

State: Illinois **Filing Company:** Medicus Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Rate/Rule Manual Update - 01/2013
Project Name/Number: /

Filing at a Glance

Company: Medicus Insurance Company
Product Name: Rate/Rule Manual Update - 01/2013
State: Illinois
TOI: 11.2 Med Mal-Claims Made Only
Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations
Filing Type: Rule
Date Submitted: 12/20/2012
SERFF Tr Num: MEIC-128818581
SERFF Status: Closed-Withdrawn
State Tr Num: MEIC-128818581
State Status:
Co Tr Num: IL2012PHYRUL-1

Effective Date: 01/01/2013
Requested (New):
Effective Date: 01/01/2013
Requested (Renewal):
Author(s): Jane Cundiff, Truman Townzen
Reviewer(s): Gayle Neuman (primary)
Disposition Date: 01/17/2013
Disposition Status: Withdrawn
Effective Date (New): 01/16/2013
Effective Date (Renewal): 01/16/2013

State Filing Description:

State: Illinois **Filing Company:** Medicus Insurance Company
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General Information

Project Name: Status of Filing in Domicile:
Project Number: Domicile Status Comments:
Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:
Filing Status Changed: 01/17/2013
State Status Changed: Deemer Date:
Created By: Jane Cundiff Submitted By: Jane Cundiff
Corresponding Filing Tracking Number:

Filing Description:

The purpose of this filing is to update our manual with the restructure of our specialty plan. The revisions are highlighted on the changes tracked manual provided through SERFF. There is no rate impact associated with this filing. No insured will receive an increase as a result of this filing.

If you have any questions concerning the above, please contact me.

Company and Contact

Filing Contact Information

Jane Cundiff, Regulatory Ccmpliance jcundiff@medicusins.com
Coordinator
4807 Spicewood Springs Road 512-879-5128 [Phone]
Bldg 4-100
Austin, TX 78759

Filing Company Information

Medicus Insurance Company	CoCode: 12754	State of Domicile: Texas
4807 Spicewood Springs Rd, Bldg.	Group Code: 11	Company Type:
4 1st Floor	Group Name: Property and	State ID Number:
Austin, TX 78759	Casualty	
(866) 815-2023 ext. [Phone]	FEIN Number: 20-5623491	

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

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

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

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

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

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

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

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

SERFF Tracking #:

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State:

Illinois

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11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

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/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Gayle Neuman	01/17/2013	01/17/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Gayle Neuman	12/26/2012	12/26/2012

Response Letters

Responded By	Created On	Date Submitted
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Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Withdraw this filing extension	Note To Reviewer	Jane Cundiff	01/16/2013	01/16/2013
	Note To Filer	Gayle Neuman	01/04/2013	01/04/2013
Extension for Response to Objection	Note To Reviewer	Truman Townzen	01/04/2013	01/04/2013

State: Illinois **Filing Company:** Medicus Insurance Company
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Disposition

Disposition Date: 01/17/2013
 Effective Date (New): 01/16/2013
 Effective Date (Renewal): 01/16/2013
 Status: Withdrawn

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	Request to Maintain Data as Trade Secret Information		Yes

State: Illinois **Filing Company:** Medicus Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Rate/Rule Manual Update - 01/2013
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/26/2012
Submitted Date	12/26/2012
Respond By Date	01/07/2013

Dear Jane Cundiff,

Introduction:

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

1. You are required to complete the "Company Rate Information" on the Rate/Rule Schedule tab. This is part of SERFF and the Statute says companies will use SERFF.
2. 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. This information is required in every rate/rule filing for medical malpractice.
3. Section II - II. Premium Computation, paragraph A states "in the following manner" however fails to provide the information. Then under paragraph D of this section, it states a premium charge "up to 30%" will be added. How will you determine this amount? Could one insured be charged 10% and the next one charged 30%?
4. Where is the information provided to define the unlabeled Codes provided in the changes? What is done for the specialties that were removed because of these changes?

Conclusion:

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

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

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

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

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

Sincerely,

Gayle Neuman

State: Illinois **Filing Company:** Medicus Insurance Company
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Product Name: Rate/Rule Manual Update - 01/2013
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Note To Reviewer

Created By:

Jane Cundiff on 01/16/2013 05:14 PM

Last Edited By:

Gayle Neuman

Submitted On:

01/17/2013 07:49 AM

Subject:

Withdraw this filing

Comments:

Ms. Neuman,

We apologize for the inconvenience, however, we would like to withdraw this filing at this time.

Please let us know if we can provide any further information.

Many thanks,

Jane Cundiff

State: Illinois **Filing Company:** Medicus Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Rate/Rule Manual Update - 01/2013
Project Name/Number: /

Note To Filer

Created By:

Gayle Neuman on 01/04/2013 09:19 AM

Last Edited By:

Gayle Neuman

Submitted On:

01/17/2013 07:49 AM

Subject:

extension

Comments:

I will extend the due date to January 18, 2013.

State: Illinois **Filing Company:** Medicus Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Rate/Rule Manual Update - 01/2013
Project Name/Number: /

Note To Reviewer

Created By:

Truman Townzen on 01/04/2013 09:04 AM

Last Edited By:

Gayle Neuman

Submitted On:

01/17/2013 07:49 AM

Subject:

Extension for Response to Objection

Comments:

Ms. Neuman,

I am requesting an extension of the due date for a response to your objection from 1/6/13 to 1/18/13.

SERFF Tracking #:

MEIC-128818581

State Tracking #:

MEIC-128818581

Company Tracking #:

IL2012PHYRUL-1

State:

Illinois

Filing Company:

Medicus Insurance Company

TOI/Sub-TOI:

11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name:

Rate/Rule Manual Update - 01/2013

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Explanatory Memorandum		
Comments:			
Attachment(s):			
Explanatory Memo.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Form RF3 - (Summary Sheet)		
Bypass Reason:	Manual Rule Filing Only. No Rate Change.		

		Item Status:	Status Date:
Bypassed - Item:	Certification		
Bypass Reason:	Manual Rule Filing Only. No Rate Change.		

		Item Status:	Status Date:
Satisfied - Item:	Manual		
Comments:			
Attachment(s):			
IL Rate Manual side by side 01-2013x.pdf			
IL Rate Manual 01 2013.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Request to Maintain Data as Trade Secret Information		
Bypass Reason:	Nothing in this filing is required to be maintained as confidential.		



December 20, 2012

RE: IL Rate/Rule Manual 01/2013

The purpose of this filing is to update our manual with the restructure of our specialty plan. The revisions are highlighted on the changes tracked manual provided through SERFF. There is no rate impact associated with this filing. No insured will receive an increase as a result of this filing. If you have any questions concerning the above, please contact me.

Thank you,

Jane M. Cundiff
Regulatory Compliance Coordinator
Direct: (512) 879-5128
jcundiff@medicusins.com



MANUAL

SECTION I

GENERAL RULES

I. PURPOSE OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

II. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

III. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

The Territory Definitions are:

1. Counties: Cook, Jackson, Madison, St. Clair and Will
2. Counties: Vermillion
3. Counties: Kane, Lake, McHenry and Winnebago
4. Counties: DuPage, Kankakee and Macon
5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph
6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

8. Remainder of State

IV. PREMIUM COMPUTATION

- A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.
- B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

V. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VI. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

- A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount; and
- B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

VII. ADDITIONAL PREMIUM CHARGES

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

VIII. RETURN PREMIUM FOR MID-TERM CHANGES

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.
- C. Retain the Policy Minimum Premium.

IX. POLICY CANCELLATIONS

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
 - 1. A policy is canceled at the Company's request.
 - 2. The Insured is leaving a group practice, or
 - 3. Death, disability or retirement of the Insured.
- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.

X. POLICY MINIMUM PREMIUM

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.

Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XI. PREMIUM PAYMENT PLAN

The Company offers the Insured the choice to pay in full or the following premium payment options:

- A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.
- B. The quarterly payment plan requires a 25% down payment and three quarterly installments of 25%.
- C. Our Automated Clearing House (ACH) option allows the Insured to have 12 equal monthly installments.

There are no extra fees associated with any premium payment plan.

XII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverage will be rated under Standard Claims-Made Rates.

XIII. LIMITS OF LIABILITY

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factor as applicable for the respective insureds and used to develop the applicable premium.

Liability Limit Factors

Liability Limit	Physicians	Surgeons
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

XIV. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the Insured, subject to underwriting.

XV. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:
 - 1. The Extended Reporting Endorsement factor from the table below is applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

<u>Year</u>	<u>Factor</u>
1 st	3.30
2 nd	3.15
3 rd	2.40
4 th	2.00

2. For First Year Claims Made step, it is applied pro-rata.
 3. For Second Year and all years of maturity, it is applied to the last year's (365 days) annualized premium from the date of cancellation.
- D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.
- E. The length of the Extended Reporting Period will be indefinite.
- F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.
1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.
 2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.
 3. The Reporting Period is unlimited.

- END OF SECTION I -

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. DEFINITION

- A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

Professional Corporations, Partnerships and Associations

- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;
2. Are organized as a legal entity;
3. Maintain common facilities (including multiple locations) and support personnel; and
4. ~~Maintain medical/dental records of patients of the group as a historical record of patient care.~~

C. An exception to this rule is the Affinity Credit on Section III.G.

II. PREMIUM COMPUTATION

- ~~A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:~~

~~The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.~~

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Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

~~B. Vicarious Liability Charge: For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.~~

~~A. A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:~~

~~B. If separate limits are desired, an endorsement to convert the entity coverage from shared limits to separate limits shall be necessary.~~

~~C. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met.~~

~~D. The premium for professional corporations, partnerships and associations, limited liability companies, or other entities may be written with a separate limit of liability and shall be computed in the following manner: The premium will be a percentage of the sum of each insured's net individual premium. For each employed physician, and ancillary staff at the practice not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage, the Company must insure at least 60% of the employed physicians at the practice, and the remaining physicians must be insured by another professional liability program acceptable to the Company.~~

~~. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage.~~

III. PREMIUM COMPUTATION (Continued)

<u>Number of Insureds</u>	<u>Percent</u>
<u>1</u>	<u>25%</u>
<u>2-5</u>	<u>12%</u>
<u>6-9</u>	<u>10%</u>
<u>10-19</u>	<u>9%</u>
<u>20-49</u>	<u>7%</u>
<u>50 or more</u>	<u>5%</u>

B. Vicarious Liability Charge: For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage. For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

E.

III. **PREMIUM MODIFICATIONS**

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

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Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.[II.A.](#)

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a rate class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
2. The rate classes are found in Section III ~~of this Manual~~ II.A.

B. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

D. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.
2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the

retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by ~~a the~~ Company [director](#).

E. Per Patient Visit Rating

1. Per patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.
2. The premium for the per patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.
3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.
4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

Specialty	Conversion Factor
Urgent Care	.000160
Emergency Medicine	.000278

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per Patient Visit Rating

II. PREMIUM COMPUTATION DETAILS

A. Specialty Class Plan

The following classification plan shall be used to determine the appropriate rating class for each individual Insured.

PHYSICIANS & SURGEONS		
Specialty	ISO Code	Class
Abdominal Surgery	80166	17
Administrative Medicine	80240(a)	2
Aerospace Medicine	80133	2
Allergy/Immunology	80254	4
Anesthesiology—All Other	80183	6
Anesthesiology—Pain Management	80182	6
Broncho-Esophagology	80101	7
Cardiac Surgery	80141	19
Cardiothoracic Surgery	80150(a)	19
Cardiovascular Disease—Minor Surgery	80281	8
Cardiovascular Disease—No Surgery	80255	3
Cardiovascular Surgery	80150	19
Colon and Rectal Surgery	80115	11
Dentistry	80210	3
Dermatology—Minor Surgery	80297(a)	3
Dermatology—No Surgery	80297	2
Diabetes—Minor Surgery	80271	4
Diabetes—No Surgery	80237	3
Emergency Medicine—incl Major Surgery	80157	12
Emergency Medicine—No Major Surgery	80102	10
Endocrinology—Minor Surgery	80272	4
Endocrinology—No Surgery	80238	2
Endocrinology Surgery	80103	12
Family Practice or General Practice—Major Surgery & OB	80117(a)	18
Family Practice or General Practice—Surgery—limited OB	80117(b)	12
Family Practice or General Practitioners—Minor Surgery, No OB	80421	9
Family Practice or General Practitioners—No Surgery	80420	3
Forensic / Legal Medicine	80240	4
Gastroenterology—Minor Surgery	80274	8
Gastroenterology—No Surgery	80241	5
Gastroenterology—Surgery	80104	12
General Surgery	80143	15
Geriatrics—Minor Surgery	80276	7
Geriatrics—No Surgery	80243	3
Geriatrics—Surgery	80105	13

Specialty	ISO Code	Class
Gynecology—Minor Surgery	80277	8
Gynecology—No Surgery	80244	4
Gynecology—Surgery	80167	12
Hand Surgery	80169	12
Head and Neck Surgery	80170	15
Head and Neck Surgery—No Plastic	80170(a)	12
Hematology—Minor Surgery	80278	7
Hematology—No Surgery	80245	3
Hospitalists—Including ER	80222(b)	11
Hospitalists—Invasive	80222(a)	9
Hospitalists—Non-Invasive	80222	5
Infectious Diseases—Minor Surgery	80279	8
Infectious Diseases—No Surgery	80246	4
Intensive Care Medicine	80283	8
Internal Medicine—Minor Surgery	80284	8
Internal Medicine—No Surgery	80257	6
Neonatal/Perinatal Medicine	80804	12
Neonatology—Major Surgery	80804(a)	16
Neoplastic—Surgery	80107	14
Neoplastic Diseases—Minor Surgery	80286	8
Neoplastic Diseases—No Surgery	80259	3
Nephrology—Minor Surgery	80287	6
Nephrology—No Surgery	80260	3
Nephrology—Surgery	80108	10
Neurology—Minor Surgery	80299(a)	8
Neurology—No Surgery	80299	4
Neurology—Surgery	80152	22
Nuclear Medicine	80262	2
Nutrition	80248	1
Obstetrics & Gynecology Surgery	80153	19
Obstetrics Surgery	80168	19
Occupational Medicine	80134	1
Oncology—Minor Surgery	80304	6
Oncology—No Surgery	80302	3
Oncology—Surgery	80164	14
Ophthalmology—Minor Surgery	80289	3
Ophthalmology—No Surgery	80263	2
Ophthalmology—Surgery	80114	3
Orthopedic Surgery Including Spine	80154(s)	20
Orthopedic Surgery Not Including Spine	80154	17
Orthopedics—Minor Surgery	80204	7
Orthopedics—No Surgery	80205(a)	4

Specialty	ISO Code	Class
Otorhinolaryngology—Minor Surgery	80294	8
Otorhinolaryngology—No Surgery	80265	4
Otorhinolaryngology—Surgery—Incl Plastic	80155	46
Otorhinolaryngology—Surgery—No Plastic	80159(a)	40
Pain Management—Advanced Procedures	80182(d)	24
Pain Management—Basic Procedures	80182(b)	13
Pain Management—Intermediate Procedures	80182(c)	18
Pain Management—No Surgery	80182(a)	7
Pathology—Minor Surgery	80305	4
Pathology—No surgery	80307	2
Pediatrics—Minor Surgery	80293	8
Pediatrics—No Surgery	80267	2
Pediatrics—Surgery	80180	46
Perinatology	80153(a)	24
Pharmacology—Clinical	80234	2
Physiatry	80209(a)	3
Physical Medicine and Rehabilitation—All Other	80209	4
Physical Medicine and Rehabilitation—Pain Management	80208	7
Physician (NOC)—Minor Surgery	80294	8
Physician (NOC)—No Surgery	80268	2
Plastic Surgery	80156	46
Podiatry	80943	3
Preventive Medicine—No Surgery Undersea/Hyperbaric Medicine	80139	2
Psychiatry	80229	2
Public Health Medicine—No Surgery	80135	2
Pulmonary Diseases—No Surgery	80269	6
Radiation Oncology	80359(a)	3
Radiology—Diagnostic—Minor Surgery	80280	8
Radiology—Diagnostic—No Surgery	80253	6
Radiology—Interventional	80360	40
Radiology—Therapeutic—Minor Surgery	80358	8
Radiology—Therapeutic—No Surgery	80359	6
Rheumatology—No Surgery	80252	2
Sports Medicine—No Surgery	80205	4
Thoracic Surgery	80144	18
Traumatic Surgery	80174	19
Urgent Care	80102(a)	5
Urological—Surgery	80145	40
Urology—Minor Surgery	80120	8
Urology—No Surgery	80124	3
Vascular Surgery	80146	49

Ancillary Specialty	ISO-Code	Class
Acupuncturists	80966	X
Art, Music and Dance Therapists	80967	X
Audiologists	80968	X
Certified Registered Nurse Anesthetist	80960	C-4
Dental Hygienists	80712	X
Inhalation/Respiratory Therapists	80969	X
Massage Therapists	80970	X
Medical Technologists	80971	X
Nurse-LPN	80963	X
Nurse-Midwife	80962	N
Nurse-Practitioner	80965	Z
Nurse-RN	80964	Y
Nutritionists/Dieticians	80972	X
Occupational Therapists	80973	Y
Opticians	80937	X
Optometrist	80994	Y
Orthotists/Prosthetists	80974	Y
Pharmacists	59112	X
Physicians or Surgeons Assistants	80116	Z
Physiotherapists	80938	Y
Psychologists	80975	Z
X-Ray Technicians	80713	Y

<u>Physician/Surgeon Specialty</u>	<u>Code</u>	<u>Class</u>
<u>Administrative Medicine</u>	<u>8901</u>	<u>2</u>
<u>Aerospace Medicine</u>	<u>9166</u>	<u>2</u>
<u>Allergy and Immunology</u>	<u>9108</u>	<u>1</u>
<u>Anesthesiology</u>	<u>8903</u>	<u>6</u>
<u>Anesthesiology (Pain Management)</u>	<u>9167</u>	<u>7</u>
<u>Cardiology (Interventional)</u>	<u>9031</u>	<u>9</u>
<u>Cardiology (Minor surgery)</u>	<u>9168</u>	<u>8</u>
<u>Cardiology (No surgery)</u>	<u>9169</u>	<u>3</u>
<u>Colon and Rectal Surgery</u>	<u>8910</u>	<u>11</u>
<u>Critical Care Medicine</u>	<u>9022</u>	<u>8</u>
<u>Dentistry (All other)</u>	<u>9171</u>	<u>3</u>
<u>Dermatology (Major Surgery)</u>	<u>9120</u>	<u>11</u>
<u>Dermatology (Minor Surgery)</u>	<u>9042</u>	<u>3</u>
<u>Dermatology (No Surgery)</u>	<u>9043</u>	<u>2</u>
<u>Emergency Medicine</u>	<u>9044</u>	<u>10</u>
<u>Emergency Medicine (with Trauma)</u>	<u>9172</u>	<u>12</u>
<u>Endocrinology</u>	<u>9013</u>	<u>2</u>
<u>Endocrinology (Minor Surgery)</u>	<u>9122</u>	<u>4</u>
<u>Endocrinology (Reproductive)</u>	<u>9173</u>	<u>12</u>

<u>Physician/Surgeon Specialty</u>	<u>Code</u>	<u>Class</u>
<u>Family Medicine (Including Obstetrics and C-Sections)</u>	<u>9113</u>	<u>18</u>
<u>Family Medicine (Including Obstetrics/No C-Sections)</u>	<u>9112</u>	<u>12</u>
<u>Family Medicine (Major Surgery)</u>	<u>9111</u>	<u>12</u>
<u>Family Medicine (Minor Surgery)</u>	<u>9110</u>	<u>9</u>
<u>Family Medicine (No Surgery)</u>	<u>9109</u>	<u>3</u>
<u>Gastroenterology</u>	<u>8915</u>	<u>5</u>
<u>Gastroenterology (Minor Surgery)</u>	<u>9174</u>	<u>8</u>
<u>General Surgery</u>	<u>8919</u>	<u>15</u>
<u>General Surgery (Including Bariatric)</u>	<u>8975</u>	<u>19</u>
<u>Geriatrics (Major Surgery)</u>	<u>9177</u>	<u>13</u>
<u>Geriatrics (Minor Surgery)</u>	<u>9175</u>	<u>7</u>
<u>Geriatrics (No Surgery)</u>	<u>9176</u>	<u>3</u>
<u>Gynecology (Major Surgery)</u>	<u>9128</u>	<u>12</u>
<u>Gynecology (Minor Surgery)</u>	<u>9066</u>	<u>8</u>
<u>Gynecology (No Surgery)</u>	<u>9067</u>	<u>4</u>
<u>Hand Surgery</u>	<u>9027</u>	<u>12</u>
<u>Hematology</u>	<u>8978</u>	<u>3</u>
<u>Hematology (Minor Surgery)</u>	<u>9163</u>	<u>7</u>
<u>Hospitalists (Including ER)</u>	<u>9178</u>	<u>9</u>
<u>Hospitalists (No ER)</u>	<u>9179</u>	<u>5</u>
<u>Hyperbaric Medicine</u>	<u>9131</u>	<u>2</u>
<u>Infectious Disease (No Surgery)</u>	<u>9180</u>	<u>4</u>
<u>Infectious Diseases (Minor Surgery)</u>	<u>9181</u>	<u>8</u>
<u>Internal Medicine (Minor Surgery)</u>	<u>9182</u>	<u>8</u>
<u>Internal Medicine (No Surgery)</u>	<u>9183</u>	<u>6</u>
<u>Legal Medicine</u>	<u>9184</u>	<u>1</u>
<u>Medical Genetics (Non-Invasive)</u>	<u>9135</u>	<u>3</u>
<u>Neonatology</u>	<u>8985</u>	<u>12</u>
<u>Nephrology (Minor Surgery)</u>	<u>9185</u>	<u>8</u>
<u>Nephrology (No Surgery)</u>	<u>9186</u>	<u>3</u>
<u>Neurology (Minor Surgery)</u>	<u>9187</u>	<u>8</u>
<u>Neurology (No Surgery)</u>	<u>9188</u>	<u>4</u>
<u>Neuromusculoskeletal Medicine/Osteopathic Manipulative Medicine Only</u>	<u>9038</u>	<u>3</u>
<u>Neurosurgery</u>	<u>8923</u>	<u>22</u>
<u>Nuclear Medicine</u>	<u>8981</u>	<u>2</u>
<u>Obstetrics and Gynecology</u>	<u>8926</u>	<u>19</u>
<u>Occupational Medicine</u>	<u>8800</u>	<u>2</u>
<u>Oncology (Major Surgery)</u>	<u>9191</u>	<u>14</u>
<u>Oncology (Minor Surgery)</u>	<u>9189</u>	<u>6</u>
<u>Oncology (No Surgery)</u>	<u>9190</u>	<u>3</u>
<u>Ophthalmology (Major Surgery)</u>	<u>9025</u>	<u>3</u>
<u>Ophthalmology (Minor Surgery)</u>	<u>9024</u>	<u>3</u>
<u>Ophthalmology (No Surgery)</u>	<u>9023</u>	<u>2</u>
<u>Oral and Maxillofacial Surgery</u>	<u>8996</u>	<u>13</u>
<u>Orthopedic Surgery (Including Spinal Surgery)</u>	<u>9037</u>	<u>20</u>
<u>Orthopedic Surgery (No Spinal Surgery)</u>	<u>9107</u>	<u>17</u>

<u>Physician/Surgeon Specialty</u>	<u>Code</u>	<u>Class</u>
<u>Orthopedics (Minor Surgery)</u>	<u>9192</u>	<u>7</u>
<u>Orthopedics (No Surgery)</u>	<u>9193</u>	<u>4</u>
<u>Otolaryngology (Minor Surgery)</u>	<u>9194</u>	<u>8</u>
<u>Otolaryngology (No Surgery)</u>	<u>9195</u>	<u>1</u>
<u>Otolaryngology (Surgery Cosmetic)</u>	<u>9196</u>	<u>14</u>
<u>Otolaryngology (Surgery Reconstructive)</u>	<u>9197</u>	<u>10</u>
<u>Pain Management - No Surgery</u>	<u>9236</u>	<u>4</u>
<u>Pain Management (Advanced Procedures)</u>	<u>9198</u>	<u>21</u>
<u>Pain Management (Basic Procedures)</u>	<u>9199</u>	<u>13</u>
<u>Pain Management (Intermediate Procedures)</u>	<u>9200</u>	<u>18</u>
<u>Pathology</u>	<u>8932</u>	<u>2</u>
<u>Pathology (Forensic)</u>	<u>9201</u>	<u>1</u>
<u>Pediatrics (Minor Surgery)</u>	<u>9145</u>	<u>8</u>
<u>Pediatrics (No Surgery)</u>	<u>9146</u>	<u>2</u>
<u>Perinatology</u>	<u>9019</u>	<u>21</u>
<u>Physical Medicine and Rehabilitation (Interventional)</u>	<u>9147</u>	<u>3</u>
<u>Physical Medicine and Rehabilitation (Non-Interventional)</u>	<u>9148</u>	<u>3</u>
<u>Physician NOC (Major Surgery)</u>	<u>9204</u>	<u>16</u>
<u>Physician NOC (Minor Surgery)</u>	<u>9202</u>	<u>8</u>
<u>Physician NOC (No Surgery)</u>	<u>9203</u>	<u>2</u>
<u>Plastic Surgery</u>	<u>8939</u>	<u>16</u>
<u>Plastic Surgery (Head and Neck, Cosmetic)</u>	<u>9205</u>	<u>15</u>
<u>Plastic Surgery (Head and Neck, Reconstructive)</u>	<u>9206</u>	<u>15</u>
<u>Podiatry (Major Surgery)</u>	<u>9207</u>	<u>7</u>
<u>Podiatry (Minor Surgery)</u>	<u>9208</u>	<u>6</u>
<u>Podiatry (No Surgery)</u>	<u>9209</u>	<u>1</u>
<u>Preventative Medicine</u>	<u>9210</u>	<u>2</u>
<u>Psychiatry (with electroconvulsive)</u>	<u>9211</u>	<u>2</u>
<u>Psychiatry (without electroconvulsive)</u>	<u>9212</u>	<u>2</u>
<u>Public Health Medicine</u>	<u>9214</u>	<u>2</u>
<u>Pulmonology</u>	<u>9215</u>	<u>6</u>
<u>Radiology (Diagnostic)</u>	<u>9216</u>	<u>2</u>
<u>Radiology (Interventional)</u>	<u>9217</u>	<u>10</u>
<u>Radiology (Oncology)</u>	<u>9218</u>	<u>5</u>
<u>Rheumatology</u>	<u>9054</u>	<u>2</u>
<u>Sleep Medicine</u>	<u>9151</u>	<u>2</u>
<u>Sports Medicine (Minor Surgery)</u>	<u>9219</u>	<u>5</u>
<u>Sports Medicine (No Surgery)</u>	<u>9220</u>	<u>4</u>
<u>Thoracic Surgery</u>	<u>8986</u>	<u>18</u>
<u>Trauma Surgery</u>	<u>9221</u>	<u>19</u>
<u>Urgent Care</u>	<u>9030</u>	<u>5</u>
<u>Urology (Major Surgery)</u>	<u>9224</u>	<u>10</u>
<u>Urology (Minor Surgery)</u>	<u>9222</u>	<u>8</u>
<u>Urology (No Surgery)</u>	<u>9223</u>	<u>3</u>
<u>Vascular (Minor Surgery)</u>	<u>9225</u>	<u>6</u>
<u>Vascular Surgery</u>	<u>9012</u>	<u>19</u>

<u>Ancillary Specialty</u>	<u>Code</u>	<u>Class</u>
<u>Certified Registered Nurse Anesthetist</u>	<u>8703</u>	<u>C-1</u>
<u>Chiropractor</u>	<u>9170</u>	<u>Z</u>
<u>Inhalation/Respiratory Therapists</u>	<u>9226</u>	<u>X</u>
<u>Midwife</u>	<u>9165</u>	<u>N</u>
<u>Nurse Practitioner</u>	<u>8704</u>	<u>Z</u>
<u>Nutritionists/Dieticians</u>	<u>9227</u>	<u>X</u>
<u>Optometrist</u>	<u>9228</u>	<u>X</u>
<u>Orthotists/Prosthetists</u>	<u>9229</u>	<u>X</u>
<u>Perfusionist</u>	<u>8700</u>	<u>Y</u>
<u>Pharmacists</u>	<u>9230</u>	<u>X</u>
<u>Physical/Occupational Therapist</u>	<u>9232</u>	<u>X</u>
<u>Physician Assistant</u>	<u>8701</u>	<u>Z</u>
<u>Psychologists</u>	<u>9213</u>	<u>Z</u>
<u>Radiology Assistant</u>	<u>9164</u>	<u>Y</u>
<u>Surgical Assistant</u>	<u>9231</u>	<u>Z</u>

B. Manual Rates

Standard Claims Made Program Step Factors

Step Factors:

First Year:	25%
Second Year:	50%
Third Year:	78%
Fourth Year:	90%
Fifth Year (Mature):	100%

**PHYSICIANS AND SURGEONS
RATE TABLE**
Mature Rates (Claims-made)
1M/3M

Class	Territory 1	Territory 2	Territory 3	Territory 4	Territory 5	Territory 6	Territory 7	Territory 8
1	\$15,401	\$13,938	\$13,214	\$11,751	\$11,027	\$9,564	\$7,377	\$8,101
2	\$20,632	\$18,672	\$17,702	\$15,742	\$14,772	\$12,812	\$9,883	\$10,852
3	\$29,059	\$26,298	\$24,933	\$22,172	\$20,806	\$18,046	\$13,919	\$15,285
4	\$31,965	\$28,928	\$27,426	\$24,389	\$22,887	\$19,850	\$15,311	\$16,814
5	\$33,418	\$30,243	\$28,673	\$25,498	\$23,927	\$20,752	\$16,007	\$17,578
6	\$35,161	\$31,821	\$30,168	\$26,828	\$25,176	\$21,835	\$16,842	\$18,495
7	\$38,648	\$34,977	\$33,160	\$29,489	\$27,672	\$24,001	\$18,513	\$20,329
8	\$42,426	\$38,396	\$36,402	\$32,371	\$30,377	\$26,347	\$20,322	\$22,316
9	\$46,204	\$41,814	\$39,643	\$35,254	\$33,082	\$28,693	\$22,132	\$24,303
10	\$49,981	\$45,233	\$42,884	\$38,136	\$35,787	\$31,038	\$23,941	\$26,290
11	\$54,922	\$49,704	\$47,123	\$41,905	\$39,324	\$34,106	\$26,307	\$28,889
12	\$61,314	\$55,490	\$52,608	\$46,783	\$43,901	\$38,076	\$29,370	\$32,251
13	\$67,417	\$61,012	\$57,844	\$51,439	\$48,270	\$41,866	\$32,293	\$35,461
14	\$73,519	\$66,535	\$63,080	\$56,095	\$52,640	\$45,655	\$35,216	\$38,671
15	\$80,784	\$73,110	\$69,313	\$61,638	\$57,841	\$50,167	\$38,696	\$42,492
16	\$88,049	\$79,684	\$75,546	\$67,181	\$63,043	\$54,678	\$42,175	\$46,314
17	\$97,638	\$88,363	\$83,774	\$74,498	\$69,909	\$60,633	\$46,769	\$51,358
18	\$109,843	\$99,408	\$94,245	\$83,810	\$78,648	\$68,213	\$52,615	\$57,777
19	\$124,663	\$112,820	\$106,961	\$95,118	\$89,259	\$77,416	\$59,714	\$65,573
20	\$134,253	\$121,499	\$115,189	\$102,435	\$96,125	\$83,371	\$64,307	\$70,617
21	\$165,927	\$150,164	\$142,365	\$126,602	\$118,804	\$103,041	\$79,479	\$87,278
22	\$205,738	\$186,193	\$176,523	\$156,978	\$147,308	\$127,763	\$98,548	\$108,218

**NON PHYSICIAN HEALTHCARE PROVIDERS
RATE TABLE**
Mature Rates (Claims-made)
1M/3M

RATE CLASS	Separate limits	Shared limits
N	30% of Class 20	15% of Class 20
X	5% of Class 3	0% of Class 3
Y	15% of Class 3	0% of Class 3
Z	10% of Class 3	4% of Class 3
C-1	15% of Class 6	10% of Class 6

III. **PREMIUM MODIFICATIONS**

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

A. **Part Time Physicians**

1. A physician who is determined to be working 20 hours or less a week is considered a part time practitioner and is eligible for a reduction of 50% on the otherwise applicable rate for that specialty.
2. A Part Time Practitioner may include any practitioner in classes 1 through 10 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

B. **Physicians in Training**

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:
 - a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
 - b. Resident - Various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
 - c. Fellow - Follows completion of residency and is a higher level of training.
2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.
3. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program.
4. The credit is not applied to the Extended Reporting Period Coverage.
5. The physician-in-training credit is 50% for 1st Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

C. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
 - a. Residency;
 - b. Fellowship program in their medical specialty;
 - c. Fulfillment of a military obligation in remuneration for medical school tuition;
 - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A credit of 30% for first and second years and 20% for the third year will be applied. No other credits are to apply concurrent with this rule.

D. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the Insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program.
2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the Insured's teaching activities.
 - a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.
 - b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.
 - c. No other credits are to apply concurrent with this rule.
 - d. The applicable percentages are based upon hours, up to 50%.

E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the Insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the following schedule:

<u>Claim Free</u>	<u>Credit</u>
0	0
1	2%
2	4%
3	6%
4	8%
5	10%
6	12%
7	14%
8	16%
9	18%
10+	20%

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

G. Affinity Credit

Affinity credit will be available for those physicians who are in Risk Purchasing Groups, PAs, Partnerships, IPAs, Networks, PCs and/or other currently unclassified group structures. The guidelines for calculating the percent of discount are as follows:

1. The number of full time physicians in the group at the time the policy becomes effective is the number that will be used to determine the credit.
2. When calculating Extended Reporting Endorsement rates, this credit cannot be applied.

3. Physicians from the same group are not required to be named on the same policy. However, all physicians of the group, whether they be full- or part-time, must be insured through Medicus Insurance Company.
4. The credit does not apply to part time physicians and ancillary healthcare personnel. However, if they are members of the group, they must be insured through Medicus Insurance Company in order for the full-time doctors to qualify for the discount.

<u>Physician/Surgeon Group Total</u>	<u>Credit (percentage)</u>
<u>< 2</u>	<u>0</u>
<u>3 to 9</u>	<u>5%</u>
<u>10 to 19</u>	<u>10%</u>
<u>20 to 49</u>	<u>15%</u>
<u>50 +</u>	<u>20%</u>

G. Affinity Credit (Continued)

5. A group is defined as such if it possesses at least one of the following characteristics:
 - a. It is billed at a common billing address and uses other common facilities like office administration or a common credentialing/human resource office.
 - b. The group is organized only to practice medicine—not to purchase products or other goods and services.
 - c. The members of the group share profits and expenses.
 - d. Members substitute for each other when fellow members are ill or unavailable to cover shifts.
 - e. The members of the group provide each other with peer oversight.
 - f. The members of the group share a common retroactive date.

H. Elite Credit

The company shall apply a 5% credit at policy inception and a 10% credit at renewal to those insureds who meet the criteria for the Elite program as described in the criteria below.

1. Board certification in area of specialization
2. No history of impairment or substance abuse
3. No incident (unless closed without any payment), including notice of a claim, claim tendered, incurred, or paid indemnity or allocated loss adjustment expense incurred or paid, and Medical Board actions reported to current or previous insurer, validated by a company generated loss run and/or a sworn signed statement by the physician/group and the insured's agent covering the past four years qualifies a physician for consideration
4. Five years of practice history in area of specialization
5. No crimes committed, other than minor traffic violations
6. Proof of no late payments in the expiring policy premium.

7. Agreement to report medical incidents within 30 days, or thereafter by written demand within the policy period.
8. Certification through the United States Medical Licensing Exam (USMLE) if a physician was trained outside the United States. The doctor must also have completed a residency and/or fellowship program in the United States.
9. Certification by the LCME. He or she must also have completed a residency and/or fellowship program in the United States.
10. No material change of risk including a change in specialty, geographic change or practice pattern from time policy is issued through renewal. Renewal requires sworn statement by physician and agent of no known incidents, no charges for crimes and no history of substance abuse.

G. I. Schedule Rating

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The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

Schedule Rating: Modifications, subject to Underwriting:

For Individuals and Groups, subject to Underwriting,

1. The Company will consider all insureds for credits/debits:

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the Insured(s) is greater/less than the expected experience for an Insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The Insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/- 25%	Characteristics of a particular Insured that differentiate the Insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the Insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient	Size and/or demographics of the patient population which

Exposures. +/- 10%	influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the Insured.
8. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The Insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record Keeping Practices. +/- 10%	Degree to which Insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification + / - 25%	

H. J. Experience Rating

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1. ~~A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:~~
- a. ~~Premiums paid~~
 - b. ~~Number of claims~~
 - c. ~~Incurred losses~~
 - d. ~~Cause of such losses~~
 - e. ~~Nature of practice~~

~~2. Such credits/debits shall apply on a one-year basis and will be subject to annual review.~~

~~1. A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:~~

- ~~a. Premiums paid~~
- ~~b. Number of claims~~
- ~~c. Incurred losses~~
- ~~d. Cause of such losses~~
- ~~e. Nature of practice~~

~~2. The Experience credits/debits shall apply on a one year basis and will be subject to annual review.~~

~~3. The formula is $L = A \times C + E \times (1 - C)$ where L is the indicated loss for the rating period, C is the credibility factor, A is the Adjusted actual historical loss, and E is the expected loss for the rating period.~~

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▲ -----
I.G. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

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J.H. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the Insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit.

Indemnity Only Deductible Per Claim		Indemnity and ALAE Deductible Per Claim	
\$5,000	2.5%	\$5,000	6.5%
\$10,000	4.5%	\$10,000	11.5%
\$15,000	6.0%	\$15,000	15.0%
\$20,000	8.0%	\$20,000	17.5%
\$25,000	9.0%	\$25,000	20.0%
\$50,000	15.0%	\$50,000	30.5%
\$100,000	25.0%	\$100,000	40.0%
\$200,000	37.5%	\$200,000	55.0%
\$250,000	42.0%	\$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

Indemnity Only Per Claim/Aggregate		Indemnity & ALAE Per Claim/Aggregate	
\$5000/15,000	2.0%	\$5000/15,000	5.5%
\$10,000/30,000	4.0%	\$10,000/30,000	10.5%
\$25,000/75,000	8.5%	\$25,000/75,000	19.0%
\$50,000/150,000	14.0%	\$50,000/150,000	29.5%
\$100,000/300,000	24.0%	\$100,000/300,000	43.0%
\$200,000/600,000	36.0%	\$200,000/600,000	53.5%
\$250,000/750,000	40.0%	\$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each

insured involved in a claim. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to \$1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	\$10,500
10/30	.038	.035	.030	.024	\$21,000
25/75	.084	.079	.070	.058	\$52,500
50/150	.145	.139	.127	.109	\$105,000
100/300	.234	.228	.216	.196	\$120,000
200/600	.348	.346	.338	.321	\$420,000
250/750	.385	.385	.381	.368	\$525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
200/600	.396	.394	.385	.366	\$510,000
250/750	.467	.467	.462	.446	\$637,500

~~K.I.~~ M. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

-END OF SECTION III-

SECTION IV

Medicus Secured Protection Program

I. OVERVIEW

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

- DEA License Suspension
- Professional Misconduct
- Successful Completion of Chemical Dependency Program
- Adverse Claims Experience (Severity and/or Frequency)
- Proctorship
- Medical Board Sanctions or Fines
- Unusual Practice Characteristics
- Physical or Mental Health Impairments
- Bare Exposure Period
- Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

II. APPLICANT REFERRAL CRITERIA:

A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

III. LENGTH OF INSURED'S REHABILITATION

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

IV. RATING APPROACH

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

V. UNDERWRITING

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

A. Coverage Modifications

1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.
2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).
3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.
4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.

B. Consent to Settle

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

VI. PHYSICIAN OR GROUP MANAGEMENT

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurrence
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

VII. INTERNAL LOGISTICS

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

VIII. MEDICUS SECURED PROTECTION PROGRAM RATING FORMULA

POINTS SCHEDULE A

Claims within the last 10 years from date of Report

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

Drug or Alcohol Impairment- Health

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

Government Agency Actions

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

Inappropriate Patient Contact

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

POINTS SCHEDULE A (cont.)

Medical Education

- A. Attended more than one medical school or a residency program due to actual or planned disciplinary action 50
- B. Residency complete at two or more facilities 50
- C. Started, but did not complete, a full residency program. 50
- D. Did not begin a residency. 50
- E. Has never received board certification 50

Medical Records

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

Informed Consent

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

Privileges - Any State

(Hospital, Surgery Center, Etc.)

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

Procedures

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

Patient Safety / Physician or group Management

- A. Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements. 100

B.	Mandatory patient safety/physician or group management previously recommended and Insured had initial compliance but no follow through.	75
	Gaps in Medical Practice	
A.	Gaps in medical practice of 6-months to 1-year duration.	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years.	150
	Payment History	
A.	Two or more late payments within the last three years.	100
B.	Two or more cancellations for non-payment of premium within the last three years.	150
	Other	
A.	Uncooperative in Claims Handling	150
B.	Patient Load:	
	For Surgeons, 61-99 patients per week	50
	For Surgeons, 100 or more patients per week	100
	For all others, 101-149 patients per week	50
	For all others, 150 or more patients per week	100
C.	Advertising: If Insured advertises his/her services on TV, newspapers, billboards or radio	25
D.	Uses collection agency that can file suit without Insured's written consent.	25
E.	Previous insurance history (bare, insolvent prior insurer or non-renewed).	100
F.	Claim experience of Associates, Partners or Corporation:	
	If one member with claim(s)	75
	If more than one member with claim(s)	100
	Favorable experience of group as a whole	-150
G.	For each claim or suit in which the physician breached the standard of care:	
	Mixed Reviews	50
	All Negative Reviews	100
	Admitted or Clear Liability	100
H.	For two or more claims, suits or incidents arising out of the same or similar procedures or treatments.	50
I.	Claim is too early in discovery period:	
	Surgical Class	-100
	Non-Surgical Class	-50
J.	For each claim or suit in which expert reviewers state the Insured met the standard of care:	
	Surgical Class	-150
	Non-Surgical Class	-100
K.	High-physician or group surgical patient selection.	150
L.	Reinstatement of nonrenewal due to company election	150
M.	Loss Ratio in excess of 500%.	150
N.	Loss Ratio less than 100%.	-100
O.	Discrepancies between application answers/documents and verification	150

FREQUENCY AND SEVERITY CLAIMS SCHEDULE

Insured: _____ Policy#: _____
(If Applicable)

Effective Date: _____ Review Date: _____

Claims Without Indemnity			
ALAE			
From:	To:	Claim Score	
\$5,001	\$25,000	1	
\$25,001	\$50,000	2	
\$50,001	\$100,000	3	
\$100,001	& up	4	
Claims With Indemnity			
Indemnity + ALAE			
From:	To:	Claim Score	
\$1	\$25,000	4	
\$25,001	\$50,000	5	
\$50,001	\$100,000	6	
\$100,001	\$250,000	7	
\$250,001	\$500,000	8	
\$500,001	\$750,000	9	
\$750,001	\$1,000,000	11	
\$1,000,001	& up	13	

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

Total: _____

Completed by: _____ Approved by: _____

Frequency and Severity Claims Schedule (Continued)

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

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

- (1) As of Review Date.
- (2) Add 25 points for each Total Claim Score above 15.

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

Points Evaluation Worksheet

Insured: _____ Policy#: _____

Effective Date: _____ (If Applicable) Review Date: _____

Criteria	Points
Claims Frequency	_____
Drug or Alcohol Impairment – Health	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges – Any State	_____
Procedures	_____
Physician or group Management	_____
Gaps in Coverage	_____
Other	_____
Total Points:	_____

Ranges & Surcharges

Point Range	Surcharge
0 – 100	0%
101-130	40%
131 – 160	45%
161 – 190	50%
191 – 210	55%
211 – 250	60%
251 – 280	70%
281 – 300	80%

Point Range	Surcharge
301 – 325	90%
326 – 350	100%
351 – 370	125%
371 – 390	150%
391 – 410	175%
411 – 430	200%
431 – 450	225%
451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Comments: _____

Completed by: _____ Approved by: _____

-END OF MANUAL-



MANUAL

SECTION I

GENERAL RULES

I. PURPOSE OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

II. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

III. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

The Territory Definitions are:

1. Counties: Cook, Jackson, Madison, St. Clair and Will
2. Counties: Vermillion
3. Counties: Kane, Lake, McHenry and Winnebago
4. Counties: DuPage, Kankakee and Macon
5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph
6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

8. Remainder of State

IV. PREMIUM COMPUTATION

- A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.
- B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

V. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VI. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

- A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount; and
- B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

VII. ADDITIONAL PREMIUM CHARGES

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

VIII. RETURN PREMIUM FOR MID-TERM CHANGES

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.
- C. Retain the Policy Minimum Premium.

IX. POLICY CANCELLATIONS

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
 - 1. A policy is canceled at the Company's request.
 - 2. The Insured is leaving a group practice, or
 - 3. Death, disability or retirement of the Insured.
- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.

X. POLICY MINIMUM PREMIUM

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.

Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XI. PREMIUM PAYMENT PLAN

The Company offers the Insured the choice to pay in full or the following premium payment options:

- A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.
- B. The quarterly payment plan requires a 25% down payment and three quarterly installments of 25%.
- C. Our Automated Clearing House (ACH) option allows the Insured to have 12 equal monthly installments.

There are no extra fees associated with any premium payment plan.

XII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverage will be rated under Standard Claims-Made Rates.

XIII. LIMITS OF LIABILITY

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factor as applicable for the respective insureds and used to develop the applicable premium.

Liability Limit Factors

Liability Limit	Physicians	Surgeons
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

XIV. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the Insured, subject to underwriting.

XV. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:
 - 1. The Extended Reporting Endorsement factor from the table below is applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

<u>Year</u>	<u>Factor</u>
1 st	3.30
2 nd	3.15
3 rd	2.40
4 th	2.00

2. For First Year Claims Made step, it is applied pro-rata.
 3. For Second Year and all years of maturity, it is applied to the last year's (365 days) annualized premium from the date of cancellation.
- D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.
- E. The length of the Extended Reporting Period will be indefinite.
- F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.
1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.
 2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.
 3. The Reporting Period is unlimited.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. DEFINITION

- A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

Professional Corporations, Partnerships and Associations

- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are organized as a legal entity;
2. Maintain common facilities (including multiple locations) and support personnel; and
3. Maintain medical/dental records of patients of the group as a historical record of patient care.

- C. An exception to this rule is the Affinity Credit on Section III.G.

II. PREMIUM COMPUTATION

- A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:
- B. If separate limits are desired, an endorsement to convert the entity coverage from shared limits to separate limits shall be necessary.
- C. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met.
- D. The premium for professional corporations, partnerships and associations, limited liability companies, or other entities may be written with a separate limit of liability and shall be computed in the following manner: The premium will be a percentage of the sum of each insured's net individual premium. For each employed physician, and ancillary staff at the practice not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage, the Company must insure at least 60% of the employed physicians at the practice, and the remaining physicians must be insured by another professional liability program acceptable to the Company.

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage.

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

- E. Vicarious Liability Charge: For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

III. PREMIUM MODIFICATIONS

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.II.A.

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a rate class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
2. The rate classes are found in Section III.II.A. of this Manual.

B. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

C. Blending Rates

1. A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.
2. A blending adjustment is available for accounts rated in one territory, but have a percentage of their practice in one or more additional territories. The insured must provide a complete distribution of their practice in order to provide an accurate rating.

D. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.
2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.
3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by a Company director.

E. Per Patient Visit Rating

1. Per patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.
2. The premium for the per patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.
3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.
4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

Specialty	Conversion Factor
Urgent Care	.000160
Emergency Medicine	.000278

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per Patient Visit Rating

II. PREMIUM COMPUTATION DETAILS

A. Specialty Class Plan

The following classification plan shall be used to determine the appropriate rating class for each individual Insured.

Physician/Surgeon Specialty	Code	Class
Administrative Medicine	8901	2
Aerospace Medicine	9166	2
Allergy and Immunology	9108	1
Anesthesiology	8903	6
Anesthesiology (Pain Management)	9167	7
Cardiology (Interventional)	9031	9
Cardiology (Minor surgery)	9168	8
Cardiology (No surgery)	9169	3
Colon and Rectal Surgery	8910	11
Critical Care Medicine	9022	8
Dentistry (All other)	9171	3
Dermatology (Major Surgery)	9120	11
Dermatology (Minor Surgery)	9042	3
Dermatology (No Surgery)	9043	2
Emergency Medicine	9044	10
Emergency Medicine (with Trauma)	9172	12
Endocrinology	9013	2
Endocrinology (Minor Surgery)	9122	4
Endocrinology (Reproductive)	9173	12
Family Medicine (Including Obstetrics and C-Sections)	9113	18
Family Medicine (Including Obstetrics/No C-Sections)	9112	12
Family Medicine (Major Surgery)	9111	12
Family Medicine (Minor Surgery)	9110	9
Family Medicine (No Surgery)	9109	3
Gastroenterology	8915	5
Gastroenterology (Minor Surgery)	9174	8
General Surgery	8919	15
General Surgery (Including Bariatric)	8975	19
Geriatrics (Major Surgery)	9177	13
Geriatrics (Minor Surgery)	9175	7
Geriatrics (No Surgery)	9176	3
Gynecology (Major Surgery)	9128	12
Gynecology (Minor Surgery)	9066	8
Gynecology (No Surgery)	9067	4
Hand Surgery	9027	12
Hematology	8978	3
Hematology (Minor Surgery)	9163	7
Hospitalists (Including ER)	9178	9
Hospitalists (No ER)	9179	5
Hyperbaric Medicine	9131	2
Infectious Disease (No Surgery)	9180	4

Physician/Surgeon Specialty	Code	Class
Infectious Diseases (Minor Surgery)	9181	8
Internal Medicine (Minor Surgery)	9182	8
Internal Medicine (No Surgery)	9183	6
Legal Medicine	9184	1
Medical Genetics (Non-Invasive)	9135	3
Neonatology	8985	12
Nephrology (Minor Surgery)	9185	8
Nephrology (No Surgery)	9186	3
Neurology (Minor Surgery)	9187	8
Neurology (No Surgery)	9188	4
Neuromusculoskeletal Medicine/Osteopathic Manipulative Medicine Only	9038	3
Neurosurgery	8923	22
Nuclear Medicine	8981	2
Obstetrics and Gynecology	8926	19
Occupational Medicine	8800	2
Oncology (Major Surgery)	9191	14
Oncology (Minor Surgery)	9189	6
Oncology (No Surgery)	9190	3
Ophthalmology (Major Surgery)	9025	3
Ophthalmology (Minor Surgery)	9024	3
Ophthalmology (No Surgery)	9023	2
Oral and Maxillofacial Surgery	8996	13
Orthopedic Surgery (Including Spinal Surgery)	9037	20
Orthopedic Surgery (No Spinal Surgery)	9107	17
Orthopedics (Minor Surgery)	9192	7
Orthopedics (No Surgery)	9193	4
Otolaryngology (Minor Surgery)	9194	8
Otolaryngology (No Surgery)	9195	1
Otolaryngology (Surgery Cosmetic)	9196	14
Otolaryngology (Surgery Reconstructive)	9197	10
Pain Management - No Surgery	9236	4
Pain Management (Advanced Procedures)	9198	21
Pain Management (Basic Procedures)	9199	13
Pain Management (Intermediate Procedures)	9200	18
Pathology	8932	2
Pathology (Forensic)	9201	1
Pediatrics (Minor Surgery)	9145	8
Pediatrics (No Surgery)	9146	2
Perinatology	9019	21
Physical Medicine and Rehabilitation (Interventional)	9147	3
Physical Medicine and Rehabilitation (Non- Interventional)	9148	3
Physician NOC (Major Surgery)	9204	16
Physician NOC (Minor Surgery)	9202	8
Physician NOC (No Surgery)	9203	2
Plastic Surgery	8939	16

Physician/Surgeon Specialty	Code	Class
Plastic Surgery (Head and Neck, Cosmetic)	9205	15
Plastic Surgery (Head and Neck, Reconstructive)	9206	15
Podiatry (Major Surgery)	9207	7
Podiatry (Minor Surgery)	9208	6
Podiatry (No Surgery)	9209	1
Preventative Medicine	9210	2
Psychiatry (with electroconvulsive)	9211	2
Psychiatry (without electroconvulsive)	9212	2
Public Health Medicine	9214	2
Pulmonology	9215	6
Radiology (Diagnostic)	9216	2
Radiology (Interventional)	9217	10
Radiology (Oncology)	9218	5
Rheumatology	9054	2
Sleep Medicine	9151	2
Sports Medicine (Minor Surgery)	9219	5
Sports Medicine (No Surgery)	9220	4
Thoracic Surgery	8986	18
Trauma Surgery	9221	19
Urgent Care	9030	5
Urology (Major Surgery)	9224	10
Urology (Minor Surgery)	9222	8
Urology (No Surgery)	9223	3
Vascular (Minor Surgery)	9225	6
Vascular Surgery	9012	19

Ancillary Specialty	Code	Class
Certified Registered Nurse Anesthetist	8703	C-1
Chiropractor	9170	Z
Inhalation/Respiratory Therapists	9226	X
Midwife	9165	N
Nurse Practitioner	8704	Z
Nutritionists/Dieticians	9227	X
Optometrist	9228	X
Orthotists/Prosthetists	9229	X
Perfusionist	8700	Y
Pharmacists	9230	X
Physical/Occupational Therapist	9232	X
Physician Assistant	8701	Z
Psychologists	9213	Z
Radiology Assistant	9164	Y
Surgical Assistant	9231	Z

B. Manual Rates

Standard Claims Made Program Step Factors

Step Factors:

First Year:	25%
Second Year:	50%
Third Year:	78%
Fourth Year:	90%
Fifth Year (Mature):	100%

**PHYSICIANS AND SURGEONS
RATE TABLE**

Mature Rates (Claims-made)
1M/3M

Class	Territory 1	Territory 2	Territory 3	Territory 4	Territory 5	Territory 6	Territory 7	Territory 8
1	\$15,401	\$13,938	\$13,214	\$11,751	\$11,027	\$9,564	\$7,377	\$8,101
2	\$20,632	\$18,672	\$17,702	\$15,742	\$14,772	\$12,812	\$9,883	\$10,852
3	\$29,059	\$26,298	\$24,933	\$22,172	\$20,806	\$18,046	\$13,919	\$15,285
4	\$31,965	\$28,928	\$27,426	\$24,389	\$22,887	\$19,850	\$15,311	\$16,814
5	\$33,418	\$30,243	\$28,673	\$25,498	\$23,927	\$20,752	\$16,007	\$17,578
6	\$35,161	\$31,821	\$30,168	\$26,828	\$25,176	\$21,835	\$16,842	\$18,495
7	\$38,648	\$34,977	\$33,160	\$29,489	\$27,672	\$24,001	\$18,513	\$20,329
8	\$42,426	\$38,396	\$36,402	\$32,371	\$30,377	\$26,347	\$20,322	\$22,316
9	\$46,204	\$41,814	\$39,643	\$35,254	\$33,082	\$28,693	\$22,132	\$24,303
10	\$49,981	\$45,233	\$42,884	\$38,136	\$35,787	\$31,038	\$23,941	\$26,290
				\$41,905	\$39,324	\$34,106	\$26,307	\$28,889
11	\$54,922	\$49,704	\$47,123					
12	\$61,314	\$55,490	\$52,608	\$46,783	\$43,901	\$38,076	\$29,370	\$32,251
13	\$67,417	\$61,012	\$57,844	\$51,439	\$48,270	\$41,866	\$32,293	\$35,461
14	\$73,519	\$66,535	\$63,080	\$56,095	\$52,640	\$45,655	\$35,216	\$38,671
15	\$80,784	\$73,110	\$69,313	\$61,638	\$57,841	\$50,167	\$38,696	\$42,492
16	\$88,049	\$79,684	\$75,546	\$67,181	\$63,043	\$54,678	\$42,175	\$46,314
17	\$97,638	\$88,363	\$83,774	\$74,498	\$69,909	\$60,633	\$46,769	\$51,358
18	\$109,843	\$99,408	\$94,245	\$83,810	\$78,648	\$68,213	\$52,615	\$57,777
19	\$124,663	\$112,820	\$106,961	\$95,118	\$89,259	\$77,416	\$59,714	\$65,573
20	\$134,253	\$121,499	\$115,189	\$102,435	\$96,125	\$83,371	\$64,307	\$70,617
21	\$165,927	\$150,164	\$142,365	\$126,602	\$118,804	\$103,041	\$79,479	\$87,278
22	\$205,738	\$186,193	\$176,523	\$156,978	\$147,308	\$127,763	\$98,548	\$108,218

**NON PHYSICIAN HEALTHCARE PROVIDERS
RATE TABLE**

Mature Rates (Claims-made)
1M/3M

RATE CLASS	Separate limits	Shared limits
N	30% of Class 20	15% of Class 20
X	5% of Class 3	0% of Class 3
Y	15% of Class 3	0% of Class 3
Z	10% of Class 3	4% of Class 3
C-1	15% of Class 6	10% of Class 6

III. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

A. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week is considered a part time practitioner and is eligible for a reduction of 50% on the otherwise applicable rate for that specialty.
2. A Part Time Practitioner may include any practitioner in classes 1 through 10 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

B. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:
 - a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
 - b. Resident - Various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
 - c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.
3. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program.
4. The credit is not applied to the Extended Reporting Period Coverage.
5. The physician-in-training credit is 50% for 1st Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

C. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
 - a. Residency;
 - b. Fellowship program in their medical specialty;
 - c. Fulfillment of a military obligation in remuneration for medical school tuition;
 - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A credit of 30% for first and second years and 20% for the third year will be applied. No other credits are to apply concurrent with this rule.

D. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the Insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program.
2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the Insured's teaching activities.
 - a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.
 - b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.
 - c. No other credits are to apply concurrent with this rule.
 - d. The applicable percentages are based upon hours, up to 50%.

E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the Insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the following schedule:

<u>Claim Free</u>	<u>Credit</u>
0	0
1	2%
2	4%
3	6%
4	8%
5	10%
6	12%
7	14%
8	16%
9	18%
10+	20%

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

G. Affinity Credit

Affinity credit will be available for those physicians who are in Risk Purchasing Groups, PAs, Partnerships, IPAs, Networks, PCs and/or other currently unclassified group structures. The guidelines for calculating the percent of discount are as follows:

1. The number of full time physicians in the group at the time the policy becomes effective is the number that will be used to determine the credit.
2. When calculating Extended Reporting Endorsement rates, this credit cannot be applied.

3. Physicians from the same group are not required to be named on the same policy. However, all physicians of the group, whether they be full- or part-time, must be insured through Medicus Insurance Company.
4. The credit does not apply to part time physicians and ancillary healthcare personnel. However, if they are members of the group, they must be insured through Medicus Insurance Company in order for the full-time doctors to qualify for the discount.

Physician/Surgeon Group Total	Credit (percentage)
≤ 2	0
3 to 9	5%
10 to 19	10%
20 to 49	15%
50 +	20%

5. A group is defined as such if it possesses at least one of the following characteristics:
 - a. It is billed at a common billing address and uses other common facilities like office administration or a common credentialing/human resource office.
 - b. The group is organized only to practice medicine—not to purchase products or other goods and services.
 - c. The members of the group share profits and expenses.
 - d. Members substitute for each other when fellow members are ill or unavailable to cover shifts.
 - e. The members of the group provide each other with peer oversight.
 - f. The members of the group share a common retroactive date.

H. Elite Credit

The company shall apply a 5% credit at policy inception and a 10% credit at renewal to those insureds who meet the criteria for the Elite program as described in the criteria below.

1. Board certification in area of specialization
2. No history of impairment or substance abuse
3. No incident (unless closed without any payment), including notice of a claim, claim tendered, incurred, or paid indemnity or allocated loss adjustment expense incurred or paid, and Medical Board actions reported to current or previous insurer, validated by a company generated loss run and/or a sworn signed statement by the physician/group and the insured's agent covering the past four years qualifies a physician for consideration
4. Five years of practice history in area of specialization
5. No crimes committed, other than minor traffic violations
6. Proof of no late payments in the expiring policy premium.
7. Agreement to report medical incidents within 30 days, or thereafter by written demand within the policy period.

8. Certification through the United States Medical Licensing Exam (USMLE) if a physician was trained outside the United States. The doctor must also have completed a residency and/or fellowship program in the United States.
9. Certification by the LCME. He or she must also have completed a residency and/or fellowship program in the United States.
10. No material change of risk including a change in specialty, geographic change or practice pattern from time policy is issued through renewal. Renewal requires sworn statement by physician and agent of no known incidents, no charges for crimes and no history of substance abuse.

I. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

Schedule Rating: Modifications, subject to Underwriting:

For Individuals and Groups, subject to Underwriting,

1. The Company will consider all insureds for credits/debits:

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the Insured(s) is greater/less than the expected experience for an Insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The Insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/- 25%	Characteristics of a particular Insured that differentiate the Insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the Insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the Insured.

+/- 10%	
8. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The Insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record Keeping Practices. +/- 10%	Degree to which Insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification + / - 25%	

J. Experience Rating

1. A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

- a. Premiums paid
- b. Number of claims
- c. Incurred losses
- d. Cause of such losses
- e. Nature of practice

2. The Experience credits/debits shall apply on a one year basis and will be subject to annual review.

3. The formula is $L = A \times C + E \times (1 - C)$
where L is the indicated loss for the rating period, C is the credibility factor, A is the Adjusted actual historical loss, and E is the expected loss for the rating period.

K. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

L. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the Insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit.

Indemnity Only Deductible Per Claim		Indemnity and ALAE Deductible Per Claim	
\$5,000	2.5%	\$5,000	6.5%
\$10,000	4.5%	\$10,000	11.5%
\$15,000	6.0%	\$15,000	15.0%
\$20,000	8.0%	\$20,000	17.5%
\$25,000	9.0%	\$25,000	20.0%
\$50,000	15.0%	\$50,000	30.5%
\$100,000	25.0%	\$100,000	40.0%
\$200,000	37.5%	\$200,000	55.0%
\$250,000	42.0%	\$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

Indemnity Only Per Claim/Aggregate		Indemnity & ALAE Per Claim/Aggregate	
\$5000/15,000	2.0%	\$5000/15,000	5.5%
\$10,000/30,000	4.0%	\$10,000/30,000	10.5%
\$25,000/75,000	8.5%	\$25,000/75,000	19.0%

\$50,000/150,000	14.0%	\$50,000/150,000	29.5%
\$100,000/300,000	24.0%	\$100,000/300,000	43.0%
\$200,000/600,000	36.0%	\$200,000/600,000	53.5%
\$250,000/750,000	40.0%	\$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a claim. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to \$1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	\$10,500
10/30	.038	.035	.030	.024	\$21,000
25/75	.084	.079	.070	.058	\$52,500
50/150	.145	.139	.127	.109	\$105,000
100/300	.234	.228	.216	.196	\$120,000
200/600	.348	.346	.338	.321	\$420,000
250/750	.385	.385	.381	.368	\$525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	

5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
200/600	.396	.394	.385	.366	\$510,000
250/750	.467	.467	.462	.446	\$637,500

G. M. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

-END OF SECTION III-

SECTION IV

Medicus Secured Protection Program

I. OVERVIEW

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

- DEA License Suspension
- Professional Misconduct
- Successful Completion of Chemical Dependency Program
- Adverse Claims Experience (Severity and/or Frequency)
- Proctorship
- Medical Board Sanctions or Fines
- Unusual Practice Characteristics
- Physical or Mental Health Impairments
- Bare Exposure Period
- Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

II. APPLICANT REFERRAL CRITERIA:

A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

III. LENGTH OF INSURED'S REHABILITATION

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

IV. RATING APPROACH

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

V. UNDERWRITING

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

A. Coverage Modifications

1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.
2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).
3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.
4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.

B. Consent to Settle

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

VI. PHYSICIAN OR GROUP MANAGEMENT

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurrence
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

VII. INTERNAL LOGISTICS

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

VIII. MEDICUS SECURED PROTECTION PROGRAM RATING FORMULA

POINTS SCHEDULE A

Claims within the last 10 years from date of Report

- | | |
|---|-------------------------|
| A. Frequency and Severity Claims Schedule | Points from
Schedule |
| B. No Claims reported in the past five full years | -100 |

Drug or Alcohol Impairment- Health

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

Government Agency Actions

- | | |
|---|-----|
| A. Medical license in any state has been revoked. | 150 |
| B. Medical license in any state has been suspended. | 100 |
| C. Medical license has been placed on probation with restrictions on the type of services he or she can provide | 75 |
| D. Medical license has been placed on probation for more than 5 years | 75 |
| E. Medical license has been placed on probation for 1 to 5 years | 50 |
| F. Medical license is under investigation | 40 |
| G. Public letter of reprimand, fine, citation, etc. | 50 |
| H. Failure to report license investigation as required by affirmative duty language in policy. | 50 |
| I. During the preceding 5 year, DEA license has been revoked suspended or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician. | 100 |
| J. Has been convicted or indicted of a criminal act, or has been found to be in a violation of a civil statute, per event. | |

Medically Related

- | | |
|---|-----|
| Within 5 years | 100 |
| More than 5 years | 50 |
| K. Medicare/Medicaid investigation | 40 |
| L. Loss of Medicare/Medicaid Privileges | 50 |
| M. Loss of any health insurance provider privileges | 50 |

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

Inappropriate Patient Contact

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

POINTS SCHEDULE A (cont.)

Medical Education

- A. Attended more than one medical school or a residency program due to actual or planned disciplinary action 50
- B. Residency complete at two or more facilities 50
- C. Started, but did not complete, a full residency program. 50
- D. Did not begin a residency. 50
- E. Has never received board certification 50

Medical Records

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

Informed Consent

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

Privileges - Any State

(Hospital, Surgery Center, Etc.)

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

Procedures

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

Patient Safety / Physician or group Management

- A. Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements. 100

B.	Mandatory patient safety/physician or group management previously recommended and Insured had initial compliance but no follow through.	75
	Gaps in Medical Practice	
A.	Gaps in medical practice of 6-months to 1-year duration.	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years.	150
	Payment History	
A.	Two or more late payments within the last three years.	100
B.	Two or more cancellations for non-payment of premium within the last three years.	150
	Other	
A.	Uncooperative in Claims Handling	150
B.	Patient Load:	
	For Surgeons, 61-99 patients per week	50
	For Surgeons, 100 or more patients per week	100
	For all others, 101-149 patients per week	50
	For all others, 150 or more patients per week	100
C.	Advertising: If Insured advertises his/her services on TV, newspapers, billboards or radio	25
D.	Uses collection agency that can file suit without Insured's written consent.	25
E.	Previous insurance history (bare, insolvent prior insurer or non-renewed).	100
F.	Claim experience of Associates, Partners or Corporation:	
	If one member with claim(s)	75
	If more than one member with claim(s)	100
	Favorable experience of group as a whole	-150
G.	For each claim or suit in which the physician breached the standard of care:	
	Mixed Reviews	50
	All Negative Reviews	100
	Admitted or Clear Liability	100
H.	For two or more claims, suits or incidents arising out of the same or similar procedures or treatments.	50
I.	Claim is too early in discovery period:	
	Surgical Class	-100
	Non-Surgical Class	-50
J.	For each claim or suit in which expert reviewers state the Insured met the standard of care:	
	Surgical Class	-150
	Non-Surgical Class	-100
K.	High-physician or group surgical patient selection.	150
L.	Reinstatement of nonrenewal due to company election	150
M.	Loss Ratio in excess of 500%.	150
N.	Loss Ratio less than 100%.	-100
O.	Discrepancies between application answers/documents and verification	150

FREQUENCY AND SEVERITY CLAIMS SCHEDULE

Insured: _____

Policy#: _____
(If Applicable)

Effective Date: _____

Review Date: _____

Claims Without Indemnity			
ALAE			
From:	To:	Claim Score	
\$5,001	\$25,000	1	
\$25,001	\$50,000	2	
\$50,001	\$100,000	3	
\$100,001	& up	4	
Claims With Indemnity			
Indemnity + ALAE			
From:	To:	Claim Score	
\$1	\$25,000	4	
\$25,001	\$50,000	5	
\$50,001	\$100,000	6	
\$100,001	\$250,000	7	
\$250,001	\$500,000	8	
\$500,001	\$750,000	9	
\$750,001	\$1,000,000	11	
\$1,000,001	& up	13	

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

Total: _____

Completed by: _____

Approved by: _____

Frequency and Severity Claims Schedule (Continued)

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

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

(1) As of Review Date.

(2) Add 25 points for each Total Claim Score above 15.

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

Points Evaluation Worksheet

Insured: _____

Policy#: _____

Effective Date: _____

(If Applicable)
Review Date: _____

Criteria

Points

Claims	_____
Frequency	_____
Drug or Alcohol Impairment – Health	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges – Any State	_____
Procedures	_____
Physician or group Management	_____
Gaps in Coverage	_____
Other	_____
Total Points:	_____

Ranges & Surcharges

Point Range	Surcharge
0 – 100	0%
101-130	40%
131 – 160	45%
161 – 190	50%
191 – 210	55%
211 – 250	60%
251 – 280	70%
281 – 300	80%

Point Range	Surcharge
301 – 325	90%
326 – 350	100%
351 – 370	125%
371 – 390	150%
391 – 410	175%
411 – 430	200%
431 – 450	225%
451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Comments: _____

Completed by: _____

Approved by: _____

-END OF MANUAL-