposure. Premium is determined by multiplying the number of RIBS times the rate. The rate is also calculated using a territorial relativity factor.

- Territorial Relativity Factor – The territorial relativity factor is actuarially determined based on historical industry losses within a geographic area. The factor effectively adjusts the base rate to account for these jurisdictional differences.

Premium Calculation (Base Rate) – In addition to the territorial relativity factors, a discount recognizing the insuring company's investment income, an administrative surcharge, and any state applicable taxes are applied.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

The premium for the \$1,000,000 base layer is developed using the following formula:

$$\text{Premium} = \text{Base Rate} \times \text{Experience Modification Factor} \times (1 - \text{Schedule Factor}) \times (1 - \text{Deductible Factor}) \times \text{RIBS}$$

Underwriting judgement, (a)-rates may be used when premiums exceed \$250,000 or unique risk characteristics exist.

1) Rating Procedures

- a) The experience modification factor for a risk will be developed in accordance with the procedure as described below and applied to the manual premium as calculated by the net base rate per RIB.
- b) A modification reflecting specified characteristics of the risk, which is not reflected in the experience, may be applied in accordance with the schedule criteria described herein. The schedule modifications developed under this plan are limited to the individual risk premium modification state limitations.
- c) Any further modifications available (such as deductible) are then applied to the modified premium generated by application of this plan.

2) Experience Modification Factor

- a) Experience Period

The experience modification will be determined from the applicant's latest available complete experience (up to ten years,) excluding the expiring 12-month period. In the event that the experience for the full ten-year period is not available, the total experience, which is available (subject to a minimum of two completed policy years), will be used in determining the experience modification.

As noted above, the experience period does not include the year immediately prior to the effective date of the experience modification.

At the discretion of the Company, experience incurred by other companies, or self-insured experience, may be used to the extent that the loss data appears reliable and the loss reserves are consistent with this Company's valuation practices.

- b) Loss Limitation

Losses are capped at \$1,000,000 per claim for determining the experience modification factor.

- c) Experience Modification Formula

The experience modification factor is calculated using the following formula:

$$\text{Experience Modification Factor} = (\text{Credibility Factor} \times (\text{Actual Losses} / \text{Expected Losses})) + (1 - \text{Credibility Factor})$$

Actual reported losses and ALAE values are compared to the expected reported losses and ALAE for the same periods to determine if each facility's experience



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

has been better or worse than the average experience underlying the premium level.

This relationship is used to determine an appropriate experience modifier for each facility. Actual losses and ALAE are divided by expected losses and ALAE to determine the indicated experience ratios. These experience ratios are then "credibility weighted" with the program average (1.00) to develop the experience modification factors applicable to each facility. Also, the more recent years carry a heavier weight than early years. The credibility, or weight, given to the experience of each facility is a function of the risk's size. That is, it is assumed that a large risk is more likely to repeat experience that is better or worse than average than is a smaller risk with similar experience. This is because chance fluctuations in either the frequency or severity of losses for a large base have less of an impact than chance fluctuations for a smaller base. The credibility standard of 2,476 exposed risk indexed beds during the experience period constitutes full credibility, at which point the risk is essentially self-rated. Credibility factors for fewer exposure units are shown in d) Summary of Credibility Factors, below.

The experience modification factors, when applied to the underlying loss rates for each risk, result in modified occupied loss rates which reflect the expectation that individual facilities will develop loss and ALAE experience that is better or worse than the experience of the insured population as a whole.

d) Summary of Credibility Factors

RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor	RIB Equivalent Exposures		Credibility Factor
From	To		From	To		From	To	
1	1	0.02	298	315	0.35	1,140	1,173	0.68
2	3	0.03	316	333	0.36	1,174	1,207	0.69
4	5	0.04	334	351	0.37	1,208	1,242	0.70
6	7	0.05	352	370	0.38	1,243	1,278	0.71
8	10	0.06	371	390	0.39	1,279	1,314	0.72
11	14	0.07	391	410	0.40	1,315	1,350	0.73
15	18	0.08	411	430	0.41	1,351	1,387	0.74
19	22	0.09	431	451	0.42	1,388	1,425	0.75
23	27	0.10	452	473	0.43	1,426	1,463	0.76
28	33	0.11	474	495	0.44	1,464	1,501	0.77
34	39	0.12	496	517	0.45	1,502	1,540	0.78
40	45	0.13	518	540	0.46	1,541	1,580	0.79
46	52	0.14	541	564	0.47	1,581	1,620	0.80
53	60	0.15	565	588	0.48	1,621	1,660	0.81
61	68	0.16	589	612	0.49	1,661	1,701	0.82
69	76	0.17	613	637	0.50	1,702	1,743	0.83
77	85	0.18	638	663	0.51	1,744	1,785	0.84
86	95	0.19	664	689	0.52	1,786	1,827	0.85
96	105	0.20	690	715	0.53	1,828	1,870	0.86
106	115	0.21	716	742	0.54	1,871	1,914	0.87
116	126	0.22	743	770	0.55	1,915	1,958	0.88
127	138	0.23	771	798	0.56	1,959	2,002	0.89
139	150	0.24	799	826	0.57	2,003	2,047	0.90
151	162	0.25	827	855	0.58	2,048	2,093	0.91

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2007

SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

163	175	0.26	856	885	0.59	2,094	2,139	0.92
176	189	0.27	886	915	0.60	2,140	2,185	0.93
190	203	0.28	916	945	0.61	2,186	2,232	0.94
204	217	0.29	946	976	0.62	2,233	2,280	0.95
218	232	0.30	977	1,008	0.63	2,281	2,328	0.96
233	248	0.31	1,009	1,040	0.64	2,329	2,376	0.97
249	264	0.32	1,041	1,072	0.65	2,377	2,425	0.98
265	280	0.33	1,073	1,105	0.66	2,426	2,475	0.99
281	297	0.34	1,106	1,139	0.67	2,476+		1.00

3) Schedule Modification

This plan permits recognition of risk characteristics identified through the experience and judgment of the underwriter that are expected to influence the frequency or severity of future losses. The modification must acknowledge risk characteristics that are not considered in or recognized by the manual rates or other applicable rating plans.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 0 1 2007

SPRINGFIELD, ILLINOIS

CRITERIA	MAXIMUM 25% CREDIT/DEBIT
Facility Profile	
• 100% of the patient care areas are equipped with sprinklers.	±10%
• Vendor contracts are reviewed by legal counsel and risk management for appropriate risk control oversight.	±10%
• Existence of an efficient patient incident reporting, analysis and trending system in each facility.	+7%
• Existence of any unusual general liability or premises liability risks. (E.g. day care, public fitness facilities, etc.)	±5%
• Screening procedures are established that include obtaining written verification of references and copies of professional licenses for all newly hired employees.	±5%
• Certificates of insurance are obtained verifying vendor liability coverage.	+5%
• Existence of a comprehensive preventive maintenance program for medical equipment in each facility.	±3%
• Written job descriptions are established for all positions.	+3%
• Each facility has a designated, full-time safety director or safety officer.	+3%
Risk Management Profile	
• Existence of functioning risk management and safety committees in each facility.	+10%
• Administrative commitment to risk management as demonstrated by a written and enforced risk management program or policy statement in each facility.	±10%
• Facility risk manager reports directly to the CEO or COO, or equivalent position.	+10%
• The quality management and risk management programs are integrated.	+7%
• Risk manager is a member of all hospital committees relating to patient care or employee safety and an ad hoc member of medical staff committees.	±5%
• Continuing risk management education requirements routinely fulfilled.	±5%
• Risk management and safety personnel are involved in the process of evaluation and approval of equipment and supplies for purchase.	±3%
• Risk management issues are addressed in new employee orientation.	+3%
• Risk management staffing complies with HCI standards (ratio of FTE's to occupied beds).	+3%
Compliance	
• Continuous accreditation through JCAHO (or other appropriate accrediting body) with no contingencies for 3 years.	±5%
• No citations or penalties by a regulatory agency within the past 3 years.	+5%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Physician Relationships	
• \$1mm/\$3mm minimum insurance requirement for staff physicians are included in the medical staff by-laws, except in states where patient compensation funds apply.	±10%
• Physicians providing services under contract maintain professional liability insurance with minimum limits of \$1 million per claim or occurrence.	±7%
• CRNA's are supervised at all times by an in-house anesthesiologist, or physician if no anesthesiologist is available.	±7%
• Emergency department physicians are board certified.	±5%

The premium resulting from the application of the experience modification factor shall be multiplied by the total credit or debit produced by the application of this schedule factor plan. The maximum schedule modification adjustment is the individual risk premium modification state limitation.

The underwriting file will include specific criteria and documentation to support the selected schedule modification factor.

4) Deductible Credit

Policies are offered with or without a deductible. Two alternative deductible arrangements are available.

In the "Indemnity Only" model, the deductible includes indemnity plus ALAE. If the indemnity exceeds the deductible amount, the Company will pay the pro rata share of the ALAE. If the indemnity does not exceed the deductible amount, all of the ALAE is allocated to the insured. In the "Indemnity plus ALAE" model, all amounts payable as indemnity plus ALAE contribute toward the erosion of the deductible.

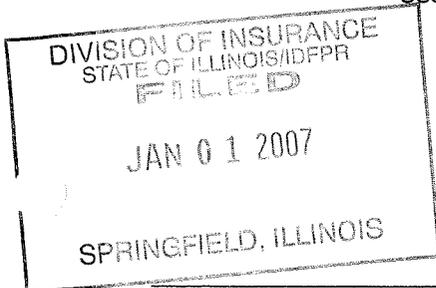
A deductible aggregate is also available and will be (a)-rated. If a deductible aggregate is provided, all indemnity plus ALAE allocated to the insured contribute toward the impairment of the deductible aggregate.

The following deductible credits based on a per occurrence limit of \$1,000,000 will be used to calculate premium reductions for an insured that selects a deductible:

Deductible	Credit	
	Indemnity Only	Indemnity plus ALAE
\$50,000	0.33	0.30
\$100,000	0.42	0.35
\$250,000	0.60	0.44
\$500,000	0.78	0.53
\$750,000	0.91	0.59
\$1,000,000	1.00	0.63

5) Liability Rate Schedule

See Addendum A

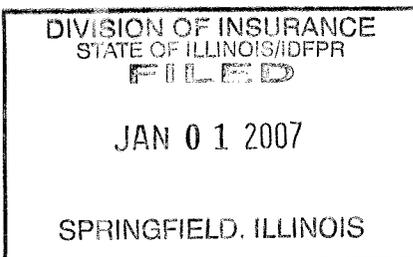


**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

III. GENERAL LIABILITY

A) Occurrence Rates

The premium for General Liability coverage is included in the professional liability premium calculation. No separate premium charges for general liability will be assessed to an insured that also has professional liability exposure unless the insured's general liability exposure is greater than contemplated in a hospital system. The company reserves the right to (a)-rate based on loss history or risk characteristics.



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

IV. PHYSICIAN & SURGEON PROFESSIONAL LIABILITY

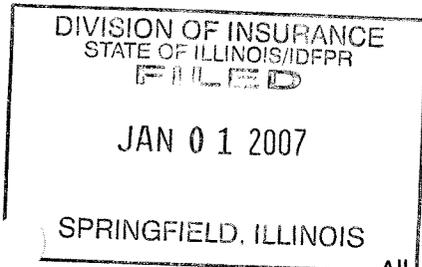
A) Applicability

Physician and surgeon professional liability risk exposure is not contemplated in the RIB statistics. The following classifications and rates apply to physician and surgeon professional liability insurance for eligible physician, surgeon, and allied health professional.

B) Coverage

1) Employed Physician, Surgeons and Allied Health Professionals - Coverage is intended to include employees of covered businesses except that an additional premium will be computed and charged for employees in the following employment categories:

- Physician and surgeon
- Allied health professional
 - Oral surgeon
 - Dentist
 - Chiropractor
 - Optometrist
 - Nurse practitioner
 - Physician assistant
 - Nurse midwife
 - Certified registered nurse anesthetist



All employed physician, surgeons and allied health professional applicants are required to submit a completed application.

2) Contracted Physicians and Surgeons/Groups - Coverage may be offered when an additional premium is computed and charged. Compliance of the following is expected:

- Commitment to a cooperative defense strategy in joint litigation;
- Coverage is provided for services performed exclusively at HCA facilities;
- Including, but not limited to, house based medical services such as anesthesia, pathology, radiology and emergency medicine;
- Risk management standards as applicable; and
- The Company shall have the right to settle any claim as it deems necessary.

Separate premium charge would apply for entity or ancillary personnel coverage, if applicable.

All contracted physicians and surgeons/group applicants are required to submit a completed application and submit five years of loss information.

C) Definitions

Physician, surgeon and allied health professional

- Contract physician Physician under contract with a facility to provide professional medical service to or on behalf of such institution

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

- **Employed physician** Physician providing health care services, including osteopathic physician and resident, who is considered an employee of an insured business
- **Full-time employee** Person employed by the facility for 40 or more hours per week (including contract employees); also known as "full time equivalent" (FTE)
- **Part-time employee** Person employed by the facility less than 40 hours per week expressed in percentage of FTE
- **Resident** Postgraduate medical student (including intern and fellow)

D) Basis of premium

- **Employed physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Allied health professional** – oral surgeon, dentist, optometrist, chiropractor, nurse midwife, certified registered nurse anesthetist, physician assistant, and nurse practitioner. The unit of exposure is per FTE, computed by dividing the number of hours worked per week by part-time employees, by 40. Full-time employees each equal one FTE regardless of number of hours worked per week.
- **Part-time physician and surgeon** – Determine total number of hours per week worked for physicians in each classification. Divide total number by 40 hours to compute FTE (e.g. 30/40 = 75% subject to note below) Multiply the result by the class premium for each specialty
- **Contract physician, surgeon and resident** – Refer to C) Definitions above. The unit of exposure is per FTE.
- **Note:** No FTE lower than 25%. FTE equal to 25% or less use 25%. FTE between 25% and 80% use 50%. FTE 80% or higher use 100%. More than 240 hours or 6 FTE use a surcharge of 25%

E) Calculation of premium

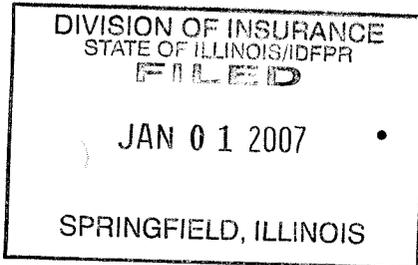
1) Physician and surgeon (including contract)

Calculate premium at the physician rate then apply schedule debits and credits as applicable. For residents, charge 40% of the physician specialty rate indicated.

2) Allied health professional

Rate is developed as a percentage of the \$1,000,000/\$3,000,000 premium for the specified classification as follows:

Oral Surgeon	Charge 50% of the class 4 rate
Nurse Midwife	Charge 25% of the class 7 rate
Certified Registered Nurse Anesthetist	Charge 25% of the class 4 rate
Physician Assistant	Charge 25% of the class 1 rate
Nurse Practitioner	Charge 25% of the class 1 rate



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Optometrist	Charge 10% of the class 1 rate
Dentist	Charge 10% of the class 4 rate
Chiropractor	Charge 10% of the class 7 rate

3) Classifications

a) Terminology Definitions

Non-Invasive (NI)

This term applies to physicians in Class 1 who do not: perform invasive procedures, perform obstetrics, perform surgery or assist in surgical procedures, practice emergency medicine, or perform endoscopic procedures. The following are considered examples of non-invasive procedures: incision of boils, treatment of superficial abscesses, suturing of skin and superficial fasciae, and administration of topical or local infiltration anesthesia.

Invasive (INV)

This term applies to physicians in Class 2 who do not: perform obstetrics, perform surgery or assist in surgical procedures, or practice emergency medicine. Endoscopic procedures not otherwise classified in a higher class code are an example of an invasive procedure and physicians who perform these procedures will be classified in Class 2 or higher.

Surgery (SRG)

This term applies to physicians who would otherwise be classified in Class 1 or 2 but who perform surgery or assist in surgical procedures, or practice emergency medicine. Examples of procedures included in this surgery category are: hair transplants, pain blocks, left heart catheterizations, vasectomies, tonsilectomies, adenoidectomies, abortions, dilation and curettage, tympanotomy with intubation. The practice of obstetrics is not included in the definition of surgery.

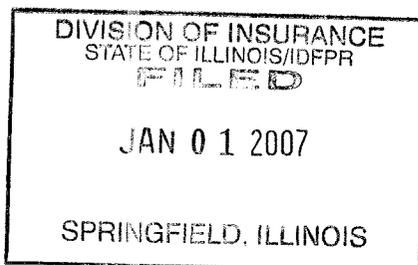
Obstetrics (OB)

This term refers to the practice of obstetrics, including cesarean sections, and normal vaginal deliveries. Physicians who practice in the specialty of obstetrics will be classified in Class 7. Physicians in the specialty of family practice who, as an incidental part of their practice, attend normal deliveries, will be classified in Class 5.

b) Specialty Classification (Class Code Listing)

CLASS 1

- ALLERGY & IMMUNOLOGY
- CARDIOLOGY – NI
- DERMATOLOGY - NI
- DIAGNOSTIC RADIOLOGY
- ENDOCRINOLOGY
- FAMILY PRACTICE - NI
- GASTROENTEROLOGY - NI
- GENERAL PRACTICE - NI
- GERIATRICS
- HEMATOLOGY - NI
- INFECTIOUS DISEASE – NI
-



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 1 Continued

- INTERNAL MEDICINE - NI
- MEDICAL GENETICS
- NEPHROLOGY
- NEUROLOGY - NI
- OCCUPATIONAL MEDICINE - NI
- ONCOLOGY - NI
- OSTEOPATHY
- PATHOLOGY
- PEDIATRICS - NI
- PHYSICAL MEDICINE & REHABILITATION
- PODIATRY - NI
- PREVENTIVE MEDICINE
- PSYCHIATRY
- PULMONARY MEDICINE - NI
- NUCLEAR MEDICINE - NI
- SPORTS MEDICINE - NI

CLASS 2

- CARDIOLOGY - INV
- DERMATOLOGY - INV
- FAMILY PRACTICE - INV
- GASTROENTEROLOGY - INV
- GENERAL PRACTICE - INV
- HEMATOLOGY - INV
- INTERNAL MEDICINE - INV
- INFECTIOUS DISEASE - INV
- INDUSTRIAL MEDICINE - INV
- NEUROLOGY - INV
- OCCUPATIONAL MEDICINE - INV
- ONCOLOGY - INV
- OPHTHALMOLOGY
- PEDIATRICS - INV
- PODIATRY - INV
- PULMONARY MEDICINE - INV
- NUCLEAR MEDICINE - INV
- SPORTS MEDICINE - INV

CLASS 3

- FAMILY PRACTICE - SRG
- GENERAL PRACTICE - SRG
- INTERNAL MEDICINE - SRG
- NEONATOLOGY
- PROCTOLOGY
- NUCLEAR MEDICINE - SRG
- HOSPITALIST

CLASS 4

- ANESTHESIOLOGY
- DENTISTRY
- EMERGENCY MEDICINE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2007

SPRINGFIELD, ILLINOIS

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

CLASS 4 Continued

- ORAL/MAZILLOFACIAL SURGERY
- OTOLARYNGOLOGY
- UROLOGY

CLASS 5

- COLON & RECTAL SURGERY
- FAMILY PRACTICE - OB
- GENERAL SURGERY
- GYNECOLOGY
- UROLOGICAL SURGERY

CLASS 6

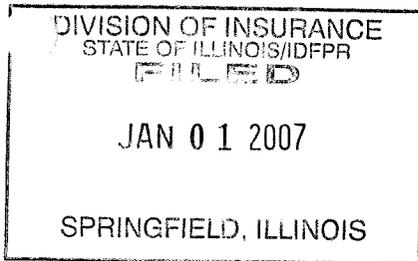
- CARDIAC SURGERY
- CARDIOVASCULAR SURGERY
- HAND SURGERY
- ORTHOPEDIC SURGERY
- PLASTIC SURGERY
- THORACIC SURGERY
- TRANSPLANT SURGERY
- VASCULAR SURGERY

CLASS 7

- OB/GYN
- OBSTETRICS

CLASS 8

- NEUROLOGICAL SURGERY



F) Schedule modification rating plan

Application of the schedule modification rating plan provides a modification factor to reflect compliance by each eligible full-time physician (including contract) of Company performance standards. Premium reduction provides a financial incentive to improve risk management practices and loss exposure. The resulting schedule debit or credit is to be applied to the premium for the physician exposure.

CRITERIA	MAXIMUM ±25% CREDIT/DEBIT
Loss experience(not available in Kansas)	+25%
Board certification	+25%
Continuing education within 12 months	+25%
Risk management policies	+25%
License related	+25%
Privilege related	+25%
Prior Coverage/Application related	+25%

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

G) Territory

Refer to the Premium Rate Schedule to determine applicable territory.

- Mid Territorial Rule – If an insured conducts activities in two or more territories, the rating of territory in which the practitioner spends the most of time is used.

H) Applicable State Fund

State fund participation surcharge rates are not included in the rates listed. Where applicable (e.g. LA, IN, KS) consult the schedule for the specific state fund following the premium rate schedule.

I) Premium Rate Schedule

See Addendum B

J) Physician prior acts coverage

1) Applicability

Physician's prior acts coverage may be provided only to physicians employed by insured business entities, and typically only at the time of employment. This is offered as a convenience to those physicians and insured businesses to simplify the transition from the physician's prior claims-made coverage to coverage provided by this Company.

In some rare circumstances, the underwriter may, at his/her discretion, offer prior acts coverage incepting at some point after the date of employment. An example of these circumstances is an insolvency of an employed physician's prior acts carrier.

2) Coverage

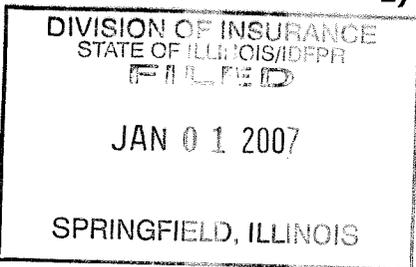
Under this prior acts coverage, professional liability insurance is provided for covered claims arising out of events which took place subsequent to the physician's retroactive date, and prior to the date of employment with the insured business, and that are reported to the Company after the date of employment. The limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period subject to a maximum \$5 million per occurrence limit.

3) Premium calculation

The prior acts premium is determined by calculating the occurrence-based annual premium as defined in this rules filing (based on \$1 million / \$3 million limits), and applying the following formula:

$$\text{Prior Acts Premium} = \text{Occurrence-based Annual Premium} \times 2.1 \times A \times B$$

"A" is a percentage discount factor based on the length of the prior acts period, as reflected in the table below:



**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

Months between Retro Date and Employment Date	Percentage Discount	"A" Multiplier
0 to 6 Months	75%	0.25
6 to 18 Months	50%	0.50
18 to 30 Months	25%	0.75
30 to 42 Months	15%	0.85
42 to 54 Months	5%	0.95
54 Months or Longer	0	1.00

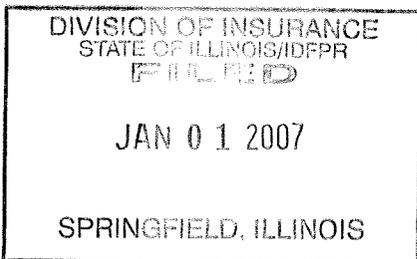
In the exceptional circumstances in which the prior acts coverage option is offered after the date of employment, the underwriter may calculate a discount in recognition of the time elapsed between the date of employment and the inception of the proposed prior acts coverage. This "B" multiplier is reflected in the table below:

Months between Employment Date and Effective Date	Percentage Discount	"B" Multiplier
0 to 18 Months	0	1.00
18 Months or Longer	25%	0.75

4) Increased Limits

As stated under J) 2) Physician prior acts coverage, the limits of liability offered under the prior acts coverage option shall not exceed the limits of liability for the coverage in place during the prior acts period, subject to a maximum \$5 million per occurrence limit. In the event the coverage for the prior acts period is to exceed limits of liability of \$1 million / \$3 million, the following increased limits factors will be applied to the premium calculation:

Limits of Liability	Decrease/Increased Limits Factor
\$100,000/300,000	0.46
\$200,000/600,000	0.60
\$250,000/750,000	0.61
\$500,000/1 million	0.84
\$500,000/1.5 million	0.87
\$1/3 million	1.00
\$2/4 million	1.24
\$2/6 million	1.27
\$3/5 million	1.37
\$4/6 million	1.45
\$5/7 million	1.50



5) Exceptions

In states that have established Patient Compensation Funds (e.g. LA, KS, IN) the limits of liability that form the basis of the prior acts premium calculation will be different than the \$1 million / \$3 million used as the basis in other states.

**HEALTH CARE INDEMNITY, INC.
PROFESSIONAL AND GENERAL LIABILITY**

K) Claims Made Step Factors

Application of the claims made step factors provides a modification factor to reflect the appropriate premium claims made reporting year of coverage based on retroactive date.

Claims Made Year	Factor to apply to 5th Year Claims Made Rate
1	0.42
2	0.66
3	0.93
4	0.98
5	1.00

L) Extended Reporting Period

Insured is provided a free 60-day extended reporting period to report occurrences. A free 5-year tail is available on claims from occurrences during the policy period and the free 60-day period. Unlimited extended reporting period with limits reinstated (100% of aggregate expiring limits for the duration) is available upon termination of the policy. The unlimited extended reporting period premium is determined by multiplying 200% by the mature claims made annual premium in effect at expiration of the policy. Premium is due within 60 days of quote made after end of policy and endorsement shall not be cancelled or refunded. Limit of liability, terms and conditions shall not exceed expiring policy. The insured must be informed of the extended reporting period premium at the time the last policy is purchased. The extended reporting period must be offered when the policy is terminated for any reason and whether the policy is terminated at the company's or insured's request.

The unlimited extended reporting period will be without charge 1) if a medical professional becomes totally and permanently disabled; 2) permanently retires from the practice of medicine at age 55 or older after five continuous years of coverage with the company ; or permanently retires from the practice of medicine at age 60 or older after three continuous years of coverage with the company; or, 3) to his or her estate if such medical professional dies during the policy period.

M) Entity Coverage

The professional association or entity may be offered coverage if requested by applying a factor of 10% to the annual premium. Each physician member and the entity must carry the same limits of liability and each must be insured by the Company.



**HEALTH CARE INDEMNITY, INC.
PHYSICIAN AND SURGEON PROFESSIONAL LIABILITY**

Addendum B

Premium Rate Schedule

ILLINOIS

Limits: \$1,000,000/\$3,000,000

Territory: Rest of State

Class 1	17,282.70	Oral Surgeons	16,821.06
Class 2	23,008.64	Nurse Midwives	16,263.20
Class 3	36,375.45	CRNA	8,410.53
Class 4	33,642.12	NP/PA	4,320.68
Class 5	45,419.64	Optometrists	1,728.27
Class 6	67,990.83	Dentists	3,364.21
Class 7	65,052.81	Chiropractors	6,505.28
Class 8	107,244.28		

Limits: \$1,000,000/\$3,000,000

Territory: Cook County

Class 1	27,556.25	Oral Surgeons	31,539.39
Class 2	38,579.85	Nurse Midwives	31,308.79
Class 3	57,319.86	CRNA	15,769.70
Class 4	63,078.79	NP/PA	6,889.06
Class 5	85,317.14	Optometrists	2,755.63
Class 6	110,229.36	Dentists	6,307.88
Class 7	125,235.16	Chiropractors	12,523.52
Class 8	165,345.14		

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JAN 01 2007

SPRINGFIELD, ILLINOIS