MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

WITHDRAWN

DEC 21 2009

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

RECEIVED

NOV 18 2009

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

November 16, 2009

Gayle Neuman, Property & Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 09-IL-135 (Amended)
COMPANY FEIN NO: 35-0506406
ILLINOIS PHYSICIANS & SURGEONS, DENTISTS and ALLIEDS
OCCURRENCE and STANDARD CLAIMS MADE
Amended to include the following:
Territory Revisions -1.5%
Class Plan Revisions -0.5%
Overall Rate Impact -2.0%

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
State Rate Pages, Section III – Physicians & Surgeons

EFFECTIVE DATE: ***Modified from January 1, 2010 to March 1, 2010***

Dear Ms. Neuman:

On November 5th, we submitted to your Department a class plan and rule filing under 09-IL-135. After further review of the filing we found several items were not included and therefore we are amending the filing accordingly. We ask that the original requested effective date be modified from January 1, 2010 to March 1, 2010.

I have included a revised RF3 form, revised Memorandum, revised state rate pages for State Rate Pages Section II (SR-IL-II-pp1-4, 3/1/10 edt) and Section III (SR-IL-III-pp1-82, 3/1/10 edt), in addition, a revised Partnership/Corporation Rating Rule (PCC-IL, 3/1/10)for review. We have also incorporated strike thru's for these changes.

In addition to the revisions, the following are hereby added to the filing for review and approval: Physicians & Surgeons Rate Pages (RTS-xxx; IL-10-01), Physicians & Surgeons Rating Territory Pages (RT-IL; 3/10 edt), Physicians & Surgeons Class Plan Pages (PRC-IL; 3/1/10 edt) and Actuarial Supporting exhibits. We have also incorporated strike thru's for these changes.

Upon completion of your review, would you please stamp the duplicate copy of this submission and return it to us in the envelope provided.

Should you have any questions regarding this filing, please contact me. Thank you.

Sincerely,

Melissa Millican

Melissa Coker Millican, Paralegal
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.millican@medpro.com

Enclosures

Neuman, Gayle

From: Millican, Melissa [Melissa.Millican@medpro.com]
Sent: Monday, December 21, 2009 1:02 PM
To: Neuman, Gayle
Subject: FW: The Medical Protective Company, company filing # 09-IL-135

Ms. Neuman,
I received your voicemessage, at this time we will withdraw the company filing #09-IL-135. We will resubmit the filing to you very soon.
Thank you for your message and your review of our filing.
Melissa

Melissa Millican, Paralegal
Legal Department

The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835
Phone: 260-486-0838
Fax: 260-486-0733
Email: melissa.millican@medpro.com
web: www.medicalprotective.com
PLEASE NOTE NEW EMAIL ADDRESS

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE

SUMMARY SHEET

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

(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1. Automobile Liability Private Passenger Commercial		
2. Automobile Physical Damage Private Passenger Commercial		
3. Liability Other Than Auto		
4. Burglary and Theft		
5. Glass		
6. Fidelity		
7. Surety		
8. Boiler and Machinery		
9. Fire		
10. Extended Coverage		
11. Inland Marine		
12. Homeowners		
13. Commercial Multi-Peril		
14. Crop Hail		
15. Other Medical Malpractice (Line of Insurance)	$23,501,916	-2.0%

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DEC 21 2009

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

Does filing only apply to certain territory (territories) or certain classes? If so, specify: Yes. The following territories are being revised: Adams, DuPage, Knox, Lake, Macon, Rock Island, Sangamon

Brief description of filing. (If filing follows rates of an advisory organization, specify organization): Revise Class Assignments for two Physician specialities, revise Physician Area assignments, Create new Area 9 for Physicians, Revise Part/corp Rating Rule, 2010 CW Rule filing revisions.

*Adjusted to reflect all prior rate changes.
**Change in Company's premium level which will result from application of new rates.

The Medical Protective Company
Name of Company

J D Thomas SVP
Official – Title

RECEIVED

NOV 18 2009

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

Filing # 09-IL-135

ILLINOIS CERTIFICATION FOR
MEDICAL MALPRACTICE RATES

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

I, Jim D. Kunce, a duly authorized officer of The Medical Protective Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Jim D. Kunce, a duly authorized actuary of The Medical Protective Company am authorized to certify on behalf of The Medical Protective Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

J D K : SVP — 11/5/09
Signature and Title of Authorized Insurance Company Officer — Date

J D K FCAS ; SVP — 11/05/09
Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 09-IL-135

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's: -Name / E-mail Melissa Millican / melissa.millican@medpro.com

-Direct Telephone and Fax Number Direct: 260-486-0838; Fax: 260-486-0733

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

PHYSICIANS & SURGEONS PROGRAM

ACTUARIAL MEMORANDUM

The Medical Protective Company (MedPro) respectfully submits the attached exhibits supporting rate revisions to the Physicians & Surgeons Occurrence and Claims Made programs in the state of Illinois. The proposed revisions will result in an overall premium decrease of 2.0%. This will be accomplished through classification relativity changes with an estimated impact of -0.5% and territory relativity changes with an estimated impact of -1.5%. The combined premium effect of these changes is -2.0% {-0.020 = [(1.0 - 0.005) x (1.0 - 0.015)] - 1.0}.

In addition to the rate revisions proposed for the Physicians & Surgeons program, the Company would like to revise several rating rules for its Physician & Surgeon, Dentists, Allied Healthcare Providers and Comprehensive Coverage for Healthcare Providers programs. The proposed effective date for these revisions is March 1, 2010 for new and renewal business.

EXHIBIT I: TERRITORY CHANGES – PHYSICIANS & SURGEONS

The proposed revisions to MedPro's Physicians & Surgeons territory plan were determined by incorporating consideration of the territory plans of other carriers and underwriting judgment. In Exhibit I-A, current and proposed relativities are listed by territory. MedPro is proposing to add a new territory 9 with a proposed relativity of 1.100.

Filing Exhibit I-B lists the seven counties MedPro proposes to move to a different territory. Corresponding territory factors for ISMIE are included. As is evident by the experience, MedPro's county changes were greatly influenced by the filed relativities of ISMIE since they write a predominant share of the business in the state.

EXHIBIT II: CLASSIFICATION CHANGES – PHYSICIANS & SURGEONS

The proposed revisions to MedPro's Physicians & Surgeons classification plan were determined by incorporating a number of considerations including: classification relativities derived from an ISO countrywide classification study, a review of the classification relativities of other carriers, an analysis of MedPro claim experience, the credibility of the classification indications, an evaluation of stability issues and underwriting judgment. For the proposed changes outlined in Exhibit II, a weighting of the indicated MedPro relativity with ISMIE and AP Capital resulted in the revised relativities for the specialties listed.

III. RULE REVISIONS — Physicians and Surgeons Program

Aggregate Credit Rule - The Company wishes to introduce the Aggregate Credit Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude New to Practice, New to Company and Membership Association credits from the cap. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section III. There is no substantive rate impact associated with this rule.

Convertible Plus/Nose Rating Plan - The Company also proposes to introduce an additional rating rule and coverage form for insureds that are currently covered under a claims-made policy form, but desire to convert to an occurrence coverage form. The Convertible Plus / Nose Coverage product will provide nose coverage, as an endorsement to the occurrence policy, to cover extended reporting period exposure for the time the insured was on a claims-made policy form, The rating for such coverage is outlined in the proposed rating rule that is attached. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section III.

Extension Contract Rating Rule - The Extension Contract Rating Rule is being revised for the Stand Alone Standard Claims Made Program to include discretionary schedule rating modifications in the calculation of the Extension Contract premium. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within General Manual Section I and further defines the differences in calculation methods for Individual Healthcare Professional versus Healthcare Facilities. The changes do not result in a rate impact.

Full Time Equivalency Rating Rule - The Company wishes to revise the Full Time Equivalency Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude Risk Management Credits from the calculation of FTE Credits, as well as clarify the audit provisions and identifies that training and residency programs are not eligible for FTE rating Please refer to the Comprehensive Liability Coverage for Healthcare Providers General Manual Section III for these revisions. There is no substantive rate impact associated with this change.

Non-Discretionary Debit Plan - The Company wishes to revise the Non-Discretionary Debit Plan for the Stand Alone Occurrence and Standard Claims Made Programs to include two newly created ISO codes to Table B. Please refer to Section III of the State Rate Pages for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is no substantive rate impact associated with this change.

Partnership / Corporation Rating Rule - The Company wishes to revise the Partnership Corporation Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to Include credit for an optional vicarious liability corporation exposure of a non-insured corporation member. Please refer to Section H of the State Rate Pages for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual page. Additionally, as a result of the introduction of a new territory (Area 9), the Partnership Corporation Caps have also

been updated to include Caps for Area 9. There is no substantive rate impact associated with this change.

Part Time Practice Rule - The Company wishes to revise the Part Time Practice Rule for the Occurrence and Standard Claims Made Programs to include the application of Schedule Rating Modifications with Part Time Credits. Please refer to the attached General Manual Section III for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is not a substantive rate impact associated with this change.

Renewal Rating Rule - The Company wishes to revise the Renewal Rating Rule for the Occurrence and Standard Claims Made Programs to hold premium constant from policy term to policy term for accounts which meet a certain premium threshold. Please refer to Section III of the State Rate Pages for the Comprehensive Liability Coverage for Healthcare providers for the applicable premium threshold. There is not a substantive rate impact associated with this change.

IV. RULE REVISIONS — Dental Program.

Aggregate Credit Rule - The Company wishes to introduce the Aggregate Credit Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude New to Practice and New to Company credits from the cap. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section IV. There is no substantive rate impact associated with this rule.

Botulineum Toxin and Dermal Fillers Rating Rule - The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently added Botulineum Toxin and Dermal Fillers Rating Rule which has recently been filed and approved for its Stand Alone Dentist program. Please refer to the attached General Manual Section IV as well as corresponding Section IV of the State Rate Pages. This modification has no rate impact on current insureds.

Convertible Claims Made Rating Rule – The Company wishes to revise the Convertible Claims Made Rating Rule to Include the use of New to Company credits in the calculation. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section IV. There is no rate impact on current insureds.

Dental Board Examination Rule – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised Dental Board Examination Rule revisions which have been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the State Rate Pages for this modification of which has no rate impact on current insureds.

Dental Facility Classification Plan – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently added Dental Facility Classification Plan which has recently been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the General Manual as well as Section IV of the attached State Rate Pages.

Extension Contract Rating Rule — The Extension Contract Rating rule is being revised for the Stand Alone Standard Claims Made Program to include discretionary schedule rating modifications in the calculation of the Extension Contract premium. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section I and further defines the differences in calculation methods for Individual Healthcare Professional versus Healthcare Facilities. The changes do not result in a rate impact.

Full Time Equivalency Rating Rule — The Company wishes to revise the Full Time Equivalency Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude Risk Management Credits from the calculation of FTE Credits, as well as clarify the audit provisions and identifies that training and residency programs are not eligible for FTE rating Please refer to the Comprehensive Liability Coverage for Healthcare Providers General Manual Section IV for these revisions. There is no substantive rate impact associated with this change.

Membership Association Credit Rule — The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised Membership Association Credit Rule which has been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the attached State Rate Pages for this modification. There is not a substantive rate impact associated with this change.

Moonlighting Rating Rule — The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised added Moonlighting Rating Rule which has been filed and approved for its Stand Alone Dentists program. Please refer to the attached General Manual Section IV and Section IV State Rate Pages for the modification. There is not a substantive rate impact associated with this change.

New to Practice Credit — The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised New to Practice Credits which have been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the attached State Rate Pages for the modification. There is not a substantive rate impact associated with this change.

Part Time Practice Rule - The Company wishes to revise the Part Time Practice Rule for the Occurrence and Standard Claims Made Programs to include the application of Schedule Rating Modifications with Part Time Credits. Additionally, please refer to the attached General Manual Section IV for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is not a substantive rate impact associated with this change.

Renewal Rating Rule - The Company wishes to revise the Renewal Rating Rule for the Occurrence and Standard Claims Made Programs to hold premium constant from policy term to policy term for accounts which meet a certain premium threshold. Please refer to Section IV of the State Rate Pages for the Comprehensive Liability Coverage for Healthcare providers for the applicable premium threshold. There is not a substantive rate impact associated with this change.

Student/Resident Rating Rule — The Company wishes to revise the Comprehensive Coverage for Healthcare Providers program Section IV General Manual and State Rate Pages to include the

Student / Resident Rating Rule. This rule has recently been filed and approved for the DDS Stand Alone program and the addition of this rule does not result in a rate impact.

V. RULE REVISIONS — Allied Healthcare Providers Program

Aggregate Credit Rule — The Company wishes to revise the Aggregate Credit Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude New to Practice, New to Company and Membership Association credits from the cap. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section V. There is no substantive rate impact associated with this rule.

Allied Healthcare Providers Class Plan — The Company wishes to revise the Allied Healthcare Providers Class Plan for the Stand Alone Occurrence and Standard Claims Made Programs. The revision consists of adding Anesthesia Assistants as their own speciality under the class plan. Currently Anesthesia Assistants are rated as CRNA's as their exposure is similar. However, the marketplace has begun to distinguish these two healthcare specialties separately and thus the Company is choosing to make that distinction in its classification plan at this time. Additionally, the addition of Anesthesia Assistant has been made to the attached Comprehensive Liability Coverage for Healthcare Providers manual, Section V of the State Rate Pages. There is no rate impact associated with this addition.

Extension Contract Rating Rule — The Extension Contract Rating rule is being revised for the Stand Alone Standard Claims Made Programs to include discretionary schedule rating modifications in the calculation of the Extension Contract premium. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section 1 and further defines the differences in calculation methods for Individual Healthcare Professional versus Healthcare Facilities. The changes do not result in a rate impact.

Full Time Equivalency Rating Rule — The Company wishes to revise the Full Time Equivalency Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude Risk Management Credits from the calculation of FIE Credits, as well as clarify the audit provisions and identifies that training and residency programs are not eligible for FIE rating. Please refer to the Comprehensive Liability Coverage for Healthcare Providers General Manual Section V for these revisions. There is no substantive rate impact associated with this change.

Part Time Practice Rule - The Company wishes to revise the Part Time Practice Rule for the Occurrence and Standard Claims Made Programs to include the application of Schedule Rating Modifications with Part Time Credits. Please refer to the attached General Manual Section V for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is not a substantive rate impact associated with this change.

Renewal Rating Rule - The Company wishes to revise the Renewal Rating Rule for the Occurrence and Standard Claims Made Programs to hold premium constant from policy term to policy term for accounts which meet a certain premium threshold. Please refer to Section V of the State Rate Pages for the Comprehensive Liability Coverage for Healthcare providers for the

applicable premium threshold. There is not a substantive rate impact associated with this change.

VI. RULE REVISIONS — Miscellaneous adjustments — Non Premium Bearing

Section II:

Extended Reporting Period Coverage Factors - The extended reporting period factors for Dentists, years 4 and 5 or more , currently on file for the Company's Stand Alone DOS program are not referenced accurately in the matrix in the State Rate Pages. The factors are being revised to accurately depict the Company's intent with regard to this rating rule.

Policy Writing Minimum Premium — The minimum premium designations currently on file for the Company's Stand Alone DDS programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Schedule Rating — Partnerships & Corporations — The schedule rating designations currently on file for the Company's Stand Alone DDS programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Small Group, Large Group & Temporary Staffing Agency Rating — Corporations — The countrywide designation of these rules is not accurately reflected in the current State Rate Pages. Therefore, the rule title is being changed to add the distinction of 'Small' groups in the title.

Section III:

Small Group & Large Group Rating — The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Section IV:

Policy Writing Minimum Premium — The minimum premium designations currently on file for the Company's Stand Alone DDS programs are not referenced accurately in the matrix In the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

New to Company Credit — The New to Practice credit designations currently on file for the Company's Stand Alone DOS programs are not referenced accurately in the matrix In the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Schedule Rating — **The** schedule rating designations currently on file for the Company's Stand Alone MD programs are not referenced accurately in the matrix in the State Rate Pages, in that the

per characteristic caps were omitted from the page. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Small Group & Large Group Rating — The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Section V:

Allied Territory Rating Plan — The Allied Territory Rating Plan currently on file for the Company's Stand Alone AHCP programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Schedule Rating he schedule rating designations currently on file for the Company's Stand Alone AHCP programs are not referenced accurately in the matrix in the State Rate Pages, in the per characteristic caps were omitted from the page. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Small Group Rating Rule — The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Large Group Rating Rule — The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Accelerated Extension Contract Rating — The rule is being updated to 'Available' to align with the Stand Alone Allied Healthcare Providers Program.

Group Rating Rule — This is being removed as it is redundant with the 'Small Group Rating Rule' and `Large Group Rating Rule.'

Neuman, Gayle

From: Neuman, Gayle
Sent: Tuesday, December 01, 2009 1:58 PM
To: 'Millican, Melissa'
Subject: RE: Filing #09-IL-135

I am requesting that you submit a complete "amended" filing. This will clarify the filing for all parties involved. Thank you for your assistance.

Gayle Neuman
Department of Insurance

From: Millican, Melissa [mailto:Melissa.Millican@medpro.com]
Sent: Wednesday, November 18, 2009 2:33 PM
To: Neuman, Gayle
Subject: RE: Filing #09-IL-135

Yes, that is correct, I wasn't sure the best way to "amend" it. If it would be cleaner for review for me to send a complete "amended" filing that incorporates the entire filing, I can send that over to you if that would be best? We tried to provide the pages that were impacted in addition the corresponding strike thrus. Just let me know what would help ease the review.
Thank you,
Melissa

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, November 18, 2009 3:17 PM
To: Millican, Melissa
Subject: Filing #09-IL-135

Ms. Millican,

I am in receipt of your November 16, 2009 submission to amend filing #09-IL-135. The filing as submitted on November 5, 2009 amended the physicians/surgeons, dentists and allied sections. The new submission only included physicians/surgeons information. Am I correct in my assumption that the 11-16 submission replaces part of the 11-5 submission, but not all of it?

Your prompt attention is appreciated.

Gayle Neuman

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

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

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

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - A

ILLINOIS

PHYSICIANS & SURGEONS

TERRITORY RELATIVITY CHANGES

Territory	Current Relativity	Proposed Relativity
1	2.000	2.000
2	1.800	1.800
3	1.700	1.700
4	1.500	1.500
5	1.400	1.400
6	1.200	1.200
7	0.900	0.900
8	1.000	1.000
9	n/a	1.100

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - B

ILLINOIS

PHYSICIANS & SURGEONS

TERRITORY COUNTY CHANGES

County	Current Territory	Proposed Territory	ISMIE Factor	Current Relativity	Proposed Relativity	% Change
Adams	8	7	0.90	1.00	0.90	-10.0%
DuPage	4	5	1.40	1.50	1.40	-6.7%
Knox	8	7	0.90	1.00	0.90	-10.0%
Lake	2	3	1.70	1.80	1.70	-5.6%
Macon	4	5	1.40	1.50	1.40	-6.7%
Rock Island	8	7	0.90	1.00	0.90	-10.0%
Sangamon	6	9	1.10	1.20	1.10	-8.3%
					Weighted Overall Impact:	**-1.5%**

Note: Above factors assume Remainder Of State territory relativity equals 1.00.

THE MEDICAL PROTECTIVE COMPANY

Exhibit II

ILLINOIS

PHYSICIANS & SURGEONS

CLASSIFICATION CHANGES

Current Class	ISO Code	Description	Current Relativity to 1B	Relative to 80420					Proposed Relativity to 1B	Proposed Class	Relativity Change	% of Book
				Current MedPro Rate Rel	MePro Indicated Rate Rel	ISMIE Indicated Rate Rel	AP Cap Indicated Rate Rel	Proposed MedPro Rate Rel				
		Class 1A										
5A	136.00	SURGERY - COSMETIC	3.500	2.979	2.161	-	-	2.426	2.850	4A	-18.6%	0.2%
5A	156.00	SURGERY - PLASTIC - N.O.C.	3.500	2.979	2.161	2.960	2.708	2.426	2.850	4A	-18.6%	1.5%
											Weighted Overall Impact:	**-0.5%**

The
Medical Protective Company
Fort Wayne, Indiana 46835
Professional Protection Exclusively Since 1899

ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,250	5,780	8,543	10,583	11,008
1B	5,667	7,707	11,391	14,111	14,678
1C	6,659	9,056	13,385	16,581	17,247
1D	7,254	9,865	14,581	18,062	18,788
2A	7,934	10,790	15,947	19,756	20,549
2B	9,351	12,717	18,796	23,284	24,219
2C	11,051	15,029	22,213	27,517	28,622
2D	12,467	16,955	25,059	31,043	32,290
3A	13,317	18,244	27,566	35,024	36,622
3B	14,734	20,186	30,499	38,750	40,519
4A	16,151	22,127	33,433	42,477	44,415
4B	17,568	24,068	36,366	46,204	48,312
5A	19,835	27,174	41,058	52,166	54,546
5B	22,101	30,278	45,749	58,126	60,778
6A	23,235	31,832	48,096	61,108	63,896
6B	26,068	35,713	53,961	68,559	71,687
7	30,035	41,148	62,172	78,992	82,596
8	43,069	59,005	89,153	113,271	118,440

The
Medical Protective Company
Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,140	1,550	2,291	2,839	2,953
1B	1,519	2,066	3,053	3,782	3,934
1C	1,785	2,428	3,588	4,445	4,623
1D	1,945	2,645	3,909	4,843	5,038
2A	2,127	2,893	4,275	5,296	5,509
2B	2,507	3,410	5,039	6,242	6,493
2C	2,963	4,030	5,956	7,378	7,674
2D	3,343	4,546	6,719	8,324	8,658
3A	3,571	4,892	7,392	9,392	9,820
3B	3,950	5,412	8,177	10,389	10,863
4A	4,330	5,932	8,963	11,388	11,908
4B	4,710	6,453	9,750	12,387	12,953
5A	5,318	7,286	11,008	13,986	14,625
5B	5,926	8,119	12,267	15,585	16,297
6A	6,230	8,535	12,896	16,385	17,133
6B	6,989	9,575	14,467	18,381	19,220
7	8,053	11,033	16,670	21,179	22,146
8	11,547	15,819	23,902	30,369	31,754

The
Medical Protective Company
Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,968	2,676	3,956	4,900	5,097
1B	2,624	3,569	5,274	6,534	6,796
1C	3,084	4,194	6,199	7,679	7,988
1D	3,359	4,568	6,752	8,364	8,700
2A	3,674	4,997	7,385	9,148	9,516
2B	4,330	5,889	8,703	10,782	11,215
2C	5,118	6,960	10,287	12,744	13,256
2D	5,774	7,853	11,606	14,377	14,955
3A	6,167	8,449	12,766	16,219	16,959
3B	6,823	9,348	14,124	17,944	18,763
4A	7,479	10,246	15,482	19,670	20,567
4B	8,136	11,146	16,842	21,398	22,374
5A	9,186	12,585	19,015	24,159	25,262
5B	10,235	14,022	21,186	26,918	28,146
6A	10,760	14,741	22,273	28,299	29,590
6B	12,072	16,539	24,989	31,749	33,198
7	13,909	19,055	28,792	36,581	38,250
8	19,945	27,325	41,286	52,455	54,849

The
Medical Protective Company
Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,108	4,227	6,247	7,739	8,050
1B	4,144	5,636	8,329	10,319	10,733
1C	4,869	6,622	9,787	12,124	12,611
1D	5,304	7,213	10,661	13,207	13,737
2A	5,801	7,889	11,660	14,444	15,025
2B	6,837	9,298	13,742	17,024	17,708
2C	8,081	10,990	16,243	20,122	20,930
2D	9,116	12,398	18,323	22,699	23,610
3A	9,738	13,341	20,158	25,611	26,780
3B	10,774	14,760	22,302	28,336	29,629
4A	11,810	16,180	24,447	31,060	32,478
4B	12,846	17,599	26,591	33,785	35,327
5A	14,504	19,870	30,023	38,146	39,886
5B	16,161	22,141	33,453	42,503	44,443
6A	16,990	23,276	35,169	44,684	46,723
6B	19,061	26,114	39,456	50,130	52,418
7	21,962	30,088	45,461	57,760	60,396
8	31,493	43,145	65,191	82,827	86,606

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,730	5,073	7,497	9,288	9,661
1B	4,973	6,763	9,996	12,383	12,880
1C	5,843	7,946	11,744	14,549	15,133
1D	6,365	8,656	12,794	15,849	16,485
2A	6,962	9,468	13,994	17,335	18,032
2B	8,204	11,157	16,490	20,428	21,248
2C	9,697	13,188	19,491	24,146	25,115
2D	10,940	14,878	21,989	27,241	28,335
3A	11,686	16,010	24,190	30,734	32,137
3B	12,929	17,713	26,763	34,003	35,555
4A	14,171	19,414	29,334	37,270	38,970
4B	15,415	21,119	31,909	40,541	42,391
5A	17,404	23,843	36,026	45,773	47,861
5B	19,393	26,568	40,144	51,004	53,331
6A	20,388	27,932	42,203	53,620	56,067
6B	22,874	31,337	47,349	60,159	62,904
7	26,355	36,106	54,555	69,314	72,476
8	37,791	51,774	78,227	99,390	103,925

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,937	5,354	7,913	9,803	10,197
1B	5,249	7,139	10,550	13,070	13,595
1C	6,167	8,387	12,396	15,356	15,973
1D	6,718	9,136	13,503	16,728	17,400
2A	7,348	9,993	14,769	18,297	19,031
2B	8,660	11,778	17,407	21,563	22,429
2C	10,235	13,920	20,572	25,485	26,509
2D	11,547	15,704	23,209	28,752	29,907
3A	12,335	16,899	25,533	32,441	33,921
3B	13,647	18,696	28,249	35,892	37,529
4A	14,959	20,494	30,965	39,342	41,137
4B	16,272	22,293	33,683	42,795	44,748
5A	18,371	25,168	38,028	48,316	50,520
5B	20,471	28,045	42,375	53,839	56,295
6A	21,520	29,482	44,546	56,598	59,180
6B	24,144	33,077	49,978	63,499	66,396
7	27,819	38,112	57,585	73,164	76,502
8	39,891	54,651	82,574	104,913	109,700

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,144	5,636	8,329	10,319	10,733
1B	5,525	7,514	11,105	13,757	14,310
1C	6,492	8,829	13,049	16,165	16,814
1D	7,072	9,618	14,215	17,609	18,316
2A	7,735	10,520	15,547	19,260	20,034
2B	9,116	12,398	18,323	22,699	23,610
2C	10,774	14,653	21,656	26,827	27,905
2D	12,155	16,531	24,432	30,266	31,481
3A	12,984	17,788	26,877	34,148	35,706
3B	14,365	19,680	29,736	37,780	39,504
4A	15,746	21,572	32,594	41,412	43,302
4B	17,128	23,465	35,455	45,047	47,102
5A	19,338	26,493	40,030	50,859	53,180
5B	21,548	29,521	44,604	56,671	59,257
6A	22,653	31,035	46,892	59,577	62,296
6B	25,415	34,819	52,609	66,841	69,891
7	29,283	40,118	60,616	77,014	80,528
8	41,990	57,526	86,919	110,434	115,473

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN OPHTHALMOLOGY.

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN ENDOCRINOLOGY.

SURGICAL SPECIALISTS TO INCLUDE: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: DIAGNOSTIC RADIOLOGY, GASTROENTEROLOGY, INFECTIOUS DISEASE, NEONATOLOGY AND NEUROLOGY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS IN PULMONARY DISEASE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DIAGNOSTIC RADIOLOGY, INTERNAL MEDICINE, RADIOLOGY - INCLUDING MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID PERFORMING ANY OF THE FOLLOWING: ACUPUNCTURE OR CARDIOLOGY (LEFT HEART CATHETERIZATION).

CLASS IIIB

SURGICAL SPECIALISTS TO INCLUDE: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

The

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ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS TO INCLUDE: COSMETIC SURGERY, GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY, ORTHOPEDIC SURGERY (EXCLUDING SPINAL) AND PLASTIC SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IVB

SURGICAL SPECIALISTS IN EMERGENCY MEDICINE.

CLASS VA

RESERVED FOR FUTURE USE.

CLASS VB

SURGICAL SPECIALISTS TO INCLUDE: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN ORTHOPEDIC SURGERY (INCLUDING SPINAL).

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS VIB

SURGICAL SPECIALISTS TO INCLUDE: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY.

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ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

	Territory								
Limit	1 Cap	2 Cap	3 Cap	4 Cap	5 Cap	6 Cap	7 Cap	8 Cap	9 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300	$22,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700	$28,300
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000	$31,900
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600	$34,800
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900	$37,200

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/CONTRACTED PHYSICIANS.

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, JACKSON, MADISON, ST. CLAIR, AND WILL COUNTIES.

TERRITORY 2: VERMILLION COUNTY.

TERRITORY 3: KANE, LAKE, MCHENRY, AND WINNEBAGO COUNTIES.

TERRITORY 4: KANKAKEE COUNTY.

TERRITORY 5: BUREAU, CHAMPAIGN, COLES, DEKALB, DUPAGE, EFFINGHAM, LASALLE, MACON, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 6: GRUNDY COUNTY.

TERRITORY 7: ADAMS, KNOX, PEORIA, AND ROCK ISLAND COUNTIES.

TERRITORY 8: REMAINDER OF STATE.

TERRITORY 9: SANGAMON COUNTY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN OPHTHALMOLOGY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN ENDOCRINOLOGY.

SURGICAL SPECIALISTS TO INCLUDE: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: DIAGNOSTIC RADIOLOGY, GASTROENTEROLOGY, INFECTIOUS DISEASE, NEONATOLOGY AND NEUROLOGY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS IN PULMONARY DISEASE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DIAGNOSTIC RADIOLOGY, INTERNAL MEDICINE, RADIOLOGY - INCLUDING MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID PERFORMING ANY OF THE FOLLOWING: ACUPUNCTURE OR CARDIOLOGY (LEFT HEART CATHETERIZATION).

CLASS IIIB

SURGICAL SPECIALISTS TO INCLUDE: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS TO INCLUDE: COSMETIC SURGERY, GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY, ORTHOPEDIC SURGERY (EXCLUDING SPINAL) AND PLASTIC SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IVB

SURGICAL SPECIALISTS IN EMERGENCY MEDICINE.

CLASS VA

RESERVED FOR FUTURE USE.

CLASS VB

SURGICAL SPECIALISTS TO INCLUDE: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN ORTHOPEDIC SURGERY (INCLUDING SPINAL).

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS VIB

SURGICAL SPECIALISTS TO INCLUDE: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, JACKSON, MADISON, ST. CLAIR, AND WILL COUNTIES.

TERRITORY 2: VERMILLION COUNTY.

TERRITORY 3: KANE, LAKE, MCHENRY, AND WINNEBAGO COUNTIES.

TERRITORY 4: KANKAKEE COUNTY.

TERRITORY 5: BUREAU, CHAMPAIGN, COLES, DEKALB, DUPAGE, EFFINGHAM, LASALLE, MACON, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 6: GRUNDY COUNTY.

TERRITORY 7: ADAMS, KNOX, PEORIA, AND ROCK ISLAND COUNTIES.

TERRITORY 8: REMAINDER OF STATE.

TERRITORY 9: SANGAMON COUNTY.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

	Territory								
Limit	1 Cap	2 Cap	3 Cap	4 Cap	5 Cap	6 Cap	7 Cap	8 Cap	9 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300	$22,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700	$28,300
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000	$31,900
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600	$34,800
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900	$37,200

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/CONTRACTED PHYSICIANS.

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

A. **Classification**

1. As defined by state statutes and formed for the purpose of rendering medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists – All Other Dental Specialties	5%	Available
Dentists – Oral Surgeons	1%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

	Territory								
Limit	1 Cap	2 Cap	3 Cap	4 Cap	5 Cap	6 Cap	7 Cap	8 Cap	9 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300	$22,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700	$28,300
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000	$31,900
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600	$34,800
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900	$37,200

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

c. The premium otherwise determined for the partnership or corporation may be discounted 50% should the insured elect to exclude the vicarious liability associated with the partners', shareholders' and employed/contracted physicians' professional services.

2. **Miscellaneous Entities**

NOT AVAILABLE

3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.900	1.150	1.200
5 or more	1.820	1.900	1.200	1.250

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$50
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 50%
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

2. **Deductible Credits**
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

3. **Self-Insured Retention Credits**

NOT AVAILABLE

4. **Small Group, Large Group & Temporary Staffing Agency Rating – Corporations**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

5. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Premium Threshold
Physicians & Surgeons	$250,000
Dentists	$25,000
Allied Health Care Providers	$250,000

6. **Quarterly Installment Option**
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

PHYSICIANS & SURGEONS

A. Classifications

1. Applicable to the Occurrence and Standard Claims-Made Programs.

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

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN OPHTHALMOLOGY.

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN ENDOCRINOLOGY.

SURGICAL SPECIALISTS TO INCLUDE: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: DIAGNOSTIC RADIOLOGY, GASTROENTEROLOGY, INFECTIOUS DISEASE, NEONATOLOGY AND NEUROLOGY.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS IN PULMONARY DISEASE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

CLASS IID

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DIAGNOSTIC RADIOLOGY, INTERNAL MEDICINE, RADIOLOGY - INCLUDING MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID PERFORMING ANY OF THE FOLLOWING: ACUPUNCTURE OR CARDIOLOGY (LEFT HEART CATHETERIZATION).

CLASS IIIB

SURGICAL SPECIALISTS TO INCLUDE: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS TO INCLUDE: COSMETIC SURGERY, GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY, ORTHOPEDIC SURGERY (EXCLUDING SPINAL) AND PLASTIC SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IVB

SURGICAL SPECIALISTS IN EMERGENCY MEDICINE.

CLASS VA

RESERVED FOR FUTURE USE.

CLASS VB

SURGICAL SPECIALISTS TO INCLUDE: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS TO INCLUDE: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY.

B. Manual Rates

1. Territory Definitions

Area 1	Cook, Jackson, Madison, St. Clair, and Will Counties.
Area 2	Vermillion County.
Area 3	Kane, Lake, McHenry, and Winnebago Counties.
Area 4	Kankakee County
Area 5	Bureau, Champaign, Coles, Dekalb, Dupage, Effingham, Lasalle, Macon, Ogle, and Randolph Counties.
Area 6	Grundy County
Area 7	Adams, Knox, Peoria, and Rock Island Counties.
Area 8	Remainder of State
Area 9	Sangamon County

2. Occurrence Program - Area 1

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,728	10,510	15,533	19,243	20,016
1B	10,304	14,013	20,711	25,657	26,687
1C	12,107	16,466	24,335	30,146	31,357
1D	13,189	17,937	26,510	32,841	34,160
2A	14,426	19,619	28,996	35,921	37,363
2B	17,002	23,123	34,174	42,335	44,035
2C	20,093	27,326	40,387	50,032	52,041
2D	22,669	30,830	45,565	56,446	58,713
3A	24,214	33,173	50,123	63,683	66,589
3B	26,790	36,702	55,455	70,458	73,673
4A	29,366	40,231	60,788	77,233	80,757
4B	31,942	43,761	66,120	84,007	87,841
5A	36,064	49,408	74,652	94,848	99,176
5B	40,186	55,055	83,185	105,689	110,512
6A	42,246	57,877	87,449	111,107	116,177
6B	47,398	64,935	98,114	124,657	130,345
7	54,611	74,817	113,045	143,627	150,180
8	78,310	107,285	162,102	205,955	215,353

2. Occurrence Program - Area 2

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,956	9,460	13,982	17,320	18,016
1B	9,274	12,613	18,641	23,092	24,020
1C	10,897	14,820	21,903	27,134	28,223
1D	11,871	16,145	23,861	29,559	30,746
2A	12,984	17,658	26,098	32,330	33,629
2B	15,302	20,811	30,757	38,102	39,632
2C	18,084	24,594	36,349	45,029	46,838
2D	20,403	27,748	41,010	50,803	52,844
3A	21,794	29,858	45,114	57,318	59,934
3B	24,112	33,033	49,912	63,415	66,308
4A	26,431	36,210	54,712	69,514	72,685
4B	28,749	39,386	59,510	75,610	79,060
5A	32,459	44,469	67,190	85,367	89,262
5B	36,169	49,552	74,870	95,124	99,465
6A	38,023	52,092	78,708	100,000	104,563
6B	42,660	58,444	88,306	112,196	117,315
7	49,152	67,338	101,745	129,270	135,168
8	70,482	96,560	145,898	185,368	193,826

2. Occurrence Program - Area 3

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,569	8,934	13,204	16,357	17,014
1B	8,758	11,911	17,604	21,807	22,683
1C	10,291	13,996	20,685	25,625	26,654
1D	11,210	15,246	22,532	27,913	29,034
2A	12,261	16,675	24,645	30,530	31,756
2B	14,451	19,653	29,047	35,983	37,428
2C	17,078	23,226	34,327	42,524	44,232
2D	19,268	26,204	38,729	47,977	49,904
3A	20,581	28,196	42,603	54,128	56,598
3B	22,771	31,196	47,136	59,888	62,620
4A	24,960	34,195	51,667	65,645	68,640
4B	27,150	37,196	56,201	71,405	74,663
5A	30,653	41,995	63,452	80,617	84,296
5B	34,156	46,794	70,703	89,830	93,929
6A	35,908	49,194	74,330	94,438	98,747
6B	40,287	55,193	83,394	105,955	110,789
7	46,417	63,591	96,083	122,077	127,647
8	66,561	91,189	137,781	175,055	183,043

2. Occurrence Program - Area 4

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,796	7,883	11,650	14,432	15,012
1B	7,728	10,510	15,533	19,243	20,016
1C	9,080	12,349	18,251	22,609	23,517
1D	9,892	13,453	19,883	24,631	25,620
2A	10,819	14,714	21,746	26,939	28,021
2B	12,751	17,341	25,630	31,750	33,025
2C	15,070	20,495	30,291	37,524	39,031
2D	17,002	23,123	34,174	42,335	44,035
3A	18,161	24,881	37,593	47,763	49,943
3B	20,093	27,527	41,593	52,845	55,256
4A	22,025	30,174	45,592	57,926	60,569
4B	23,957	32,821	49,591	63,007	65,882
5A	27,048	37,056	55,989	71,136	74,382
5B	30,139	41,290	62,388	79,266	82,882
6A	31,685	43,408	65,588	83,332	87,134
6B	35,549	48,702	73,586	93,494	97,760
7	40,958	56,112	84,783	107,720	112,635
8	58,733	80,464	121,577	154,468	161,516

2. Occurrence Program - Area 5

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,410	7,358	10,874	13,471	14,012
1B	7,213	9,810	14,498	17,960	18,682
1C	8,475	11,526	17,035	21,103	21,950
1D	9,233	12,557	18,558	22,990	23,913
2A	10,098	13,733	20,297	25,144	26,154
2B	11,901	16,185	23,921	29,633	30,824
2C	14,065	19,128	28,271	35,022	36,428
2D	15,869	21,582	31,897	39,514	41,101
3A	16,951	23,223	35,089	44,581	46,615
3B	18,754	25,693	38,821	49,323	51,574
4A	20,557	28,163	42,553	54,065	56,532
4B	22,360	30,633	46,285	58,807	61,490
5A	25,246	34,587	52,259	66,397	69,427
5B	28,131	38,539	58,231	73,985	77,360
6A	29,573	40,515	61,216	77,777	81,326
6B	33,180	45,457	68,683	87,263	91,245
7	38,229	52,374	79,134	100,542	105,130
8	54,819	75,102	113,475	144,174	150,752

2. Occurrence Program - Area 6

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,637	6,306	9,320	11,546	12,010
1B	6,182	8,408	12,426	15,393	16,011
1C	7,264	9,879	14,601	18,087	18,814
1D	7,913	10,762	15,905	19,703	20,495
2A	8,655	11,771	17,397	21,551	22,416
2B	10,200	13,872	20,502	25,398	26,418
2C	12,055	16,395	24,231	30,017	31,222
2D	13,600	18,496	27,336	33,864	35,224
3A	14,528	19,903	30,073	38,209	39,952
3B	16,073	22,020	33,271	42,272	44,201
4A	17,619	24,138	36,471	46,338	48,452
4B	19,164	26,255	39,669	50,401	52,701
5A	21,637	29,643	44,789	56,905	59,502
5B	24,110	33,031	49,908	63,409	66,303
6A	25,346	34,724	52,466	66,660	69,702
6B	28,437	38,959	58,865	74,789	78,202
7	32,765	44,888	67,824	86,172	90,104
8	46,983	64,367	97,255	123,565	129,203

2. Occurrence Program - Area 7

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,478	4,730	6,991	8,660	9,008
1B	4,637	6,306	9,320	11,546	12,010
1C	5,448	7,409	10,950	13,566	14,110
1D	5,935	8,072	11,929	14,778	15,372
2A	6,492	8,829	13,049	16,165	16,814
2B	7,651	10,405	15,379	19,051	19,816
2C	9,042	12,297	18,174	22,515	23,419
2D	10,201	13,873	20,504	25,400	26,421
3A	10,897	14,929	22,557	28,659	29,967
3B	12,056	16,517	24,956	31,707	33,154
4A	13,215	18,105	27,355	34,755	36,341
4B	14,375	19,694	29,756	37,806	39,531
5A	16,230	22,235	33,596	42,685	44,633
5B	18,084	24,775	37,434	47,561	49,731
6A	19,012	26,046	39,355	50,002	52,283
6B	21,330	29,222	44,153	56,098	58,658
7	24,576	33,669	50,872	64,635	67,584
8	35,241	48,280	72,949	92,684	96,913

2. Occurrence Program - Area 8

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,864	5,255	7,767	9,621	10,008
1B	5,152	7,007	10,356	12,828	13,344
1C	6,054	8,233	12,169	15,074	15,680
1D	6,595	8,969	13,256	16,422	17,081
2A	7,213	9,810	14,498	17,960	18,682
2B	8,501	11,561	17,087	21,167	22,018
2C	10,046	13,663	20,192	25,015	26,019
2D	11,334	15,414	22,781	28,222	29,355
3A	12,107	16,587	25,061	31,841	33,294
3B	13,395	18,351	27,728	35,229	36,836
4A	14,683	20,116	30,394	38,616	40,378
4B	15,971	21,880	33,060	42,004	43,920
5A	18,032	24,704	37,326	47,424	49,588
5B	20,093	27,527	41,593	52,845	55,256
6A	21,123	28,939	43,725	55,553	58,088
6B	23,699	32,468	49,057	62,328	65,172
7	27,306	37,409	56,523	71,815	75,092
8	39,155	53,642	81,051	102,978	107,676

2. Occurrence Program - Area 9

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,250	5,780	8,543	10,583	11,008
1B	5,667	7,707	11,391	14,111	14,678
1C	6,659	9,056	13,385	16,581	17,247
1D	7,254	9,865	14,581	18,062	18,788
2A	7,934	10,790	15,947	19,756	20,549
2B	9,351	12,717	18,796	23,284	24,219
2C	11,051	15,029	22,213	27,517	28,622
2D	12,467	16,955	25,059	31,043	32,290
3A	13,317	18,244	27,566	35,024	36,622
3B	14,734	20,186	30,499	38,750	40,519
4A	16,151	22,127	33,433	42,477	44,415
4B	17,568	24,068	36,366	46,204	48,312
5A	19,835	27,174	41,058	52,166	54,546
5B	22,101	30,278	45,749	58,126	60,778
6A	23,235	31,832	48,096	61,108	63,896
6B	26,068	35,713	53,961	68,559	71,687
7	30,035	41,148	62,172	78,992	82,596
8	43,069	59,005	89,153	113,271	118,440

3. Standard Claims-Made Programs - Area 1

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,072	2,818	4,165	5,159	5,366
1B	2,763	3,758	5,554	6,880	7,156
1C	3,246	4,415	6,524	8,083	8,407
1D	3,536	4,809	7,107	8,805	9,158
2A	3,868	5,260	7,775	9,631	10,018
2B	4,558	6,199	9,162	11,349	11,805
2C	5,387	7,326	10,828	13,414	13,952
2D	6,078	8,266	12,217	15,134	15,742
3A	6,492	8,894	13,438	17,074	17,853
3B	7,183	9,841	14,869	18,891	19,753
4A	7,874	10,787	16,299	20,709	21,654
4B	8,564	11,733	17,727	22,523	23,551
5A	9,669	13,247	20,015	25,429	26,590
5B	10,774	14,760	22,302	28,336	29,629
6A	11,327	15,518	23,447	29,790	31,149
6B	12,708	17,410	26,306	33,422	34,947
7	14,642	20,060	30,309	38,508	40,266
8	20,996	28,765	43,462	55,219	57,739

3. Standard Claims-Made Programs - Area 1

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,793	20,266	30,622	38,906	40,681
5A	16,701	22,880	34,571	43,924	45,928
5B	18,610	25,496	38,523	48,944	51,178
6A	19,565	26,804	40,500	51,456	53,804
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

3. Standard Claims-Made Programs - Area 1

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,853	12,040	17,795	22,044	22,929
1D	9,644	13,116	19,384	24,014	24,978
2A	10,548	14,345	21,201	26,265	27,319
2B	12,432	16,908	24,988	30,956	32,199
2C	14,693	19,982	29,533	36,586	38,055
2D	16,576	22,543	33,318	41,274	42,932
3A	17,706	24,257	36,651	46,567	48,692
3B	19,590	26,838	40,551	51,522	53,873
4A	21,473	29,418	44,449	56,474	59,051
4B	23,357	31,999	48,349	61,429	64,232
5A	26,371	36,128	54,588	69,356	72,520
5B	29,384	40,256	60,825	77,280	80,806
6A	30,892	42,322	63,946	81,246	84,953
6B	34,659	47,483	71,744	91,153	95,312
7	39,933	54,708	82,661	105,024	109,816
8	57,263	78,450	118,534	150,602	157,473

3. Standard Claims-Made Programs - Area 1

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,782	9,224	13,632	16,887	17,565
1B	9,041	12,296	18,172	22,512	23,416
1C	10,624	14,449	21,354	26,454	27,516
1D	11,573	15,739	23,262	28,817	29,974
2A	12,658	17,215	25,443	31,518	32,784
2B	14,918	20,288	29,985	37,146	38,638
2C	17,631	23,978	35,438	43,901	45,664
2D	19,891	27,052	39,981	49,529	51,518
3A	21,247	29,108	43,981	55,880	58,429
3B	23,508	32,206	48,662	61,826	64,647
4A	25,768	35,302	53,340	67,770	70,862
4B	28,029	38,400	58,020	73,716	77,080
5A	31,645	43,354	65,505	83,226	87,024
5B	35,261	48,308	72,990	92,736	96,968
6A	37,070	50,786	76,735	97,494	101,943
6B	41,591	56,980	86,093	109,384	114,375
7	47,920	65,650	99,194	126,030	131,780
8	68,715	94,140	142,240	180,720	188,966

3. Standard Claims-Made Programs - Area 1

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,158	9,735	14,388	17,823	18,539
1B	9,544	12,980	19,183	23,765	24,719
1C	11,214	15,251	22,540	27,923	29,044
1D	12,216	16,614	24,554	30,418	31,639
2A	13,361	18,171	26,856	33,269	34,605
2B	15,747	21,416	31,651	39,210	40,785
2C	18,611	25,311	37,408	46,341	48,202
2D	20,996	28,555	42,202	52,280	54,380
3A	22,428	30,726	46,426	58,986	61,677
3B	24,814	33,995	51,365	65,261	68,239
4A	27,199	37,263	56,302	71,533	74,797
4B	29,586	40,533	61,243	77,811	81,362
5A	33,403	45,762	69,144	87,850	91,858
5B	37,220	50,991	77,045	97,889	102,355
6A	39,130	53,608	80,999	102,912	107,608
6B	43,901	60,144	90,875	115,460	120,728
7	50,582	69,297	104,705	133,031	139,101
8	72,533	99,370	150,143	190,762	199,466

3. Standard Claims-Made Programs - Area 1

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,535	10,248	15,145	18,762	19,516
1B	10,046	13,663	20,192	25,015	26,019
1C	11,804	16,053	23,726	29,392	30,572
1D	12,859	17,488	25,847	32,019	33,305
2A	14,064	19,127	28,269	35,019	36,426
2B	16,576	22,543	33,318	41,274	42,932
2C	19,590	26,642	39,376	48,779	50,738
2D	22,101	30,057	44,423	55,031	57,242
3A	23,608	32,343	48,869	62,089	64,922
3B	26,120	35,784	54,068	68,696	71,830
4A	28,631	39,224	59,266	75,300	78,735
4B	31,143	42,666	64,466	81,906	85,643
5A	35,161	48,171	72,783	92,473	96,693
5B	39,179	53,675	81,101	103,041	107,742
6A	41,189	56,429	85,261	108,327	113,270
6B	46,212	63,310	95,659	121,538	127,083
7	53,244	72,944	110,215	140,032	146,421
8	76,350	104,600	158,045	200,801	209,963

3. Standard Claims-Made Programs - Area 2

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,865	2,536	3,749	4,644	4,830
1B	2,486	3,381	4,997	6,190	6,439
1C	2,921	3,973	5,871	7,273	7,565
1D	3,182	4,328	6,396	7,923	8,241
2A	3,481	4,734	6,997	8,668	9,016
2B	4,102	5,579	8,245	10,214	10,624
2C	4,848	6,593	9,744	12,072	12,556
2D	5,470	7,439	10,995	13,620	14,167
3A	5,843	8,005	12,095	15,367	16,068
3B	6,464	8,856	13,380	17,000	17,776
4A	7,086	9,708	14,668	18,636	19,487
4B	7,707	10,559	15,953	20,269	21,194
5A	8,702	11,922	18,013	22,886	23,931
5B	9,697	13,285	20,073	25,503	26,667
6A	10,194	13,966	21,102	26,810	28,034
6B	11,437	15,669	23,675	30,079	31,452
7	13,177	18,052	27,276	34,656	36,237
8	18,896	25,888	39,115	49,696	51,964

3. Standard Claims-Made Programs - Area 2

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,294	5,840	8,631	10,692	11,121
1C	5,046	6,863	10,142	12,565	13,069
1D	5,497	7,476	11,049	13,688	14,237
2A	6,012	8,176	12,084	14,970	15,571
2B	7,086	9,637	14,243	17,644	18,353
2C	8,374	11,389	16,832	20,851	21,689
2D	9,448	12,849	18,990	23,526	24,470
3A	10,092	13,826	20,890	26,542	27,753
3B	11,166	15,297	23,114	29,367	30,707
4A	12,239	16,767	25,335	32,189	33,657
4B	13,313	18,239	27,558	35,013	36,611
5A	15,031	20,592	31,114	39,532	41,335
5B	16,749	22,946	34,670	44,050	46,060
6A	17,607	24,122	36,446	46,306	48,419
6B	19,755	27,064	40,893	51,956	54,326
7	22,761	31,183	47,115	59,861	62,593
8	32,638	44,714	67,561	85,838	89,755

3. Standard Claims-Made Programs - Area 2

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,781	9,222	13,630	16,885	17,563
1C	7,967	10,835	16,014	19,838	20,635
1D	8,679	11,803	17,445	21,611	22,479
2A	9,493	12,910	19,081	23,638	24,587
2B	11,189	15,217	22,490	27,861	28,980
2C	13,223	17,983	26,578	32,925	34,248
2D	14,918	20,288	29,985	37,146	38,638
3A	15,935	21,831	32,985	41,909	43,821
3B	17,630	24,153	36,494	46,367	48,483
4A	19,325	26,475	40,003	50,825	53,144
4B	21,020	28,797	43,511	55,283	57,805
5A	23,733	32,514	49,127	62,418	65,266
5B	26,445	36,230	54,741	69,550	72,724
6A	27,801	38,087	57,548	73,117	76,453
6B	31,192	42,733	64,567	82,035	85,778
7	35,938	49,235	74,392	94,517	98,830
8	51,534	70,602	106,675	135,534	141,719

3. Standard Claims-Made Programs - Area 2

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,103	8,300	12,267	15,196	15,807
1B	8,137	11,066	16,355	20,261	21,075
1C	9,561	13,003	19,218	23,807	24,763
1D	10,415	14,164	20,934	25,933	26,975
2A	11,391	15,492	22,896	28,364	29,503
2B	13,426	18,259	26,986	33,431	34,773
2C	15,867	21,579	31,893	39,509	41,096
2D	17,901	24,345	35,981	44,573	46,364
3A	19,121	26,196	39,580	50,288	52,583
3B	21,156	28,984	43,793	55,640	58,179
4A	23,190	31,770	48,003	60,990	63,773
4B	25,224	34,557	52,214	66,339	69,366
5A	28,480	39,018	58,954	74,902	78,320
5B	31,734	43,476	65,689	83,460	87,269
6A	33,361	45,705	69,057	87,739	91,743
6B	37,430	51,279	77,480	98,441	102,933
7	43,125	59,081	89,269	113,419	118,594
8	61,841	84,722	128,011	162,642	170,063

3. Standard Claims-Made Programs - Area 2

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,442	8,761	12,948	16,041	16,685
1B	8,589	11,681	17,264	21,387	22,246
1C	10,092	13,725	20,285	25,129	26,138
1D	10,993	14,950	22,096	27,373	28,472
2A	12,024	16,353	24,168	29,940	31,142
2B	14,172	19,274	28,486	35,288	36,705
2C	16,749	22,779	33,665	41,705	43,380
2D	18,896	25,699	37,981	47,051	48,941
3A	20,184	27,652	41,781	53,084	55,506
3B	22,332	30,595	46,227	58,733	61,413
4A	24,479	33,536	50,672	64,380	67,317
4B	26,626	36,478	55,116	70,026	73,222
5A	30,062	41,185	62,228	79,063	82,671
5B	33,497	45,891	69,339	88,097	92,117
6A	35,215	48,245	72,895	92,615	96,841
6B	39,510	54,129	81,786	103,911	108,653
7	45,521	62,364	94,228	119,720	125,183
8	65,276	89,428	135,121	171,676	179,509

3. Standard Claims-Made Programs - Area 2

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,781	9,222	13,630	16,885	17,563
1B	9,041	12,296	18,172	22,512	23,416
1C	10,623	14,447	21,352	26,451	27,514
1D	11,572	15,738	23,260	28,814	29,971
2A	12,657	17,214	25,441	31,516	32,782
2B	14,918	20,288	29,985	37,146	38,638
2C	17,630	23,977	35,436	43,899	45,662
2D	19,890	27,050	39,979	49,526	51,515
3A	21,246	29,107	43,979	55,877	58,427
3B	23,507	32,205	48,659	61,823	64,644
4A	25,767	35,301	53,338	67,767	70,859
4B	28,027	38,397	58,016	73,711	77,074
5A	31,644	43,352	65,503	83,224	87,021
5B	35,260	48,306	72,988	92,734	96,965
6A	37,068	50,783	76,731	97,489	101,937
6B	41,589	56,977	86,089	109,379	114,370
7	47,917	65,646	99,188	126,022	131,772
8	68,712	94,135	142,234	180,713	188,958

3. Standard Claims-Made Programs - Area 3

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,761	2,395	3,540	4,385	4,561
1B	2,348	3,193	4,719	5,847	6,081
1C	2,759	3,752	5,546	6,870	7,146
1D	3,006	4,088	6,042	7,485	7,786
2A	3,288	4,472	6,609	8,187	8,516
2B	3,874	5,269	7,787	9,646	10,034
2C	4,579	6,227	9,204	11,402	11,860
2D	5,166	7,026	10,384	12,863	13,380
3A	5,518	7,560	11,422	14,512	15,175
3B	6,105	8,364	12,637	16,056	16,789
4A	6,692	9,168	13,852	17,600	18,403
4B	7,280	9,974	15,070	19,146	20,020
5A	8,219	11,260	17,013	21,616	22,602
5B	9,158	12,546	18,957	24,086	25,185
6A	9,628	13,190	19,930	25,322	26,477
6B	10,802	14,799	22,360	28,409	29,706
7	12,446	17,051	25,763	32,733	34,227
8	17,846	24,449	36,941	46,935	49,077

3. Standard Claims-Made Programs - Area 3

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,042	4,137	6,114	7,575	7,879
1B	4,056	5,516	8,153	10,099	10,505
1C	4,766	6,482	9,580	11,867	12,344
1D	5,192	7,061	10,436	12,928	13,447
2A	5,679	7,723	11,415	14,141	14,709
2B	6,692	9,101	13,451	16,663	17,332
2C	7,909	10,756	15,897	19,693	20,484
2D	8,923	12,135	17,935	22,218	23,111
3A	9,532	13,059	19,731	25,069	26,213
3B	10,545	14,447	21,828	27,733	28,999
4A	11,560	15,837	23,929	30,403	31,790
4B	12,574	17,226	26,028	33,070	34,579
5A	14,196	19,449	29,386	37,335	39,039
5B	15,818	21,671	32,743	41,601	43,500
6A	16,630	22,783	34,424	43,737	45,733
6B	18,658	25,561	38,622	49,071	51,310
7	21,497	29,451	44,499	56,537	59,117
8	30,826	42,232	63,810	81,072	84,772

3. Standard Claims-Made Programs - Area 3

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,803	6,532	9,654	11,959	12,440
1B	6,404	8,709	12,872	15,946	16,586
1C	7,525	10,234	15,125	18,737	19,490
1D	8,198	11,149	16,478	20,413	21,233
2A	8,966	12,194	18,022	22,325	23,222
2B	10,567	14,371	21,240	26,312	27,369
2C	12,488	16,984	25,101	31,095	32,344
2D	14,090	19,162	28,321	35,084	36,493
3A	15,050	20,619	31,154	39,582	41,388
3B	16,651	22,812	34,468	43,792	45,790
4A	18,252	25,005	37,782	48,003	50,193
4B	19,853	27,199	41,096	52,213	54,596
5A	22,415	30,709	46,399	58,951	61,641
5B	24,977	34,218	51,702	65,690	68,687
6A	26,258	35,973	54,354	69,059	72,210
6B	29,459	40,359	60,980	77,477	81,012
7	33,943	46,502	70,262	89,270	93,343
8	48,672	66,681	100,751	128,007	133,848

3. Standard Claims-Made Programs - Area 3

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,764	7,839	11,586	14,352	14,929
1B	7,685	10,452	15,447	19,136	19,904
1C	9,030	12,281	18,150	22,485	23,388
1D	9,837	13,378	19,772	24,494	25,478
2A	10,760	14,634	21,628	26,792	27,868
2B	12,680	17,245	25,487	31,573	32,841
2C	14,986	20,381	30,122	37,315	38,814
2D	16,907	22,994	33,983	42,098	43,789
3A	18,060	24,742	37,384	47,498	49,665
3B	19,981	27,374	41,361	52,550	54,948
4A	21,902	30,006	45,337	57,602	60,231
4B	23,824	32,639	49,316	62,657	65,516
5A	26,898	36,850	55,679	70,742	73,970
5B	29,972	41,062	62,042	78,826	82,423
6A	31,509	43,167	65,224	82,869	86,650
6B	35,351	48,431	73,177	92,973	97,215
7	40,731	55,801	84,313	107,123	112,010
8	58,406	80,016	120,900	153,608	160,617

3. Standard Claims-Made Programs - Area 3

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,084	8,274	12,229	15,149	15,758
1B	8,112	11,032	16,305	20,199	21,010
1C	9,531	12,962	19,157	23,732	24,685
1D	10,384	14,122	20,872	25,856	26,895
2A	11,357	15,446	22,828	28,279	29,415
2B	13,385	18,204	26,904	33,329	34,667
2C	15,818	21,512	31,794	39,387	40,969
2D	17,847	24,272	35,872	44,439	46,224
3A	19,064	26,118	39,462	50,138	52,426
3B	21,091	28,895	43,658	55,469	58,000
4A	23,119	31,673	47,856	60,803	63,577
4B	25,147	34,451	52,054	66,137	69,154
5A	28,393	38,898	58,774	74,674	78,081
5B	31,637	43,343	65,489	83,205	87,002
6A	33,260	45,566	68,848	87,474	91,465
6B	37,315	51,122	77,242	98,138	102,616
7	42,994	58,902	88,998	113,074	118,234
8	61,651	84,462	127,618	162,142	169,540

3. Standard Claims-Made Programs - Area 3

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,404	8,709	12,872	15,946	16,586
1B	8,539	11,613	17,163	21,262	22,116
1C	10,033	13,645	20,166	24,982	25,985
1D	10,930	14,865	21,969	27,216	28,309
2A	11,955	16,259	24,030	29,768	30,963
2B	14,089	19,161	28,319	35,082	36,491
2C	16,651	22,645	33,469	41,461	43,126
2D	18,786	25,549	37,760	46,777	48,656
3A	20,067	27,492	41,539	52,776	55,184
3B	22,201	30,415	45,956	58,389	61,053
4A	24,336	33,340	50,376	64,004	66,924
4B	26,471	36,265	54,795	69,619	72,795
5A	29,887	40,945	61,866	78,603	82,189
5B	33,302	45,624	68,935	87,584	91,581
6A	35,010	47,964	72,471	92,076	96,278
6B	39,279	53,812	81,308	103,304	108,017
7	45,257	62,002	93,682	119,026	124,457
8	64,896	88,908	134,335	170,676	178,464

3. Standard Claims-Made Programs - Area 4

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,554	2,113	3,124	3,869	4,025
1B	2,072	2,818	4,165	5,159	5,366
1C	2,435	3,312	4,894	6,063	6,307
1D	2,652	3,607	5,331	6,603	6,869
2A	2,901	3,945	5,831	7,223	7,514
2B	3,419	4,650	6,872	8,513	8,855
2C	4,041	5,496	8,122	10,062	10,466
2D	4,559	6,200	9,164	11,352	11,808
3A	4,869	6,671	10,079	12,805	13,390
3B	5,388	7,382	11,153	14,170	14,817
4A	5,906	8,091	12,225	15,533	16,242
4B	6,424	8,801	13,298	16,895	17,666
5A	7,253	9,937	15,014	19,075	19,946
5B	8,081	11,071	16,728	21,253	22,223
6A	8,496	11,640	17,587	22,344	23,364
6B	9,532	13,059	19,731	25,069	26,213
7	10,982	15,045	22,733	28,883	30,201
8	15,748	21,575	32,598	41,417	43,307

3. Standard Claims-Made Programs - Area 4

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,684	3,650	5,395	6,683	6,952
1B	3,579	4,867	7,194	8,912	9,270
1C	4,206	5,720	8,454	10,473	10,894
1D	4,581	6,230	9,208	11,407	11,865
2A	5,011	6,815	10,072	12,477	12,978
2B	5,906	8,032	11,871	14,706	15,297
2C	6,979	9,491	14,028	17,378	18,076
2D	7,874	10,709	15,827	19,606	20,394
3A	8,411	11,523	17,411	22,121	23,130
3B	9,306	12,749	19,263	24,475	25,592
4A	10,201	13,975	21,116	26,829	28,053
4B	11,096	15,202	22,969	29,182	30,514
5A	12,527	17,162	25,931	32,946	34,449
5B	13,959	19,124	28,895	36,712	38,387
6A	14,675	20,105	30,377	38,595	40,356
6B	16,464	22,556	34,080	43,300	45,276
7	18,970	25,989	39,268	49,891	52,168
8	27,201	37,265	56,306	71,539	74,803

3. Standard Claims-Made Programs - Area 4

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,238	5,764	8,518	10,553	10,976
1B	5,651	7,685	11,359	14,071	14,636
1C	6,641	9,032	13,348	16,536	17,200
1D	7,234	9,838	14,540	18,013	18,736
2A	7,912	10,760	15,903	19,701	20,492
2B	9,325	12,682	18,743	23,219	24,152
2C	11,020	14,987	22,150	27,440	28,542
2D	12,433	16,909	24,990	30,958	32,201
3A	13,280	18,194	27,490	34,926	36,520
3B	14,693	20,129	30,415	38,643	40,406
4A	16,106	22,065	33,339	42,359	44,292
4B	17,519	24,001	36,264	46,075	48,177
5A	19,780	27,099	40,945	52,021	54,395
5B	22,040	30,195	45,623	57,965	60,610
6A	23,171	31,744	47,964	60,940	63,720
6B	25,996	35,615	53,812	68,369	71,489
7	29,952	41,034	62,001	78,774	82,368
8	42,950	58,842	88,907	112,959	118,113

3. Standard Claims-Made Programs - Area 4

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,782	9,224	13,632	16,887	17,565
1C	7,969	10,838	16,018	19,843	20,640
1D	8,681	11,806	17,449	21,616	22,484
2A	9,494	12,912	19,083	23,640	24,589
2B	11,190	15,218	22,492	27,863	28,982
2C	13,224	17,985	26,580	32,928	34,250
2D	14,919	20,290	29,987	37,148	38,640
3A	15,936	21,832	32,988	41,912	43,824
3B	17,632	24,156	36,498	46,372	48,488
4A	19,328	26,479	40,009	50,833	53,152
4B	21,023	28,802	43,518	55,290	57,813
5A	23,736	32,518	49,134	62,426	65,274
5B	26,448	36,234	54,747	69,558	72,732
6A	27,805	38,093	57,556	73,127	76,464
6B	31,195	42,737	64,574	82,043	85,786
7	35,942	49,241	74,400	94,527	98,841
8	51,539	70,608	106,686	135,548	141,732

3. Standard Claims-Made Programs - Area 4

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,368	7,300	10,790	13,366	13,903
1B	7,158	9,735	14,388	17,823	18,539
1C	8,411	11,439	16,906	20,943	21,784
1D	9,163	12,462	18,418	22,816	23,732
2A	10,022	13,630	20,144	24,955	25,957
2B	11,811	16,063	23,740	29,409	30,590
2C	13,958	18,983	28,056	34,755	36,151
2D	15,748	21,417	31,653	39,213	40,787
3A	16,822	23,046	34,822	44,242	46,261
3B	18,611	25,497	38,525	48,947	51,180
4A	20,401	27,949	42,230	53,655	56,103
4B	22,191	30,402	45,935	58,362	61,025
5A	25,054	34,324	51,862	65,892	68,899
5B	27,918	38,248	57,790	73,424	76,775
6A	29,349	40,208	60,752	77,188	80,710
6B	32,928	45,111	68,161	86,601	90,552
7	37,939	51,976	78,534	99,780	104,332
8	54,403	74,532	112,614	143,080	149,608

3. Standard Claims-Made Programs - Area 4

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,854	12,041	17,797	22,046	22,932
1D	9,645	13,117	19,386	24,016	24,981
2A	10,549	14,347	21,203	26,267	27,322
2B	12,433	16,909	24,990	30,958	32,201
2C	14,693	19,982	29,533	36,586	38,055
2D	16,577	22,545	33,320	41,277	42,934
3A	17,707	24,259	36,653	46,569	48,694
3B	19,591	26,840	40,553	51,524	53,875
4A	21,475	29,421	44,453	56,479	59,056
4B	23,359	32,002	48,353	61,434	64,237
5A	26,373	36,131	54,592	69,361	72,526
5B	29,387	40,260	60,831	77,288	80,814
6A	30,894	42,325	63,951	81,251	84,959
6B	34,661	47,486	71,748	91,158	95,318
7	39,936	54,712	82,668	105,032	109,824
8	57,266	78,454	118,541	150,610	157,482

3. Standard Claims-Made Programs - Area 5

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,450	1,972	2,915	3,611	3,756
1B	1,934	2,630	3,887	4,816	5,009
1C	2,272	3,090	4,567	5,657	5,884
1D	2,475	3,366	4,975	6,163	6,410
2A	2,707	3,682	5,441	6,740	7,011
2B	3,191	4,340	6,414	7,946	8,265
2C	3,771	5,129	7,580	9,390	9,767
2D	4,254	5,785	8,551	10,592	11,018
3A	4,544	6,225	9,406	11,951	12,496
3B	5,028	6,888	10,408	13,224	13,827
4A	5,511	7,550	11,408	14,494	15,155
4B	5,995	8,213	12,410	15,767	16,486
5A	6,768	9,272	14,010	17,800	18,612
5B	7,542	10,333	15,612	19,835	20,741
6A	7,929	10,863	16,413	20,853	21,805
6B	8,895	12,186	18,413	23,394	24,461
7	10,249	14,041	21,215	26,955	28,185
8	14,697	20,135	30,423	38,653	40,417

3. Standard Claims-Made Programs - Area 5

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,505	3,407	5,035	6,237	6,488
1B	3,340	4,542	6,713	8,317	8,651
1C	3,925	5,338	7,889	9,773	10,166
1D	4,275	5,814	8,593	10,645	11,072
2A	4,676	6,359	9,399	11,643	12,111
2B	5,511	7,495	11,077	13,722	14,273
2C	6,513	8,858	13,091	16,217	16,869
2D	7,348	9,993	14,769	18,297	19,031
3A	7,849	10,753	16,247	20,643	21,585
3B	8,684	11,897	17,976	22,839	23,881
4A	9,519	13,041	19,704	25,035	26,177
4B	10,355	14,186	21,435	27,234	28,476
5A	11,691	16,017	24,200	30,747	32,150
5B	13,027	17,847	26,966	34,261	35,824
6A	13,695	18,762	28,349	36,018	37,661
6B	15,365	21,050	31,806	40,410	42,254
7	17,703	24,253	36,645	46,559	48,683
8	25,385	34,777	52,547	66,763	69,809

3. Standard Claims-Made Programs - Area 5

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,956	5,380	7,952	9,850	10,246
1B	5,274	7,173	10,601	13,132	13,660
1C	6,197	8,428	12,456	15,431	16,050
1D	6,751	9,181	13,570	16,810	17,485
2A	7,384	10,042	14,842	18,386	19,125
2B	8,702	11,835	17,491	21,668	22,538
2C	10,284	13,986	20,671	25,607	26,636
2D	11,603	15,780	23,322	28,891	30,052
3A	12,394	16,980	25,656	32,596	34,084
3B	13,712	18,785	28,384	36,063	37,708
4A	15,031	20,592	31,114	39,532	41,335
4B	16,349	22,398	33,842	42,998	44,960
5A	18,459	25,289	38,210	48,547	50,762
5B	20,569	28,180	42,578	54,096	56,565
6A	21,623	29,624	44,760	56,868	59,463
6B	24,260	33,236	50,218	63,804	66,715
7	27,953	38,296	57,863	73,516	76,871
8	40,082	54,912	82,970	105,416	110,226

3. Standard Claims-Made Programs - Area 5

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,747	6,456	9,541	11,820	12,295
1B	6,329	8,607	12,721	15,759	16,392
1C	7,437	10,114	14,948	18,518	19,262
1D	8,101	11,017	16,283	20,171	20,982
2A	8,861	12,051	17,811	22,064	22,950
2B	10,443	14,202	20,990	26,003	27,047
2C	12,341	16,784	24,805	30,729	31,963
2D	13,923	18,935	27,985	34,668	36,061
3A	14,873	20,376	30,787	39,116	40,901
3B	16,455	22,543	34,062	43,277	45,251
4A	18,037	24,711	37,337	47,437	49,602
4B	19,619	26,878	40,611	51,598	53,952
5A	22,151	30,347	45,853	58,257	60,915
5B	24,683	33,816	51,094	64,916	67,878
6A	25,948	35,549	53,712	68,243	71,357
6B	29,112	39,883	60,262	76,565	80,058
7	33,543	45,954	69,434	88,218	92,243
8	48,099	65,896	99,565	126,500	132,272

3. Standard Claims-Made Programs - Area 5

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,274	7,173	10,601	13,132	13,660
1B	7,032	9,564	14,134	17,510	18,213
1C	8,263	11,238	16,609	20,575	21,401
1D	9,001	12,241	18,092	22,412	23,313
2A	9,845	13,389	19,788	24,514	25,499
2B	11,603	15,780	23,322	28,891	30,052
2C	13,712	18,648	27,561	34,143	35,514
2D	15,470	21,039	31,095	38,520	40,067
3A	16,525	22,639	34,207	43,461	45,444
3B	18,283	25,048	37,846	48,084	50,278
4A	20,041	27,456	41,485	52,708	55,113
4B	21,799	29,865	45,124	57,331	59,947
5A	24,612	33,718	50,947	64,730	67,683
5B	27,425	37,572	56,770	72,128	75,419
6A	28,831	39,498	59,680	75,826	79,285
6B	32,347	44,315	66,958	85,073	88,954
7	37,270	51,060	77,149	98,020	102,493
8	53,443	73,217	110,627	140,555	146,968

3. Standard Claims-Made Programs - Area 5

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,274	7,173	10,601	13,132	13,660
1B	7,032	9,564	14,134	17,510	18,213
1C	8,263	11,238	16,609	20,575	21,401
1D	9,001	12,241	18,092	22,412	23,313
2A	9,845	13,389	19,788	24,514	25,499
2B	11,603	15,780	23,322	28,891	30,052
2C	13,712	18,648	27,561	34,143	35,514
2D	15,470	21,039	31,095	38,520	40,067
3A	16,525	22,639	34,207	43,461	45,444
3B	18,283	25,048	37,846	48,084	50,278
4A	20,041	27,456	41,485	52,708	55,113
4B	21,799	29,865	45,124	57,331	59,947
5A	24,612	33,718	50,947	64,730	67,683
5B	27,425	37,572	56,770	72,128	75,419
6A	28,831	39,498	59,680	75,826	79,285
6B	32,347	44,315	66,958	85,073	88,954
7	37,270	51,060	77,149	98,020	102,493
8	53,443	73,217	110,627	140,555	146,968

3. Standard Claims-Made Programs - Area 6

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,243	1,690	2,498	3,095	3,219
1B	1,658	2,255	3,333	4,128	4,294
1C	1,948	2,649	3,915	4,851	5,045
1D	2,122	2,886	4,265	5,284	5,496
2A	2,321	3,157	4,665	5,779	6,011
2B	2,735	3,720	5,497	6,810	7,084
2C	3,233	4,397	6,498	8,050	8,373
2D	3,647	4,960	7,330	9,081	9,446
3A	3,896	5,338	8,065	10,246	10,714
3B	4,310	5,905	8,922	11,335	11,853
4A	4,725	6,473	9,781	12,427	12,994
4B	5,139	7,040	10,638	13,516	14,132
5A	5,802	7,949	12,010	15,259	15,956
5B	6,465	8,857	13,383	17,003	17,779
6A	6,797	9,312	14,070	17,876	18,692
6B	7,625	10,446	15,784	20,054	20,969
7	8,786	12,037	18,187	23,107	24,162
8	12,599	17,261	26,080	33,135	34,647

3. Standard Claims-Made Programs - Area 6

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,147	2,920	4,315	5,346	5,561
1B	2,863	3,894	5,755	7,129	7,415
1C	3,364	4,575	6,762	8,376	8,713
1D	3,665	4,984	7,367	9,126	9,492
2A	4,009	5,452	8,058	9,982	10,383
2B	4,724	6,425	9,495	11,763	12,235
2C	5,584	7,594	11,224	13,904	14,463
2D	6,299	8,567	12,661	15,685	16,314
3A	6,729	9,219	13,929	17,697	18,505
3B	7,445	10,200	15,411	19,580	20,474
4A	8,161	11,181	16,893	21,463	22,443
4B	8,876	12,160	18,373	23,344	24,409
5A	10,022	13,730	20,746	26,358	27,561
5B	11,167	15,299	23,116	29,369	30,709
6A	11,740	16,084	24,302	30,876	32,285
6B	13,171	18,044	27,264	34,640	36,220
7	15,175	20,790	31,412	39,910	41,731
8	21,761	29,813	45,045	57,231	59,843

3. Standard Claims-Made Programs - Area 6

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,947	13,528	19,993	24,768	25,763
3A	10,625	14,556	21,994	27,944	29,219
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

3. Standard Claims-Made Programs - Area 6

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,069	5,534	8,179	10,132	10,539
1B	5,425	7,378	10,904	13,508	14,051
1C	6,375	8,670	12,814	15,874	16,511
1D	6,944	9,444	13,957	17,291	17,985
2A	7,595	10,329	15,266	18,912	19,671
2B	8,951	12,173	17,992	22,288	23,183
2C	10,580	14,389	21,266	26,344	27,402
2D	11,936	16,233	23,991	29,721	30,914
3A	12,749	17,466	26,390	33,530	35,060
3B	14,106	19,325	29,199	37,099	38,792
4A	15,462	21,183	32,006	40,665	42,521
4B	16,818	23,041	34,813	44,231	46,250
5A	18,988	26,014	39,305	49,938	52,217
5B	21,158	28,986	43,797	55,646	58,185
6A	22,244	30,474	46,045	58,502	61,171
6B	24,956	34,190	51,659	65,634	68,629
7	28,753	39,392	59,519	75,620	79,071
8	41,232	56,488	85,350	108,440	113,388

3. Standard Claims-Made Programs - Area 6

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,295	5,841	8,633	10,695	11,124
1B	5,727	7,789	11,511	14,260	14,833
1C	6,729	9,151	13,525	16,755	17,428
1D	7,330	9,969	14,733	18,252	18,985
2A	8,017	10,903	16,114	19,962	20,764
2B	9,449	12,851	18,992	23,528	24,473
2C	11,167	15,187	22,446	27,806	28,923
2D	12,599	17,135	25,324	31,372	32,631
3A	13,458	18,437	27,858	35,395	37,010
3B	14,889	20,398	30,820	39,158	40,945
4A	16,321	22,360	33,784	42,924	44,883
4B	17,753	24,322	36,749	46,690	48,821
5A	20,043	27,459	41,489	52,713	55,118
5B	22,334	30,598	46,231	58,738	61,419
6A	23,479	32,166	48,602	61,750	64,567
6B	26,343	36,090	54,530	69,282	72,443
7	30,351	41,581	62,827	79,823	83,465
8	43,522	59,625	90,091	114,463	119,686

3. Standard Claims-Made Programs - Area 6

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,521	6,149	9,087	11,257	11,709
1B	6,028	8,198	12,116	15,010	15,613
1C	7,083	9,633	14,237	17,637	18,345
1D	7,716	10,494	15,509	19,213	19,984
2A	8,439	11,477	16,962	21,013	21,857
2B	9,946	13,527	19,991	24,766	25,760
2C	11,755	15,987	23,628	29,270	30,445
2D	13,262	18,036	26,657	33,022	34,349
3A	14,166	19,407	29,324	37,257	38,957
3B	15,673	21,472	32,443	41,220	43,101
4A	17,180	23,537	35,563	45,183	47,245
4B	18,687	25,601	38,682	49,147	51,389
5A	21,098	28,904	43,673	55,488	58,020
5B	23,509	32,207	48,664	61,829	64,650
6A	24,715	33,860	51,160	65,000	67,966
6B	27,729	37,989	57,399	72,927	76,255
7	31,948	43,769	66,132	84,023	87,857
8	45,813	62,764	94,833	120,488	125,986

3. Standard Claims-Made Programs - Area 7

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	933	1,269	1,875	2,323	2,416
1B	1,243	1,690	2,498	3,095	3,219
1C	1,461	1,987	2,937	3,638	3,784
1D	1,591	2,164	3,198	3,962	4,121
2A	1,740	2,366	3,497	4,333	4,507
2B	2,052	2,791	4,125	5,109	5,315
2C	2,424	3,297	4,872	6,036	6,278
2D	2,735	3,720	5,497	6,810	7,084
3A	2,922	4,003	6,049	7,685	8,036
3B	3,233	4,429	6,692	8,503	8,891
4A	3,543	4,854	7,334	9,318	9,743
4B	3,854	5,280	7,978	10,136	10,599
5A	4,352	5,962	9,009	11,446	11,968
5B	4,849	6,643	10,037	12,753	13,335
6A	5,097	6,983	10,551	13,405	14,017
6B	5,719	7,835	11,838	15,041	15,727
7	6,589	9,027	13,639	17,329	18,120
8	9,449	12,945	19,559	24,851	25,985

3. Standard Claims-Made Programs - Area 7

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,611	2,191	3,238	4,011	4,172
1B	2,147	2,920	4,315	5,346	5,561
1C	2,523	3,431	5,071	6,282	6,535
1D	2,749	3,739	5,525	6,845	7,120
2A	3,006	4,088	6,042	7,485	7,786
2B	3,544	4,820	7,123	8,825	9,179
2C	4,188	5,696	8,418	10,428	10,847
2D	4,724	6,425	9,495	11,763	12,235
3A	5,046	6,913	10,445	13,271	13,877
3B	5,584	7,650	11,559	14,686	15,356
4A	6,120	8,384	12,668	16,096	16,830
4B	6,657	9,120	13,780	17,508	18,307
5A	7,516	10,297	15,558	19,767	20,669
5B	8,375	11,474	17,336	22,026	23,031
6A	8,805	12,063	18,226	23,157	24,214
6B	9,879	13,534	20,450	25,982	27,167
7	11,381	15,592	23,559	29,932	31,298
8	16,321	22,360	33,784	42,924	44,883

3. Standard Claims-Made Programs - Area 7

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,543	3,458	5,111	6,332	6,586
1B	3,391	4,612	6,816	8,444	8,783
1C	3,984	5,418	8,008	9,920	10,319
1D	4,340	5,902	8,723	10,807	11,241
2A	4,747	6,456	9,541	11,820	12,295
2B	5,595	7,609	11,246	13,932	14,491
2C	6,612	8,992	13,290	16,464	17,125
2D	7,460	10,146	14,995	18,575	19,321
3A	7,968	10,916	16,494	20,956	21,912
3B	8,816	12,078	18,249	23,186	24,244
4A	9,664	13,240	20,004	25,416	26,576
4B	10,511	14,400	21,758	27,644	28,905
5A	11,868	16,259	24,567	31,213	32,637
5B	13,224	18,117	27,374	34,779	36,366
6A	13,902	19,046	28,777	36,562	38,231
6B	15,598	21,369	32,288	41,023	42,895
7	17,971	24,620	37,200	47,264	49,420
8	25,770	35,305	53,344	67,775	70,868

3. Standard Claims-Made Programs - Area 7

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,052	4,151	6,135	7,599	7,905
1B	4,069	5,534	8,179	10,132	10,539
1C	4,781	6,502	9,610	11,905	12,383
1D	5,208	7,083	10,468	12,968	13,489
2A	5,696	7,747	11,449	14,183	14,753
2B	6,714	9,131	13,495	16,718	17,389
2C	7,934	10,790	15,947	19,756	20,549
2D	8,951	12,173	17,992	22,288	23,183
3A	9,562	13,100	19,793	25,148	26,296
3B	10,580	14,495	21,901	27,825	29,095
4A	11,597	15,888	24,006	30,500	31,892
4B	12,614	17,281	26,111	33,175	34,689
5A	14,242	19,512	29,481	37,456	39,166
5B	15,869	21,741	32,849	41,735	43,640
6A	16,682	22,854	34,532	43,874	45,876
6B	18,717	25,642	38,744	49,226	51,472
7	21,565	29,544	44,640	56,716	59,304
8	30,924	42,366	64,013	81,330	85,041

3. Standard Claims-Made Programs - Area 7

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,295	5,841	8,633	10,695	11,124
1C	5,046	6,863	10,142	12,565	13,069
1D	5,498	7,477	11,051	13,690	14,240
2A	6,013	8,178	12,086	14,972	15,574
2B	7,087	9,638	14,245	17,647	18,355
2C	8,375	11,390	16,834	20,854	21,691
2D	9,449	12,851	18,992	23,528	24,473
3A	10,093	13,827	20,893	26,545	27,756
3B	11,167	15,299	23,116	29,369	30,709
4A	12,241	16,770	25,339	32,194	33,663
4B	13,314	18,240	27,560	35,016	36,614
5A	15,033	20,595	31,118	39,537	41,341
5B	16,750	22,948	34,673	44,053	46,063
6A	17,609	24,124	36,451	46,312	48,425
6B	19,757	27,067	40,897	51,961	54,332
7	22,763	31,185	47,119	59,867	62,598
8	32,642	44,720	67,569	85,848	89,766

3. Standard Claims-Made Programs - Area 7

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

3. Standard Claims-Made Programs - Area 8

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,036	1,409	2,082	2,580	2,683
1B	1,381	1,878	2,776	3,439	3,577
1C	1,623	2,207	3,262	4,041	4,204
1D	1,768	2,404	3,554	4,402	4,579
2A	1,934	2,630	3,887	4,816	5,009
2B	2,279	3,099	4,581	5,675	5,903
2C	2,694	3,664	5,415	6,708	6,977
2D	3,039	4,133	6,108	7,567	7,871
3A	3,246	4,447	6,719	8,537	8,927
3B	3,592	4,921	7,435	9,447	9,878
4A	3,937	5,394	8,150	10,354	10,827
4B	4,282	5,866	8,864	11,262	11,776
5A	4,835	6,624	10,008	12,716	13,296
5B	5,387	7,380	11,151	14,168	14,814
6A	5,663	7,758	11,722	14,894	15,573
6B	6,354	8,705	13,153	16,711	17,474
7	7,321	10,030	15,154	19,254	20,133
8	10,498	14,382	21,731	27,610	28,870

3. Standard Claims-Made Programs - Area 8

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,789	2,433	3,596	4,455	4,634
1B	2,386	3,245	4,796	5,941	6,180
1C	2,803	3,812	5,634	6,979	7,260
1D	3,054	4,153	6,139	7,604	7,910
2A	3,340	4,542	6,713	8,317	8,651
2B	3,937	5,354	7,913	9,803	10,197
2C	4,653	6,328	9,353	11,586	12,051
2D	5,249	7,139	10,550	13,070	13,595
3A	5,607	7,682	11,606	14,746	15,419
3B	6,204	8,499	12,842	16,317	17,061
4A	6,800	9,316	14,076	17,884	18,700
4B	7,396	10,133	15,310	19,451	20,339
5A	8,351	11,441	17,287	21,963	22,965
5B	9,305	12,748	19,261	24,472	25,589
6A	9,782	13,401	20,249	25,727	26,901
6B	10,975	15,036	22,718	28,864	30,181
7	12,645	17,324	26,175	33,256	34,774
8	18,133	24,842	37,535	47,690	49,866

3. Standard Claims-Made Programs - Area 8

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,825	3,842	5,678	7,034	7,317
1B	3,767	5,123	7,572	9,380	9,757
1C	4,427	6,021	8,898	11,023	11,466
1D	4,822	6,558	9,692	12,007	12,489
2A	5,274	7,173	10,601	13,132	13,660
2B	6,216	8,454	12,494	15,478	16,099
2C	7,346	9,991	14,765	18,292	19,026
2D	8,288	11,272	16,659	20,637	21,466
3A	8,853	12,129	18,326	23,283	24,346
3B	9,795	13,419	20,276	25,761	26,936
4A	10,737	14,710	22,226	28,238	29,527
4B	11,678	15,999	24,173	30,713	32,115
5A	13,186	18,065	27,295	34,679	36,262
5B	14,693	20,129	30,415	38,643	40,406
6A	15,446	21,161	31,973	40,623	42,477
6B	17,330	23,742	35,873	45,578	47,658
7	19,967	27,355	41,332	52,513	54,909
8	28,631	39,224	59,266	75,300	78,735

3. Standard Claims-Made Programs - Area 8

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,390	4,610	6,814	8,441	8,780
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,786	7,869	11,630	14,407	14,986
2A	6,329	8,607	12,721	15,759	16,392
2B	7,459	10,144	14,993	18,573	19,319
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,754	16,103	24,331	30,913	32,324
4A	12,884	17,651	26,670	33,885	35,431
4B	14,014	19,199	29,009	36,857	38,539
5A	15,823	21,678	32,754	41,614	43,513
5B	17,631	24,154	36,496	46,370	48,485
6A	18,535	25,393	38,367	48,747	50,971
6B	20,795	28,489	43,046	54,691	57,186
7	23,960	32,825	49,597	63,015	65,890
8	34,358	47,070	71,121	90,362	94,485

3. Standard Claims-Made Programs - Area 8

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,792	20,265	30,619	38,903	40,678
5A	16,702	22,882	34,573	43,926	45,931
5B	18,611	25,497	38,525	48,947	51,180
6A	19,564	26,803	40,497	51,453	53,801
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

3. Standard Claims-Made Programs - Area 8

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,767	5,123	7,572	9,380	9,757
1B	5,023	6,831	10,096	12,507	13,010
1C	5,902	8,027	11,863	14,696	15,286
1D	6,429	8,743	12,922	16,008	16,651
2A	7,032	9,564	14,134	17,510	18,213
2B	8,288	11,272	16,659	20,637	21,466
2C	9,795	13,321	19,688	24,390	25,369
2D	11,051	15,029	22,213	27,517	28,622
3A	11,804	16,171	24,434	31,045	32,461
3B	13,060	17,892	27,034	34,348	35,915
4A	14,316	19,613	29,634	37,651	39,369
4B	15,571	21,332	32,232	40,952	42,820
5A	17,581	24,086	36,393	46,238	48,348
5B	19,590	26,838	40,551	51,522	53,873
6A	20,594	28,214	42,630	54,162	56,634
6B	23,106	31,655	47,829	60,769	63,542
7	26,622	36,472	55,108	70,016	73,211
8	38,175	52,300	79,022	100,400	104,981

3. Standard Claims-Made Programs - Area 9

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,140	1,550	2,291	2,839	2,953
1B	1,519	2,066	3,053	3,782	3,934
1C	1,785	2,428	3,588	4,445	4,623
1D	1,945	2,645	3,909	4,843	5,038
2A	2,127	2,893	4,275	5,296	5,509
2B	2,507	3,410	5,039	6,242	6,493
2C	2,963	4,030	5,956	7,378	7,674
2D	3,343	4,546	6,719	8,324	8,658
3A	3,571	4,892	7,392	9,392	9,820
3B	3,950	5,412	8,177	10,389	10,863
4A	4,330	5,932	8,963	11,388	11,908
4B	4,710	6,453	9,750	12,387	12,953
5A	5,318	7,286	11,008	13,986	14,625
5B	5,926	8,119	12,267	15,585	16,297
6A	6,230	8,535	12,896	16,385	17,133
6B	6,989	9,575	14,467	18,381	19,220
7	8,053	11,033	16,670	21,179	22,146
8	11,547	15,819	23,902	30,369	31,754

3. Standard Claims-Made Programs - Area 9

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,968	2,676	3,956	4,900	5,097
1B	2,624	3,569	5,274	6,534	6,796
1C	3,084	4,194	6,199	7,679	7,988
1D	3,359	4,568	6,752	8,364	8,700
2A	3,674	4,997	7,385	9,148	9,516
2B	4,330	5,889	8,703	10,782	11,215
2C	5,118	6,960	10,287	12,744	13,256
2D	5,774	7,853	11,606	14,377	14,955
3A	6,167	8,449	12,766	16,219	16,959
3B	6,823	9,348	14,124	17,944	18,763
4A	7,479	10,246	15,482	19,670	20,567
4B	8,136	11,146	16,842	21,398	22,374
5A	9,186	12,585	19,015	24,159	25,262
5B	10,235	14,022	21,186	26,918	28,146
6A	10,760	14,741	22,273	28,299	29,590
6B	12,072	16,539	24,989	31,749	33,198
7	13,909	19,055	28,792	36,581	38,250
8	19,945	27,325	41,286	52,455	54,849

3. Standard Claims-Made Programs - Area 9

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,108	4,227	6,247	7,739	8,050
1B	4,144	5,636	8,329	10,319	10,733
1C	4,869	6,622	9,787	12,124	12,611
1D	5,304	7,213	10,661	13,207	13,737
2A	5,801	7,889	11,660	14,444	15,025
2B	6,837	9,298	13,742	17,024	17,708
2C	8,081	10,990	16,243	20,122	20,930
2D	9,116	12,398	18,323	22,699	23,610
3A	9,738	13,341	20,158	25,611	26,780
3B	10,774	14,760	22,302	28,336	29,629
4A	11,810	16,180	24,447	31,060	32,478
4B	12,846	17,599	26,591	33,785	35,327
5A	14,504	19,870	30,023	38,146	39,886
5B	16,161	22,141	33,453	42,503	44,443
6A	16,990	23,276	35,169	44,684	46,723
6B	19,061	26,114	39,456	50,130	52,418
7	21,962	30,088	45,461	57,760	60,396
8	31,493	43,145	65,191	82,827	86,606

3. Standard Claims-Made Programs - Area 9

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,730	5,073	7,497	9,288	9,661
1B	4,973	6,763	9,996	12,383	12,880
1C	5,843	7,946	11,744	14,549	15,133
1D	6,365	8,656	12,794	15,849	16,485
2A	6,962	9,468	13,994	17,335	18,032
2B	8,204	11,157	16,490	20,428	21,248
2C	9,697	13,188	19,491	24,146	25,115
2D	10,940	14,878	21,989	27,241	28,335
3A	11,686	16,010	24,190	30,734	32,137
3B	12,929	17,713	26,763	34,003	35,555
4A	14,171	19,414	29,334	37,270	38,970
4B	15,415	21,119	31,909	40,541	42,391
5A	17,404	23,843	36,026	45,773	47,861
5B	19,393	26,568	40,144	51,004	53,331
6A	20,388	27,932	42,203	53,620	56,067
6B	22,874	31,337	47,349	60,159	62,904
7	26,355	36,106	54,555	69,314	72,476
8	37,791	51,774	78,227	99,390	103,925

3. Standard Claims-Made Programs - Area 9

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,937	5,354	7,913	9,803	10,197
1B	5,249	7,139	10,550	13,070	13,595
1C	6,167	8,387	12,396	15,356	15,973
1D	6,718	9,136	13,503	16,728	17,400
2A	7,348	9,993	14,769	18,297	19,031
2B	8,660	11,778	17,407	21,563	22,429
2C	10,235	13,920	20,572	25,485	26,509
2D	11,547	15,704	23,209	28,752	29,907
3A	12,335	16,899	25,533	32,441	33,921
3B	13,647	18,696	28,249	35,892	37,529
4A	14,959	20,494	30,965	39,342	41,137
4B	16,272	22,293	33,683	42,795	44,748
5A	18,371	25,168	38,028	48,316	50,520
5B	20,471	28,045	42,375	53,839	56,295
6A	21,520	29,482	44,546	56,598	59,180
6B	24,144	33,077	49,978	63,499	66,396
7	27,819	38,112	57,585	73,164	76,502
8	39,891	54,651	82,574	104,913	109,700

3. Standard Claims-Made Programs - Area 9

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,144	5,636	8,329	10,319	10,733
1B	5,525	7,514	11,105	13,757	14,310
1C	6,492	8,829	13,049	16,165	16,814
1D	7,072	9,618	14,215	17,609	18,316
2A	7,735	10,520	15,547	19,260	20,034
2B	9,116	12,398	18,323	22,699	23,610
2C	10,774	14,653	21,656	26,827	27,905
2D	12,155	16,531	24,432	30,266	31,481
3A	12,984	17,788	26,877	34,148	35,706
3B	14,365	19,680	29,736	37,780	39,504
4A	15,746	21,572	32,594	41,412	43,302
4B	17,128	23,465	35,455	45,047	47,102
5A	19,338	26,493	40,030	50,859	53,180
5B	21,548	29,521	44,604	56,671	59,257
6A	22,653	31,035	46,892	59,577	62,296
6B	25,415	34,819	52,609	66,841	69,891
7	29,283	40,118	60,616	77,014	80,528
8	41,990	57,526	86,919	110,434	115,473

3. Increased Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

4. Excess Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
1M/1M xs 1M/3M	1.270	1.300	1.300
2M/2M xs 1M/3M	1.430	1.480	1.480
3M/3M xs 1M/3M	1.560	1.620	1.620
4M/4M xs 1M/3M	1.670	1.740	1.740

Note: For aggregate limits not listed above, refer to company.

5. Extended Reporting Period Coverage Factors

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.700
4 OR MORE	1.820

6. Shared Limits Modification

Modification
Up to 25%

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Physician & Surgeons	$250

D. **Premium Modifications**

1. **Part Time Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

3. **Locum Tenens**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

4. **Temporary Staffing Agency Rating**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **New Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

6. **Physician Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

7. **Physicians Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

8. **Physicians Military Leave of Absence Credit**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification		**-50% / +50%**

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

10. **Risk Management**
(Occurrence, & Standard Claims Made Programs)

Year	Credit	Addtl Credit if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

11. **Claim Free Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 8	10%
8 but less than 10	15%
10 or more	20%

12. **Deductible Credits**
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non-Discretionary Debit Rating Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Claim Threshold	Points
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

Schedule B:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code. ***Refer to the Classification Translation Table – Specialty Description to ISO Code at the end of this section.***

16. **Small Group & Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Convertible Coverage Rating Plan**

NOT AVAILABLE

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

20. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
$250,000

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

25. **Membership Credit**
(Occurrence & Standard Claims Made Programs)

Credit
5%

26. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max Available Credit
50%

27. **Quarterly Installment Option**
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

28. **Convertible Plus / Nose Rating Plan**
(Occurrence Program)

A healthcare provider that is currently insured under a claims-made policy form may be eligible for Convertible / Nose coverage, subject to underwriting guidelines. This coverage will provide nose coverage to healthcare providers that seek to convert to an occurrence policy form. The rating for such coverage is based upon the insureds standard mature claims made rate times the factor identified in the table below.

Years Retroactive Date Precedes Policy Inception Date	Factor
1	.75
2	1.08
3	1.18
4 or More	1.25

The applicable premium under this plan shall be in addition to the healthcare provider's standard occurrence premium and shall be paid to the Company over an installment period.

In the event the insured cancels the occurrence coverage, within the first five years subsequent to the issuance of the product, for reasons other than non-renewal, death, total and permanent disability or permanent retirement, additional premium shall be due and payable. Additional premium shall be calculated at the Company's filed rate for an extension contract endorsement at the time the Convertible Plus Claims Made coverage is issued. Any unpaid balance between this amount and any payments made prior to the cancellation date is due sixty (60) days from the date of cancellation.

The rating under this rule is subject to applicable Part-Time and Schedule Rating modifications.

*****Classification Translation Table – Specialty Description to ISO Code**

	Speciality Code	MD	DO	Class
Allergy	39	80254	84254	1A
Cardiology (Including Swan-Ganz)	33	80255	84255	2A
Dermatology	31	80256	84256	1A
Family/General Practice	19	80420	84420	1C
Aerospace	19	80230	84230	1A
Forensic Medicine	36	80240	84240	1A
Geriatrics	32	80243	84243	1B
Nuclear Medicine	37	80262	84262	1A
Nutrition	32	80248	84248	1A
Occupational Medicine	19	80233	84233	1A
Physiatry	19	80235	84235	1A
Public Health	19	80236	84236	1A
Gynecology	15	80244	84244	1B
Internal Medicine	32	80257	84257	1D
Diabetes	32	80237	84237	2A
Endocrinology	32	80238	84238	1B
Gastroenterology	32	80241	84241	2B
Hematology / Oncology	32	80245	84245	2A
Infectious Disease	32	80246	84246	2B
Nephrology	32	80260	84260	1C
Pharmacology	32	80234	84234	1B
Preventative Medicine	32	80231	84231	1A
Rheumatology	32	80252	84252	1C
Neonatology	34	80471	84471	2B
Neurology	40	80261	84261	2B
Ophthalmology	16	80263	84263	1A
Otolaryngology	23	80265	84265	1B
Otology	23	80264	84264	1B
Larynogology	23	80258	84258	1B

	Speciality Code	MD	DO	Class
Rhinology	23	80247	84247	1B
Pathology	36	80266	84266	1B
Pediatrics	34	80267	84267	1C
Psychiatry - Inc. Child	35	80249	84249	1B
Hypnosis	35	80232	84232	1B
Psychoanalysis	35	80250	84250	1B
Psychosomatic	35	80251	84251	1B
Pulmonary Disease	38	80269	84269	2C
Radiology - Diagnostic	37	80253	84253	2B
Urgent Care	26	80102	84102	2A
Retired Physician	XX	80179	84179	
Physician - N.O.C.	19	80268	84268	1B
Surgical Specialist Performing No Surgery, But Still Practicing In That Speciality		80268	84268	1B
Cardiology (Right Heart Cath. Only)	33	80281	84281	2C
Dermatology	31	80282	84282	1B
Family/General Practice	19	80421	84421	2C
Geriatrics	32	80276	84276	2B
Physicians - N.O.C.	XX	80294	84294	2B
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80274	84274	2C
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279	84279	2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287	84287	2B
Neurology	40	80288	84288	3A
Ophthalmology	16	80289	84289	1C
Otorhinolaryngology	23	80291	84291	2B
Otology	23	80290	84290	2B
Laryngology	23	80285	84285	2B
Rhinology	23	80270	84270	2B

	Speciality Code	MD	DO	Class
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Psychiatry - Inc. Shock Therapy	35	80431	84431	2B
Radiology - Diagnostic	37	80280	84280	2D
Radiology - Teleradiology	90	80280	84280	2D
Radiology - Therapy	37	80425	84425	2B
Radiology - Teleradiology	90	80425	84425	2B
Pain Management	19, 30, 40	80295	84295	2A
Hospitalist	32	80296	84296	1D
Surgical Specialist Performing Minor Surgery On Their Own Patients While Practicing In That Speciality:		80294	84294	2B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Radiation Therapy	XX	80425	84425	2B
Radiopaque Dye Injection	XX	80449	84449	2D
Radiology - incld. Mammography	37	80472	84472	2D
Radiology - Teleradiology	90	80472	84472	2D
Shock Therapy	XX	80431	84431	2B
Physicians Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients - Not Primarily Engaged In Major Surgery:				
Dermatology	31	80282	84282	1B
Family/General Practice	19	80117	84117	3B
Geriatrics	19	80105	84105	3B
Physicians - N.O.C.	19	80294		
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Diabetes	32	80271		
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80104	84104	3A
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279		2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287		2B
Neurology	40	80288	84288	3A
Otorhinolaryngology	23	80291	84291	2B

	Speciality Code	MD	DO	Class
Otology	23	80290		2B
Laryngology	23	80285		2B
Rhinology	23	80270		2B
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Emergency Medicine (No Major Surg)	25	80102	84102	4A
Surgical Specialists:				
Ophthalmology	16	80114	84114	1D
Colon and Rectal	24	80115	84115	3B
Emergency Medicine (Incl. Major Surg)	25	80157	84157	4B
Surgical Specialist Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients While Practicing In That Speciality, But Not Primarily Engaged In Major Surgery:		80117	84117	3B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Acupuncture	XX	80437	84437	3A
Cardiology (Incl. Left Heart Cath.)	33	80422	84422	3A
Internal Medicine (Incl. Left Heart Cath.)	32	80422	84422	3A
Urology	17	80145	84145	3A
Fam./Gen. Practice - incl. deliveries	29	80273	84273	3A
Anesthesiology	30	80151	84151	2A
Abdominal	10	80166	84166	6B
Cosmetic	10, 15, 16, 20, 23, 31	80136	84136	4A
General - N.O.C.	10	80143	84143	6B
Otorhinolaryngology	23	80159	84159	3A
Otology	23	80158	84158	3A
Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	4A
Head and Neck	13	80170	84170	4A
Obstetrics/Gynecology	15	80153	84153	6B
Obstetrics	15	80168	84168	6B
Gynecology	18	80167	84167	4A
Plastic - N.O.C.	20	80156	84156	4A

	Speciality Code	MD	DO	Class
Cardiovascular	21	80150	84150	5B
Neurological	12	80152	84152	8
Orthopedic (Excl. back)	13	80176	84176	4A
Orthopedic (Incl. back)	13	80154	84154	6A
Thoracic	14	80144	84144	5B
Traumatic	10	80171	84171	7
Vascular	22	80146	84146	5B

The
Medical Protective Company
Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,250	5,780	8,543	10,583	11,008
1B	5,667	7,707	11,391	14,111	14,678
1C	6,659	9,056	13,385	16,581	17,247
1D	7,254	9,865	14,581	18,062	18,788
2A	7,934	10,790	15,947	19,756	20,549
2B	9,351	12,717	18,796	23,284	24,219
2C	11,051	15,029	22,213	27,517	28,622
2D	12,467	16,955	25,059	31,043	32,290
3A	13,317	18,244	27,566	35,024	36,622
3B	14,734	20,186	30,499	38,750	40,519
4A	16,151	22,127	33,433	42,477	44,415
4B	17,568	24,068	36,366	46,204	48,312
5A	19,835	27,174	41,058	52,166	54,546
5B	22,101	30,278	45,749	58,126	60,778
6A	23,235	31,832	48,096	61,108	63,896
6B	26,068	35,713	53,961	68,559	71,687
7	30,035	41,148	62,172	78,992	82,596
8	43,069	59,005	89,153	113,271	118,440

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,140	1,550	2,291	2,839	2,953
1B	1,519	2,066	3,053	3,782	3,934
1C	1,785	2,428	3,588	4,445	4,623
1D	1,945	2,645	3,909	4,843	5,038
2A	2,127	2,893	4,275	5,296	5,509
2B	2,507	3,410	5,039	6,242	6,493
2C	2,963	4,030	5,956	7,378	7,674
2D	3,343	4,546	6,719	8,324	8,658
3A	3,571	4,892	7,392	9,392	9,820
3B	3,950	5,412	8,177	10,389	10,863
4A	4,330	5,932	8,963	11,388	11,908
4B	4,710	6,453	9,750	12,387	12,953
5A	5,318	7,286	11,008	13,986	14,625
5B	5,926	8,119	12,267	15,585	16,297
6A	6,230	8,535	12,896	16,385	17,133
6B	6,989	9,575	14,467	18,381	19,220
7	8,053	11,033	16,670	21,179	22,146
8	11,547	15,819	23,902	30,369	31,754

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,968	2,676	3,956	4,900	5,097
1B	2,624	3,569	5,274	6,534	6,796
1C	3,084	4,194	6,199	7,679	7,988
1D	3,359	4,568	6,752	8,364	8,700
2A	3,674	4,997	7,385	9,148	9,516
2B	4,330	5,889	8,703	10,782	11,215
2C	5,118	6,960	10,287	12,744	13,256
2D	5,774	7,853	11,606	14,377	14,955
3A	6,167	8,449	12,766	16,219	16,959
3B	6,823	9,348	14,124	17,944	18,763
4A	7,479	10,246	15,482	19,670	20,567
4B	8,136	11,146	16,842	21,398	22,374
5A	9,186	12,585	19,015	24,159	25,262
5B	10,235	14,022	21,186	26,918	28,146
6A	10,760	14,741	22,273	28,299	29,590
6B	12,072	16,539	24,989	31,749	33,198
7	13,909	19,055	28,792	36,581	38,250
8	19,945	27,325	41,286	52,455	54,849

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,108	4,227	6,247	7,739	8,050
1B	4,144	5,636	8,329	10,319	10,733
1C	4,869	6,622	9,787	12,124	12,611
1D	5,304	7,213	10,661	13,207	13,737
2A	5,801	7,889	11,660	14,444	15,025
2B	6,837	9,298	13,742	17,024	17,708
2C	8,081	10,990	16,243	20,122	20,930
2D	9,116	12,398	18,323	22,699	23,610
3A	9,738	13,341	20,158	25,611	26,780
3B	10,774	14,760	22,302	28,336	29,629
4A	11,810	16,180	24,447	31,060	32,478
4B	12,846	17,599	26,591	33,785	35,327
5A	14,504	19,870	30,023	38,146	39,886
5B	16,161	22,141	33,453	42,503	44,443
6A	16,990	23,276	35,169	44,684	46,723
6B	19,061	26,114	39,456	50,130	52,418
7	21,962	30,088	45,461	57,760	60,396
8	31,493	43,145	65,191	82,827	86,606

The
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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,730	5,073	7,497	9,288	9,661
1B	4,973	6,763	9,996	12,383	12,880
1C	5,843	7,946	11,744	14,549	15,133
1D	6,365	8,656	12,794	15,849	16,485
2A	6,962	9,468	13,994	17,335	18,032
2B	8,204	11,157	16,490	20,428	21,248
2C	9,697	13,188	19,491	24,146	25,115
2D	10,940	14,878	21,989	27,241	28,335
3A	11,686	16,010	24,190	30,734	32,137
3B	12,929	17,713	26,763	34,003	35,555
4A	14,171	19,414	29,334	37,270	38,970
4B	15,415	21,119	31,909	40,541	42,391
5A	17,404	23,843	36,026	45,773	47,861
5B	19,393	26,568	40,144	51,004	53,331
6A	20,388	27,932	42,203	53,620	56,067
6B	22,874	31,337	47,349	60,159	62,904
7	26,355	36,106	54,555	69,314	72,476
8	37,791	51,774	78,227	99,390	103,925

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,937	5,354	7,913	9,803	10,197
1B	5,249	7,139	10,550	13,070	13,595
1C	6,167	8,387	12,396	15,356	15,973
1D	6,718	9,136	13,503	16,728	17,400
2A	7,348	9,993	14,769	18,297	19,031
2B	8,660	11,778	17,407	21,563	22,429
2C	10,235	13,920	20,572	25,485	26,509
2D	11,547	15,704	23,209	28,752	29,907
3A	12,335	16,899	25,533	32,441	33,921
3B	13,647	18,696	28,249	35,892	37,529
4A	14,959	20,494	30,965	39,342	41,137
4B	16,272	22,293	33,683	42,795	44,748
5A	18,371	25,168	38,028	48,316	50,520
5B	20,471	28,045	42,375	53,839	56,295
6A	21,520	29,482	44,546	56,598	59,180
6B	24,144	33,077	49,978	63,499	66,396
7	27,819	38,112	57,585	73,164	76,502
8	39,891	54,651	82,574	104,913	109,700

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ILLINOIS - AREA 9

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,144	5,636	8,329	10,319	10,733
1B	5,525	7,514	11,105	13,757	14,310
1C	6,492	8,829	13,049	16,165	16,814
1D	7,072	9,618	14,215	17,609	18,316
2A	7,735	10,520	15,547	19,260	20,034
2B	9,116	12,398	18,323	22,699	23,610
2C	10,774	14,653	21,656	26,827	27,905
2D	12,155	16,531	24,432	30,266	31,481
3A	12,984	17,788	26,877	34,148	35,706
3B	14,365	19,680	29,736	37,780	39,504
4A	15,746	21,572	32,594	41,412	43,302
4B	17,128	23,465	35,455	45,047	47,102
5A	19,338	26,493	40,030	50,859	53,180
5B	21,548	29,521	44,604	56,671	59,257
6A	22,653	31,035	46,892	59,577	62,296
6B	25,415	34,819	52,609	66,841	69,891
7	29,283	40,118	60,616	77,014	80,528
8	41,990	57,526	86,919	110,434	115,473

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ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, JACKSON, MADISON, ST. CLAIR, AND WILL COUNTIES.

TERRITORY 2: ~~LAKE, AND~~ VERMILLION COUNTY~~IES~~.

TERRITORY 3: KANE, ~~—~~LAKE, MCHENRY, AND WINNEBAGO COUNTIES.

TERRITORY 4: ~~DUPAGE,~~ KANKAKEE~~, AND MACON,~~ COUNTY~~IES~~.

TERRITORY 5: BUREAU, CHAMPAIGN, COLES, DEKALB, DUPAGE, EFFINGHAM, LASALLE, MACON, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 6: GRUNDY ~~& SANGAMON~~ COUNTY~~IES~~.

TERRITORY 7: ADAMS, KNOX, PEORIA AND ROCK ISLAND COUNT~~Y~~IES.

TERRITORY 8: REMAINDER OF STATE.

TERRITORY9: SANGAMON COUNTY.

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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, JACKSON, MADISON, ST. CLAIR, AND WILL COUNTIES.

TERRITORY 2: ~~LAKE, AND~~ VERMILLION COUNTY~~IES~~.

TERRITORY 3: KANE, ~~—~~LAKE, MCHENRY, AND WINNEBAGO COUNTIES.

TERRITORY 4: ~~DUPAGE, KANKAKEE, AND MACON,~~ COUNTY~~IES~~.

TERRITORY 5: BUREAU, CHAMPAIGN, COLES, DEKALB, DUPAGE, EFFINGHAM, LASALLE, MACON, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 6: GRUNDY ~~& SANGAMON~~ COUNTY~~IES~~.

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

	Territory								
Limit	1 Cap	2 Cap	3 Cap	4 Cap	5 Cap	6 Cap	7 Cap	8 Cap	9 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300	$22,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700	$28,300
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000	$31,900
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600	$34,800
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900	$37,200

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/CONTRACTED PHYSICIANS.

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

	Territory								
Limit	1 Cap	2 Cap	3 Cap	4 Cap	5 Cap	6 Cap	7 Cap	8 Cap	9 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300	$22,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700	$28,300
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000	$31,900
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600	$34,800
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900	$37,200

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/CONTRACTED PHYSICIANS.

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:- ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ —— DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:- FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ —— OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE:- HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN:~~—~~ OPHTHALMOLOGY.

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PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:- ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:- FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE:- HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN~~:~~ OPHTHALMOLOGY.

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

~~SPECIALTIES~~ SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ ENDOCRINOLOGY.

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: DIAGNOSTIC RADIOLOGY, GASTROENTEROLOGY, INFECTIOUS DISEASE, ~~NEUROLOGY AND RADIOLOGY - DIAGNOSTIC~~NEONATOLOGY AND NEUROLOGY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, ~~NEONATOLOGY,~~ NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS ~~TO INCLUDE:~~ IN PULMONARY DISEASE.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DIAGNOSTIC RADIOLOGY, INTERNAL MEDICINE, RADIOLOGY ~~DIAGNOSTIC, RADIOLOGY INCL~~ - INCLUDING MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID~~:~~ PERFORMING ANY OF THE FOLLOWING: ACUPUNCTURE OR CARDIOLOGY (LEFT HEART CATHETERIZATION) ~~AND ACUPUNCTURE~~.

CLASS IIIB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS ~~IN:~~ TO INCLUDE: COSMETIC SURGERY, GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY ~~AND~~, ORTHOPEDIC SURGERY (EXCLUDING SPINAL~~)~~) AND PLASTIC SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IVB

SURGICAL SPECIALISTS IN:~~-~~ EMERGENCY MEDICINE.

CLASS VA

~~SURGICAL SPECIALISTS IN: PLASTIC - NOT OTHERWISE CLASSIFIED.~~
RESERVED FOR FUTURE USE.

CLASS VB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN:~~-~~ ORTHOPEDIC SURGERY (INCLUDING SPINAL).

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PHYSICIANS & SURGEONS RATE CLASSES

CLASS VIB

SURGICAL SPECIALISTS ~~IN~~INTO INCLUDE: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN~~:~~- TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN~~:~~- NEUROLOGICAL SURGERY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:- ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:- FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE:- HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN~~:~~ OPHTHALMOLOGY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

~~SPECIALTIES~~ SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ ENDOCRINOLOGY.

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: DIAGNOSTIC RADIOLOGY, GASTROENTEROLOGY, INFECTIOUS DISEASE, ~~NEUROLOGY AND RADIOLOGY - DIAGNOSTIC~~NEONATOLOGY AND NEUROLOGY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, ~~NEONATOLOGY,~~ NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS ~~TO INCLUDE:~~ IN PULMONARY DISEASE.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

ILLINOIS

STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DIAGNOSTIC RADIOLOGY, INTERNAL MEDICINE, RADIOLOGY ~~-DIAGNOSTIC, RADIOLOGY INCL~~ - INCLUDING MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID~~:~~ PERFORMING ANY OF THE FOLLOWING: ACUPUNCTURE OR CARDIOLOGY (LEFT HEART CATHETERIZATION) ~~-AND ACUPUNCTURE~~.

CLASS IIIB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS ~~IN:~~ TO INCLUDE: COSMETIC SURGERY, GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY ~~AND~~, ORTHOPEDIC SURGERY (EXCLUDING SPINAL~~)~~) AND PLASTIC SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IVB

SURGICAL SPECIALISTS IN~~:~~ EMERGENCY MEDICINE.

CLASS VA

~~SURGICAL SPECIALISTS IN: PLASTIC - NOT OTHERWISE CLASSIFIED.~~
RESERVED FOR FUTURE USE.

CLASS VB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN~~:~~ ORTHOPEDIC SURGERY (INCLUDING SPINAL).

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS VIB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN~~:~~ TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN~~:~~ NEUROLOGICAL SURGERY.

A. **Classification**

1. As defined by state statutes and formed for the purpose of rendering medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists – All Other Dental Specialties	5%	Available
Dentists – Oral Surgeons	1%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

	Territory								
Limit	1 Cap	2 Cap	3 Cap	4 Cap	5 Cap	6 Cap	7 Cap	8 Cap	9 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300	$22,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700	$28,300
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000	$31,900
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600	$34,800
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900	$37,200

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

c. The premium otherwise determined for the partnership or corporation may be discounted 50% should the insured elect to exclude the vicarious liability associated with the partners', shareholders' and employed/contracted physicians' professional services.

2. **Miscellaneous Entities**

NOT AVAILABLE

3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.900~~750~~	1.150	1.200
5 or more	1.820	1.900~~750~~	1.200	1.250

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$50~~25~~
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 50%~~35%~~
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

2. Deductible Credits
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

3. Self-Insured Retention Credits

NOT AVAILABLE

4. Small Group, Large Group & Temporary Staffing Agency Rating – Corporations
(Occurrence & Standard Claims Made Programs)

AVAILABLE

5. Renewal Rate Rule
(Occurrence & Standard Claims Made Programs)

Specialty Type	Premium Threshold
Physicians & Surgeons	$250,000
Dentists	$25,000
Allied Health Care Providers	$250,000

~~5.~~6. Quarterly Installment Option
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

PHYSICIANS & SURGEONS

A. Classifications

1. Applicable to the Occurrence and Standard Claims-Made Programs.

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

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:- ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

~~SPECIALTIES~~
SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:- FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE:- HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN~~:~~ OPHTHALMOLOGY.

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

~~SPECIALTIES~~ SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS IN~~CLUDING:~~ ENDOCRINOLOGY.

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: DIAGNOSTIC RADIOLOGY, GASTROENTEROLOGY, INFECTIOUS DISEASE, ~~NEUROLOGY AND RADIOLOGY - DIAGNOSTIC~~NEONATOLOGY AND NEUROLOGY.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, ~~NEONATOLOGY,~~ NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS ~~TO INCLUDE:~~ IN PULMONARY DISEASE.

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

CLASS IID

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DIAGNOSTIC RADIOLOGY, INTERNAL MEDICINE, RADIOLOGY~~-DIAGNOSTIC, RADIOLOGY-INCL~~ - INCLUDING MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

~~SPECIALTIES~~SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID~~:~~ PERFORMING ANY OF THE FOLLOWING: ACUPUNCTURE OR CARDIOLOGY (LEFT HEART CATHETERIZATION)~~ AND ACUPUNCTURE~~.

CLASS IIIB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS ~~IN:~~ TO INCLUDE: COSMETIC SURGERY, GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY~~ AND~~, ORTHOPEDIC SURGERY (EXCLUDING SPINAL~~)~~) AND PLASTIC SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IVB

SURGICAL SPECIALISTS IN~~:~~ EMERGENCY MEDICINE.

CLASS VA

~~SURGICAL SPECIALISTS IN: COSMETIC SURGERY, PLASTIC - NOT OTHERWISE CLASSIFIED.~~ RESERVED FOR FUTURE USE.

CLASS VB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN~~:~~ ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS ~~IN~~TO INCLUDE: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN~~:~~ TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN~~:~~ NEUROLOGICAL SURGERY.

B. Manual Rates

1. Territory Definitions

Area 1	Cook, Jackson, Madison, St. Clair, and Will Counties
Area 2	~~Lake, and~~ Vermillion County~~ies~~
Area 3	Kane, Lake, McHenry, and Winnebago Counties.
Area 4	~~Dupage,~~ Kankakee~~, and Macon,~~ County~~ies~~
Area 5	Bureau, Champaign, Coles, Dekalb, Dupage, Effingham, Lasalle, Macon, Ogle, and Randolph Counties
Area 6	Grundy ~~and Sangamon Counties~~County
Area 7	Adams, Knox, Peoria & Rock Island County~~y~~ies.
Area 8	Remainder of State
Area 9	Sangamon County

2. Occurrence Program – Area 1

~~a. Area 1~~

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,728	10,510	15,533	19,243	20,016
1B	10,304	14,013	20,711	25,657	26,687
1C	12,107	16,466	24,335	30,146	31,357
1D	13,189	17,937	26,510	32,841	34,160
2A	14,426	19,619	28,996	35,921	37,363
2B	17,002	23,123	34,174	42,335	44,035
2C	20,093	27,326	40,387	50,032	52,041
2D	22,669	30,830	45,565	56,446	58,713
3A	24,214	33,173	50,123	63,683	66,589
3B	26,790	36,702	55,455	70,458	73,673
4A	29,366	40,231	60,788	77,233	80,757
4B	31,942	43,761	66,120	84,007	87,841
5A	36,064	49,408	74,652	94,848	99,176
5B	40,186	55,055	83,185	105,689	110,512
6A	42,246	57,877	87,449	111,107	116,177
6B	47,398	64,935	98,114	124,657	130,345
7	54,611	74,817	113,045	143,627	150,180
8	78,310	107,285	162,102	205,955	215,353

~~b. Area 2~~

2. Occurrence Program – Area 2

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,956	9,460	13,982	17,320	18,016
1B	9,274	12,613	18,641	23,092	24,020
1C	10,897	14,820	21,903	27,134	28,223
1D	11,871	16,145	23,861	29,559	30,746
2A	12,984	17,658	26,098	32,330	33,629
2B	15,302	20,811	30,757	38,102	39,632
2C	18,084	24,594	36,349	45,029	46,838
2D	20,403	27,748	41,010	50,803	52,844
3A	21,794	29,858	45,114	57,318	59,934
3B	24,112	33,033	49,912	63,415	66,308
4A	26,431	36,210	54,712	69,514	72,685
4B	28,749	39,386	59,510	75,610	79,060
5A	32,459	44,469	67,190	85,367	89,262
5B	36,169	49,552	74,870	95,124	99,465
6A	38,023	52,092	78,708	100,000	104,563
6B	42,660	58,444	88,306	112,196	117,315
7	49,152	67,338	101,745	129,270	135,168
8	70,482	96,560	145,898	185,368	193,826

~~e. Area 3~~

2. Occurrence Program – Area 3

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,569	8,934	13,204	16,357	17,014
1B	8,758	11,911	17,604	21,807	22,683
1C	10,291	13,996	20,685	25,625	26,654
1D	11,210	15,246	22,532	27,913	29,034
2A	12,261	16,675	24,645	30,530	31,756
2B	14,451	19,653	29,047	35,983	37,428
2C	17,078	23,226	34,327	42,524	44,232
2D	19,268	26,204	38,729	47,977	49,904
3A	20,581	28,196	42,603	54,128	56,598
3B	22,771	31,196	47,136	59,888	62,620
4A	24,960	34,195	51,667	65,645	68,640
4B	27,150	37,196	56,201	71,405	74,663
5A	30,653	41,995	63,452	80,617	84,296
5B	34,156	46,794	70,703	89,830	93,929
6A	35,908	49,194	74,330	94,438	98,747
6B	40,287	55,193	83,394	105,955	110,789
7	46,417	63,591	96,083	122,077	127,647
8	66,561	91,189	137,781	175,055	183,043

~~d. Area 4~~

2. Occurrence Program – Area 4

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,796	7,883	11,650	14,432	15,012
1B	7,728	10,510	15,533	19,243	20,016
1C	9,080	12,349	18,251	22,609	23,517
1D	9,892	13,453	19,883	24,631	25,620
2A	10,819	14,714	21,746	26,939	28,021
2B	12,751	17,341	25,630	31,750	33,025
2C	15,070	20,495	30,291	37,524	39,031
2D	17,002	23,123	34,174	42,335	44,035
3A	18,161	24,881	37,593	47,763	49,943
3B	20,093	27,527	41,593	52,845	55,256
4A	22,025	30,174	45,592	57,926	60,569
4B	23,957	32,821	49,591	63,007	65,882
5A	27,048	37,056	55,989	71,136	74,382
5B	30,139	41,290	62,388	79,266	82,882
6A	31,685	43,408	65,588	83,332	87,134
6B	35,549	48,702	73,586	93,494	97,760
7	40,958	56,112	84,783	107,720	112,635
8	58,733	80,464	121,577	154,468	161,516

~~e. Area 5~~

2. Occurrence Program – Area 5

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,410	7,358	10,874	13,471	14,012
1B	7,213	9,810	14,498	17,960	18,682
1C	8,475	11,526	17,035	21,103	21,950
1D	9,233	12,557	18,558	22,990	23,913
2A	10,098	13,733	20,297	25,144	26,154
2B	11,901	16,185	23,921	29,633	30,824
2C	14,065	19,128	28,271	35,022	36,428
2D	15,869	21,582	31,897	39,514	41,101
3A	16,951	23,223	35,089	44,581	46,615
3B	18,754	25,693	38,821	49,323	51,574
4A	20,557	28,163	42,553	54,065	56,532
4B	22,360	30,633	46,285	58,807	61,490
5A	25,246	34,587	52,259	66,397	69,427
5B	28,131	38,539	58,231	73,985	77,360
6A	29,573	40,515	61,216	77,777	81,326
6B	33,180	45,457	68,683	87,263	91,245
7	38,229	52,374	79,134	100,542	105,130
8	54,819	75,102	113,475	144,174	150,752

~~f. Area 6~~

2. Occurrence Program – Area 6

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,637	6,306	9,320	11,546	12,010
1B	6,182	8,408	12,426	15,393	16,011
1C	7,264	9,879	14,601	18,087	18,814
1D	7,913	10,762	15,905	19,703	20,495
2A	8,655	11,771	17,397	21,551	22,416
2B	10,200	13,872	20,502	25,398	26,418
2C	12,055	16,395	24,231	30,017	31,222
2D	13,600	18,496	27,336	33,864	35,224
3A	14,528	19,903	30,073	38,209	39,952
3B	16,073	22,020	33,271	42,272	44,201
4A	17,619	24,138	36,471	46,338	48,452
4B	19,164	26,255	39,669	50,401	52,701
5A	21,637	29,643	44,789	56,905	59,502
5B	24,110	33,031	49,908	63,409	66,303
6A	25,346	34,724	52,466	66,660	69,702
6B	28,437	38,959	58,865	74,789	78,202
7	32,765	44,888	67,824	86,172	90,104
8	46,983	64,367	97,255	123,565	129,203

~~g. Area 7~~

2. Occurrence Program – Area 7

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,478	4,730	6,991	8,660	9,008
1B	4,637	6,306	9,320	11,546	12,010
1C	5,448	7,409	10,950	13,566	14,110
1D	5,935	8,072	11,929	14,778	15,372
2A	6,492	8,829	13,049	16,165	16,814
2B	7,651	10,405	15,379	19,051	19,816
2C	9,042	12,297	18,174	22,515	23,419
2D	10,201	13,873	20,504	25,400	26,421
3A	10,897	14,929	22,557	28,659	29,967
3B	12,056	16,517	24,956	31,707	33,154
4A	13,215	18,105	27,355	34,755	36,341
4B	14,375	19,694	29,756	37,806	39,531
5A	16,230	22,235	33,596	42,685	44,633
5B	18,084	24,775	37,434	47,561	49,731
6A	19,012	26,046	39,355	50,002	52,283
6B	21,330	29,222	44,153	56,098	58,658
7	24,576	33,669	50,872	64,635	67,584
8	35,241	48,280	72,949	92,684	96,913

~~h. Area 8~~

2. Occurrence Program – Area 8

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,864	5,255	7,767	9,621	10,008
1B	5,152	7,007	10,356	12,828	13,344
1C	6,054	8,233	12,169	15,074	15,680
1D	6,595	8,969	13,256	16,422	17,081
2A	7,213	9,810	14,498	17,960	18,682
2B	8,501	11,561	17,087	21,167	22,018
2C	10,046	13,663	20,192	25,015	26,019
2D	11,334	15,414	22,781	28,222	29,355
3A	12,107	16,587	25,061	31,841	33,294
3B	13,395	18,351	27,728	35,229	36,836
4A	14,683	20,116	30,394	38,616	40,378
4B	15,971	21,880	33,060	42,004	43,920
5A	18,032	24,704	37,326	47,424	49,588
5B	20,093	27,527	41,593	52,845	55,256
6A	21,123	28,939	43,725	55,553	58,088
6B	23,699	32,468	49,057	62,328	65,172
7	27,306	37,409	56,523	71,815	75,092
8	39,155	53,642	81,051	102,978	107,676

2. Occurrence Program – Area 9

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,250	5,780	8,543	10,583	11,008
1B	5,667	7,707	11,391	14,111	14,678
1C	6,659	9,056	13,385	16,581	17,247
1D	7,254	9,865	14,581	18,062	18,788
2A	7,934	10,790	15,947	19,756	20,549
2B	9,351	12,717	18,796	23,284	24,219
2C	11,051	15,029	22,213	27,517	28,622
2D	12,467	16,955	25,059	31,043	32,290
3A	13,317	18,244	27,566	35,024	36,622
3B	14,734	20,186	30,499	38,750	40,519
4A	16,151	22,127	33,433	42,477	44,415
4B	17,568	24,068	36,366	46,204	48,312
5A	19,835	27,174	41,058	52,166	54,546
5B	22,101	30,278	45,749	58,126	60,778
6A	23,235	31,832	48,096	61,108	63,896
6B	26,068	35,713	53,961	68,559	71,687
7	30,035	41,148	62,172	78,992	82,596
8	43,069	59,005	89,153	113,271	118,440

3. Standard Claims-Made Program – Area 1

~~a. Area 1~~

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,072	2,818	4,165	5,159	5,366
1B	2,763	3,758	5,554	6,880	7,156
1C	3,246	4,415	6,524	8,083	8,407
1D	3,536	4,809	7,107	8,805	9,158
2A	3,868	5,260	7,775	9,631	10,018
2B	4,558	6,199	9,162	11,349	11,805
2C	5,387	7,326	10,828	13,414	13,952
2D	6,078	8,266	12,217	15,134	15,742
3A	6,492	8,894	13,438	17,074	17,853
3B	7,183	9,841	14,869	18,891	19,753
4A	7,874	10,787	16,299	20,709	21,654
4B	8,564	11,733	17,727	22,523	23,551
5A	9,669	13,247	20,015	25,429	26,590
5B	10,774	14,760	22,302	28,336	29,629
6A	11,327	15,518	23,447	29,790	31,149
6B	12,708	17,410	26,306	33,422	34,947
7	14,642	20,060	30,309	38,508	40,266
8	20,996	28,765	43,462	55,219	57,739

3. Standard Claims-Made Program – Area 1

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,793	20,266	30,622	38,906	40,681
5A	16,701	22,880	34,571	43,924	45,928
5B	18,610	25,496	38,523	48,944	51,178
6A	19,565	26,804	40,500	51,456	53,804
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

3. Standard Claims-Made Program – Area 1

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,853	12,040	17,795	22,044	22,929
1D	9,644	13,116	19,384	24,014	24,978
2A	10,548	14,345	21,201	26,265	27,319
2B	12,432	16,908	24,988	30,956	32,199
2C	14,693	19,982	29,533	36,586	38,055
2D	16,576	22,543	33,318	41,274	42,932
3A	17,706	24,257	36,651	46,567	48,692
3B	19,590	26,838	40,551	51,522	53,873
4A	21,473	29,418	44,449	56,474	59,051
4B	23,357	31,999	48,349	61,429	64,232
5A	26,371	36,128	54,588	69,356	72,520
5B	29,384	40,256	60,825	77,280	80,806
6A	30,892	42,322	63,946	81,246	84,953
6B	34,659	47,483	71,744	91,153	95,312
7	39,933	54,708	82,661	105,024	109,816
8	57,263	78,450	118,534	150,602	157,473

3. Standard Claims-Made Program – Area 1

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,782	9,224	13,632	16,887	17,565
1B	9,041	12,296	18,172	22,512	23,416
1C	10,624	14,449	21,354	26,454	27,516
1D	11,573	15,739	23,262	28,817	29,974
2A	12,658	17,215	25,443	31,518	32,784
2B	14,918	20,288	29,985	37,146	38,638
2C	17,631	23,978	35,438	43,901	45,664
2D	19,891	27,052	39,981	49,529	51,518
3A	21,247	29,108	43,981	55,880	58,429
3B	23,508	32,206	48,662	61,826	64,647
4A	25,768	35,302	53,340	67,770	70,862
4B	28,029	38,400	58,020	73,716	77,080
5A	31,645	43,354	65,505	83,226	87,024
5B	35,261	48,308	72,990	92,736	96,968
6A	37,070	50,786	76,735	97,494	101,943
6B	41,591	56,980	86,093	109,384	114,375
7	47,920	65,650	99,194	126,030	131,780
8	68,715	94,140	142,240	180,720	188,966

3. Standard Claims-Made Program – Area 1

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,158	9,735	14,388	17,823	18,539
1B	9,544	12,980	19,183	23,765	24,719
1C	11,214	15,251	22,540	27,923	29,044
1D	12,216	16,614	24,554	30,418	31,639
2A	13,361	18,171	26,856	33,269	34,605
2B	15,747	21,416	31,651	39,210	40,785
2C	18,611	25,311	37,408	46,341	48,202
2D	20,996	28,555	42,202	52,280	54,380
3A	22,428	30,726	46,426	58,986	61,677
3B	24,814	33,995	51,365	65,261	68,239
4A	27,199	37,263	56,302	71,533	74,797
4B	29,586	40,533	61,243	77,811	81,362
5A	33,403	45,762	69,144	87,850	91,858
5B	37,220	50,991	77,045	97,889	102,355
6A	39,130	53,608	80,999	102,912	107,608
6B	43,901	60,144	90,875	115,460	120,728
7	50,582	69,297	104,705	133,031	139,101
8	72,533	99,370	150,143	190,762	199,466

3. Standard Claims-Made Program – Area 1

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,535	10,248	15,145	18,762	19,516
1B	10,046	13,663	20,192	25,015	26,019
1C	11,804	16,053	23,726	29,392	30,572
1D	12,859	17,488	25,847	32,019	33,305
2A	14,064	19,127	28,269	35,019	36,426
2B	16,576	22,543	33,318	41,274	42,932
2C	19,590	26,642	39,376	48,779	50,738
2D	22,101	30,057	44,423	55,031	57,242
3A	23,608	32,343	48,869	62,089	64,922
3B	26,120	35,784	54,068	68,696	71,830
4A	28,631	39,224	59,266	75,300	78,735
4B	31,143	42,666	64,466	81,906	85,643
5A	35,161	48,171	72,783	92,473	96,693
5B	39,179	53,675	81,101	103,041	107,742
6A	41,189	56,429	85,261	108,327	113,270
6B	46,212	63,310	95,659	121,538	127,083
7	53,244	72,944	110,215	140,032	146,421
8	76,350	104,600	158,045	200,801	209,963

3. Standard Claims-Made Program – Area 2

~~b. Area 2~~

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,865	2,536	3,749	4,644	4,830
1B	2,486	3,381	4,997	6,190	6,439
1C	2,921	3,973	5,871	7,273	7,565
1D	3,182	4,328	6,396	7,923	8,241
2A	3,481	4,734	6,997	8,668	9,016
2B	4,102	5,579	8,245	10,214	10,624
2C	4,848	6,593	9,744	12,072	12,556
2D	5,470	7,439	10,995	13,620	14,167
3A	5,843	8,005	12,095	15,367	16,068
3B	6,464	8,856	13,380	17,000	17,776
4A	7,086	9,708	14,668	18,636	19,487
4B	7,707	10,559	15,953	20,269	21,194
5A	8,702	11,922	18,013	22,886	23,931
5B	9,697	13,285	20,073	25,503	26,667
6A	10,194	13,966	21,102	26,810	28,034
6B	11,437	15,669	23,675	30,079	31,452
7	13,177	18,052	27,276	34,656	36,237
8	18,896	25,888	39,115	49,696	51,964

3. Standard Claims-Made Program – Area 2

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,294	5,840	8,631	10,692	11,121
1C	5,046	6,863	10,142	12,565	13,069
1D	5,497	7,476	11,049	13,688	14,237
2A	6,012	8,176	12,084	14,970	15,571
2B	7,086	9,637	14,243	17,644	18,353
2C	8,374	11,389	16,832	20,851	21,689
2D	9,448	12,849	18,990	23,526	24,470
3A	10,092	13,826	20,890	26,542	27,753
3B	11,166	15,297	23,114	29,367	30,707
4A	12,239	16,767	25,335	32,189	33,657
4B	13,313	18,239	27,558	35,013	36,611
5A	15,031	20,592	31,114	39,532	41,335
5B	16,749	22,946	34,670	44,050	46,060
6A	17,607	24,122	36,446	46,306	48,419
6B	19,755	27,064	40,893	51,956	54,326
7	22,761	31,183	47,115	59,861	62,593
8	32,638	44,714	67,561	85,838	89,755

3. Standard Claims-Made Program – Area 2

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,781	9,222	13,630	16,885	17,563
1C	7,967	10,835	16,014	19,838	20,635
1D	8,679	11,803	17,445	21,611	22,479
2A	9,493	12,910	19,081	23,638	24,587
2B	11,189	15,217	22,490	27,861	28,980
2C	13,223	17,983	26,578	32,925	34,248
2D	14,918	20,288	29,985	37,146	38,638
3A	15,935	21,831	32,985	41,909	43,821
3B	17,630	24,153	36,494	46,367	48,483
4A	19,325	26,475	40,003	50,825	53,144
4B	21,020	28,797	43,511	55,283	57,805
5A	23,733	32,514	49,127	62,418	65,266
5B	26,445	36,230	54,741	69,550	72,724
6A	27,801	38,087	57,548	73,117	76,453
6B	31,192	42,733	64,567	82,035	85,778
7	35,938	49,235	74,392	94,517	98,830
8	51,534	70,602	106,675	135,534	141,719

3. Standard Claims-Made Program – Area 2

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,103	8,300	12,267	15,196	15,807
1B	8,137	11,066	16,355	20,261	21,075
1C	9,561	13,003	19,218	23,807	24,763
1D	10,415	14,164	20,934	25,933	26,975
2A	11,391	15,492	22,896	28,364	29,503
2B	13,426	18,259	26,986	33,431	34,773
2C	15,867	21,579	31,893	39,509	41,096
2D	17,901	24,345	35,981	44,573	46,364
3A	19,121	26,196	39,580	50,288	52,583
3B	21,156	28,984	43,793	55,640	58,179
4A	23,190	31,770	48,003	60,990	63,773
4B	25,224	34,557	52,214	66,339	69,366
5A	28,480	39,018	58,954	74,902	78,320
5B	31,734	43,476	65,689	83,460	87,269
6A	33,361	45,705	69,057	87,739	91,743
6B	37,430	51,279	77,480	98,441	102,933
7	43,125	59,081	89,269	113,419	118,594
8	61,841	84,722	128,011	162,642	170,063

3. Standard Claims-Made Program – Area 2

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,442	8,761	12,948	16,041	16,685
1B	8,589	11,681	17,264	21,387	22,246
1C	10,092	13,725	20,285	25,129	26,138
1D	10,993	14,950	22,096	27,373	28,472
2A	12,024	16,353	24,168	29,940	31,142
2B	14,172	19,274	28,486	35,288	36,705
2C	16,749	22,779	33,665	41,705	43,380
2D	18,896	25,699	37,981	47,051	48,941
3A	20,184	27,652	41,781	53,084	55,506
3B	22,332	30,595	46,227	58,733	61,413
4A	24,479	33,536	50,672	64,380	67,317
4B	26,626	36,478	55,116	70,026	73,222
5A	30,062	41,185	62,228	79,063	82,671
5B	33,497	45,891	69,339	88,097	92,117
6A	35,215	48,245	72,895	92,615	96,841
6B	39,510	54,129	81,786	103,911	108,653
7	45,521	62,364	94,228	119,720	125,183
8	65,276	89,428	135,121	171,676	179,509

3. Standard Claims-Made Program – Area 2

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,781	9,222	13,630	16,885	17,563
1B	9,041	12,296	18,172	22,512	23,416
1C	10,623	14,447	21,352	26,451	27,514
1D	11,572	15,738	23,260	28,814	29,971
2A	12,657	17,214	25,441	31,516	32,782
2B	14,918	20,288	29,985	37,146	38,638
2C	17,630	23,977	35,436	43,899	45,662
2D	19,890	27,050	39,979	49,526	51,515
3A	21,246	29,107	43,979	55,877	58,427
3B	23,507	32,205	48,659	61,823	64,644
4A	25,767	35,301	53,338	67,767	70,859
4B	28,027	38,397	58,016	73,711	77,074
5A	31,644	43,352	65,503	83,224	87,021
5B	35,260	48,306	72,988	92,734	96,965
6A	37,068	50,783	76,731	97,489	101,937
6B	41,589	56,977	86,089	109,379	114,370
7	47,917	65,646	99,188	126,022	131,772
8	68,712	94,135	142,234	180,713	188,958

~~e. Area 3~~

3. Standard Claims-Made Program – Area 3

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,761	2,395	3,540	4,385	4,561
1B	2,348	3,193	4,719	5,847	6,081
1C	2,759	3,752	5,546	6,870	7,146
1D	3,006	4,088	6,042	7,485	7,786
2A	3,288	4,472	6,609	8,187	8,516
2B	3,874	5,269	7,787	9,646	10,034
2C	4,579	6,227	9,204	11,402	11,860
2D	5,166	7,026	10,384	12,863	13,380
3A	5,518	7,560	11,422	14,512	15,175
3B	6,105	8,364	12,637	16,056	16,789
4A	6,692	9,168	13,852	17,600	18,403
4B	7,280	9,974	15,070	19,146	20,020
5A	8,219	11,260	17,013	21,616	22,602
5B	9,158	12,546	18,957	24,086	25,185
6A	9,628	13,190	19,930	25,322	26,477
6B	10,802	14,799	22,360	28,409	29,706
7	12,446	17,051	25,763	32,733	34,227
8	17,846	24,449	36,941	46,935	49,077

3. Standard Claims-Made Program – Area 3

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,042	4,137	6,114	7,575	7,879
1B	4,056	5,516	8,153	10,099	10,505
1C	4,766	6,482	9,580	11,867	12,344
1D	5,192	7,061	10,436	12,928	13,447
2A	5,679	7,723	11,415	14,141	14,709
2B	6,692	9,101	13,451	16,663	17,332
2C	7,909	10,756	15,897	19,693	20,484
2D	8,923	12,135	17,935	22,218	23,111
3A	9,532	13,059	19,731	25,069	26,213
3B	10,545	14,447	21,828	27,733	28,999
4A	11,560	15,837	23,929	30,403	31,790
4B	12,574	17,226	26,028	33,070	34,579
5A	14,196	19,449	29,386	37,335	39,039
5B	15,818	21,671	32,743	41,601	43,500
6A	16,630	22,783	34,424	43,737	45,733
6B	18,658	25,561	38,622	49,071	51,310
7	21,497	29,451	44,499	56,537	59,117
8	30,826	42,232	63,810	81,072	84,772

3. Standard Claims-Made Program – Area 3

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,803	6,532	9,654	11,959	12,440
1B	6,404	8,709	12,872	15,946	16,586
1C	7,525	10,234	15,125	18,737	19,490
1D	8,198	11,149	16,478	20,413	21,233
2A	8,966	12,194	18,022	22,325	23,222
2B	10,567	14,371	21,240	26,312	27,369
2C	12,488	16,984	25,101	31,095	32,344
2D	14,090	19,162	28,321	35,084	36,493
3A	15,050	20,619	31,154	39,582	41,388
3B	16,651	22,812	34,468	43,792	45,790
4A	18,252	25,005	37,782	48,003	50,193
4B	19,853	27,199	41,096	52,213	54,596
5A	22,415	30,709	46,399	58,951	61,641
5B	24,977	34,218	51,702	65,690	68,687
6A	26,258	35,973	54,354	69,059	72,210
6B	29,459	40,359	60,980	77,477	81,012
7	33,943	46,502	70,262	89,270	93,343
8	48,672	66,681	100,751	128,007	133,848

3. Standard Claims-Made Program – Area 3

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,764	7,839	11,586	14,352	14,929
1B	7,685	10,452	15,447	19,136	19,904
1C	9,030	12,281	18,150	22,485	23,388
1D	9,837	13,378	19,772	24,494	25,478
2A	10,760	14,634	21,628	26,792	27,868
2B	12,680	17,245	25,487	31,573	32,841
2C	14,986	20,381	30,122	37,315	38,814
2D	16,907	22,994	33,983	42,098	43,789
3A	18,060	24,742	37,384	47,498	49,665
3B	19,981	27,374	41,361	52,550	54,948
4A	21,902	30,006	45,337	57,602	60,231
4B	23,824	32,639	49,316	62,657	65,516
5A	26,898	36,850	55,679	70,742	73,970
5B	29,972	41,062	62,042	78,826	82,423
6A	31,509	43,167	65,224	82,869	86,650
6B	35,351	48,431	73,177	92,973	97,215
7	40,731	55,801	84,313	107,123	112,010
8	58,406	80,016	120,900	153,608	160,617

3. Standard Claims-Made Program – Area 3

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,084	8,274	12,229	15,149	15,758
1B	8,112	11,032	16,305	20,199	21,010
1C	9,531	12,962	19,157	23,732	24,685
1D	10,384	14,122	20,872	25,856	26,895
2A	11,357	15,446	22,828	28,279	29,415
2B	13,385	18,204	26,904	33,329	34,667
2C	15,818	21,512	31,794	39,387	40,969
2D	17,847	24,272	35,872	44,439	46,224
3A	19,064	26,118	39,462	50,138	52,426
3B	21,091	28,895	43,658	55,469	58,000
4A	23,119	31,673	47,856	60,803	63,577
4B	25,147	34,451	52,054	66,137	69,154
5A	28,393	38,898	58,774	74,674	78,081
5B	31,637	43,343	65,489	83,205	87,002
6A	33,260	45,566	68,848	87,474	91,465
6B	37,315	51,122	77,242	98,138	102,616
7	42,994	58,902	88,998	113,074	118,234
8	61,651	84,462	127,618	162,142	169,540

3. Standard Claims-Made Program – Area 3

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,404	8,709	12,872	15,946	16,586
1B	8,539	11,613	17,163	21,262	22,116
1C	10,033	13,645	20,166	24,982	25,985
1D	10,930	14,865	21,969	27,216	28,309
2A	11,955	16,259	24,030	29,768	30,963
2B	14,089	19,161	28,319	35,082	36,491
2C	16,651	22,645	33,469	41,461	43,126
2D	18,786	25,549	37,760	46,777	48,656
3A	20,067	27,492	41,539	52,776	55,184
3B	22,201	30,415	45,956	58,389	61,053
4A	24,336	33,340	50,376	64,004	66,924
4B	26,471	36,265	54,795	69,619	72,795
5A	29,887	40,945	61,866	78,603	82,189
5B	33,302	45,624	68,935	87,584	91,581
6A	35,010	47,964	72,471	92,076	96,278
6B	39,279	53,812	81,308	103,304	108,017
7	45,257	62,002	93,682	119,026	124,457
8	64,896	88,908	134,335	170,676	178,464

~~d. Area 4~~

3. Standard Claims-Made Program – Area 4

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,554	2,113	3,124	3,869	4,025
1B	2,072	2,818	4,165	5,159	5,366
1C	2,435	3,312	4,894	6,063	6,307
1D	2,652	3,607	5,331	6,603	6,869
2A	2,901	3,945	5,831	7,223	7,514
2B	3,419	4,650	6,872	8,513	8,855
2C	4,041	5,496	8,122	10,062	10,466
2D	4,559	6,200	9,164	11,352	11,808
3A	4,869	6,671	10,079	12,805	13,390
3B	5,388	7,382	11,153	14,170	14,817
4A	5,906	8,091	12,225	15,533	16,242
4B	6,424	8,801	13,298	16,895	17,666
5A	7,253	9,937	15,014	19,075	19,946
5B	8,081	11,071	16,728	21,253	22,223
6A	8,496	11,640	17,587	22,344	23,364
6B	9,532	13,059	19,731	25,069	26,213
7	10,982	15,045	22,733	28,883	30,201
8	15,748	21,575	32,598	41,417	43,307

3. Standard Claims-Made Program – Area 4

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,684	3,650	5,395	6,683	6,952
1B	3,579	4,867	7,194	8,912	9,270
1C	4,206	5,720	8,454	10,473	10,894
1D	4,581	6,230	9,208	11,407	11,865
2A	5,011	6,815	10,072	12,477	12,978
2B	5,906	8,032	11,871	14,706	15,297
2C	6,979	9,491	14,028	17,378	18,076
2D	7,874	10,709	15,827	19,606	20,394
3A	8,411	11,523	17,411	22,121	23,130
3B	9,306	12,749	19,263	24,475	25,592
4A	10,201	13,975	21,116	26,829	28,053
4B	11,096	15,202	22,969	29,182	30,514
5A	12,527	17,162	25,931	32,946	34,449
5B	13,959	19,124	28,895	36,712	38,387
6A	14,675	20,105	30,377	38,595	40,356
6B	16,464	22,556	34,080	43,300	45,276
7	18,970	25,989	39,268	49,891	52,168
8	27,201	37,265	56,306	71,539	74,803

3. Standard Claims-Made Program – Area 4

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,238	5,764	8,518	10,553	10,976
1B	5,651	7,685	11,359	14,071	14,636
1C	6,641	9,032	13,348	16,536	17,200
1D	7,234	9,838	14,540	18,013	18,736
2A	7,912	10,760	15,903	19,701	20,492
2B	9,325	12,682	18,743	23,219	24,152
2C	11,020	14,987	22,150	27,440	28,542
2D	12,433	16,909	24,990	30,958	32,201
3A	13,280	18,194	27,490	34,926	36,520
3B	14,693	20,129	30,415	38,643	40,406
4A	16,106	22,065	33,339	42,359	44,292
4B	17,519	24,001	36,264	46,075	48,177
5A	19,780	27,099	40,945	52,021	54,395
5B	22,040	30,195	45,623	57,965	60,610
6A	23,171	31,744	47,964	60,940	63,720
6B	25,996	35,615	53,812	68,369	71,489
7	29,952	41,034	62,001	78,774	82,368
8	42,950	58,842	88,907	112,959	118,113

3. Standard Claims-Made Program – Area 4

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,782	9,224	13,632	16,887	17,565
1C	7,969	10,838	16,018	19,843	20,640
1D	8,681	11,806	17,449	21,616	22,484
2A	9,494	12,912	19,083	23,640	24,589
2B	11,190	15,218	22,492	27,863	28,982
2C	13,224	17,985	26,580	32,928	34,250
2D	14,919	20,290	29,987	37,148	38,640
3A	15,936	21,832	32,988	41,912	43,824
3B	17,632	24,156	36,498	46,372	48,488
4A	19,328	26,479	40,009	50,833	53,152
4B	21,023	28,802	43,518	55,290	57,813
5A	23,736	32,518	49,134	62,426	65,274
5B	26,448	36,234	54,747	69,558	72,732
6A	27,805	38,093	57,556	73,127	76,464
6B	31,195	42,737	64,574	82,043	85,786
7	35,942	49,241	74,400	94,527	98,841
8	51,539	70,608	106,686	135,548	141,732

3. Standard Claims-Made Program – Area 4

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,368	7,300	10,790	13,366	13,903
1B	7,158	9,735	14,388	17,823	18,539
1C	8,411	11,439	16,906	20,943	21,784
1D	9,163	12,462	18,418	22,816	23,732
2A	10,022	13,630	20,144	24,955	25,957
2B	11,811	16,063	23,740	29,409	30,590
2C	13,958	18,983	28,056	34,755	36,151
2D	15,748	21,417	31,653	39,213	40,787
3A	16,822	23,046	34,822	44,242	46,261
3B	18,611	25,497	38,525	48,947	51,180
4A	20,401	27,949	42,230	53,655	56,103
4B	22,191	30,402	45,935	58,362	61,025
5A	25,054	34,324	51,862	65,892	68,899
5B	27,918	38,248	57,790	73,424	76,775
6A	29,349	40,208	60,752	77,188	80,710
6B	32,928	45,111	68,161	86,601	90,552
7	37,939	51,976	78,534	99,780	104,332
8	54,403	74,532	112,614	143,080	149,608

3. Standard Claims-Made Program – Area 4

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,854	12,041	17,797	22,046	22,932
1D	9,645	13,117	19,386	24,016	24,981
2A	10,549	14,347	21,203	26,267	27,322
2B	12,433	16,909	24,990	30,958	32,201
2C	14,693	19,982	29,533	36,586	38,055
2D	16,577	22,545	33,320	41,277	42,934
3A	17,707	24,259	36,653	46,569	48,694
3B	19,591	26,840	40,553	51,524	53,875
4A	21,475	29,421	44,453	56,479	59,056
4B	23,359	32,002	48,353	61,434	64,237
5A	26,373	36,131	54,592	69,361	72,526
5B	29,387	40,260	60,831	77,288	80,814
6A	30,894	42,325	63,951	81,251	84,959
6B	34,661	47,486	71,748	91,158	95,318
7	39,936	54,712	82,668	105,032	109,824
8	57,266	78,454	118,541	150,610	157,482

~~e. Area 5~~

3. Standard Claims-Made Program – Area 5

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,450	1,972	2,915	3,611	3,756
1B	1,934	2,630	3,887	4,816	5,009
1C	2,272	3,090	4,567	5,657	5,884
1D	2,475	3,366	4,975	6,163	6,410
2A	2,707	3,682	5,441	6,740	7,011
2B	3,191	4,340	6,414	7,946	8,265
2C	3,771	5,129	7,580	9,390	9,767
2D	4,254	5,785	8,551	10,592	11,018
3A	4,544	6,225	9,406	11,951	12,496
3B	5,028	6,888	10,408	13,224	13,827
4A	5,511	7,550	11,408	14,494	15,155
4B	5,995	8,213	12,410	15,767	16,486
5A	6,768	9,272	14,010	17,800	18,612
5B	7,542	10,333	15,612	19,835	20,741
6A	7,929	10,863	16,413	20,853	21,805
6B	8,895	12,186	18,413	23,394	24,461
7	10,249	14,041	21,215	26,955	28,185
8	14,697	20,135	30,423	38,653	40,417

3. Standard Claims-Made Program – Area 5

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,505	3,407	5,035	6,237	6,488
1B	3,340	4,542	6,713	8,317	8,651
1C	3,925	5,338	7,889	9,773	10,166
1D	4,275	5,814	8,593	10,645	11,072
2A	4,676	6,359	9,399	11,643	12,111
2B	5,511	7,495	11,077	13,722	14,273
2C	6,513	8,858	13,091	16,217	16,869
2D	7,348	9,993	14,769	18,297	19,031
3A	7,849	10,753	16,247	20,643	21,585
3B	8,684	11,897	17,976	22,839	23,881
4A	9,519	13,041	19,704	25,035	26,177
4B	10,355	14,186	21,435	27,234	28,476
5A	11,691	16,017	24,200	30,747	32,150
5B	13,027	17,847	26,966	34,261	35,824
6A	13,695	18,762	28,349	36,018	37,661
6B	15,365	21,050	31,806	40,410	42,254
7	17,703	24,253	36,645	46,559	48,683
8	25,385	34,777	52,547	66,763	69,809

3. Standard Claims-Made Program – Area 5

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,956	5,380	7,952	9,850	10,246
1B	5,274	7,173	10,601	13,132	13,660
1C	6,197	8,428	12,456	15,431	16,050
1D	6,751	9,181	13,570	16,810	17,485
2A	7,384	10,042	14,842	18,386	19,125
2B	8,702	11,835	17,491	21,668	22,538
2C	10,284	13,986	20,671	25,607	26,636
2D	11,603	15,780	23,322	28,891	30,052
3A	12,394	16,980	25,656	32,596	34,084
3B	13,712	18,785	28,384	36,063	37,708
4A	15,031	20,592	31,114	39,532	41,335
4B	16,349	22,398	33,842	42,998	44,960
5A	18,459	25,289	38,210	48,547	50,762
5B	20,569	28,180	42,578	54,096	56,565
6A	21,623	29,624	44,760	56,868	59,463
6B	24,260	33,236	50,218	63,804	66,715
7	27,953	38,296	57,863	73,516	76,871
8	40,082	54,912	82,970	105,416	110,226

3. Standard Claims-Made Program – Area 5

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,747	6,456	9,541	11,820	12,295
1B	6,329	8,607	12,721	15,759	16,392
1C	7,437	10,114	14,948	18,518	19,262
1D	8,101	11,017	16,283	20,171	20,982
2A	8,861	12,051	17,811	22,064	22,950
2B	10,443	14,202	20,990	26,003	27,047
2C	12,341	16,784	24,805	30,729	31,963
2D	13,923	18,935	27,985	34,668	36,061
3A	14,873	20,376	30,787	39,116	40,901
3B	16,455	22,543	34,062	43,277	45,251
4A	18,037	24,711	37,337	47,437	49,602
4B	19,619	26,878	40,611	51,598	53,952
5A	22,151	30,347	45,853	58,257	60,915
5B	24,683	33,816	51,094	64,916	67,878
6A	25,948	35,549	53,712	68,243	71,357
6B	29,112	39,883	60,262	76,565	80,058
7	33,543	45,954	69,434	88,218	92,243
8	48,099	65,896	99,565	126,500	132,272

3. Standard Claims-Made Program – Area 5

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,010	6,814	10,070	12,475	12,976
1B	6,680	9,085	13,427	16,633	17,301
1C	7,850	10,676	15,779	19,547	20,332
1D	8,551	11,629	17,188	21,292	22,147
2A	9,353	12,720	18,800	23,289	24,224
2B	11,023	14,991	22,156	27,447	28,550
2C	13,026	17,715	26,182	32,435	33,737
2D	14,697	19,988	29,541	36,596	38,065
3A	15,699	21,508	32,497	41,288	43,172
3B	17,369	23,796	35,954	45,680	47,765
4A	19,039	26,083	39,411	50,073	52,357
4B	20,709	28,371	42,868	54,465	56,950
5A	23,381	32,032	48,399	61,492	64,298
5B	26,054	35,694	53,932	68,522	71,649
6A	27,389	37,523	56,695	72,033	75,320
6B	30,730	42,100	63,611	80,820	84,508
7	35,407	48,508	73,292	93,120	97,369
8	50,771	69,556	105,096	133,528	139,620

3. Standard Claims-Made Program – Area 5

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,274	7,173	10,601	13,132	13,660
1B	7,032	9,564	14,134	17,510	18,213
1C	8,263	11,238	16,609	20,575	21,401
1D	9,001	12,241	18,092	22,412	23,313
2A	9,845	13,389	19,788	24,514	25,499
2B	11,603	15,780	23,322	28,891	30,052
2C	13,712	18,648	27,561	34,143	35,514
2D	15,470	21,039	31,095	38,520	40,067
3A	16,525	22,639	34,207	43,461	45,444
3B	18,283	25,048	37,846	48,084	50,278
4A	20,041	27,456	41,485	52,708	55,113
4B	21,799	29,865	45,124	57,331	59,947
5A	24,612	33,718	50,947	64,730	67,683
5B	27,425	37,572	56,770	72,128	75,419
6A	28,831	39,498	59,680	75,826	79,285
6B	32,347	44,315	66,958	85,073	88,954
7	37,270	51,060	77,149	98,020	102,493
8	53,443	73,217	110,627	140,555	146,968

~~f. Area 6~~

3. Standard Claims-Made Program – Area 6

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,243	1,690	2,498	3,095	3,219
1B	1,658	2,255	3,333	4,128	4,294
1C	1,948	2,649	3,915	4,851	5,045
1D	2,122	2,886	4,265	5,284	5,496
2A	2,321	3,157	4,665	5,779	6,011
2B	2,735	3,720	5,497	6,810	7,084
2C	3,233	4,397	6,498	8,050	8,373
2D	3,647	4,960	7,330	9,081	9,446
3A	3,896	5,338	8,065	10,246	10,714
3B	4,310	5,905	8,922	11,335	11,853
4A	4,725	6,473	9,781	12,427	12,994
4B	5,139	7,040	10,638	13,516	14,132
5A	5,802	7,949	12,010	15,259	15,956
5B	6,465	8,857	13,383	17,003	17,779
6A	6,797	9,312	14,070	17,876	18,692
6B	7,625	10,446	15,784	20,054	20,969
7	8,786	12,037	18,187	23,107	24,162
8	12,599	17,261	26,080	33,135	34,647

3. Standard Claims-Made Program – Area 6

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,147	2,920	4,315	5,346	5,561
1B	2,863	3,894	5,755	7,129	7,415
1C	3,364	4,575	6,762	8,376	8,713
1D	3,665	4,984	7,367	9,126	9,492
2A	4,009	5,452	8,058	9,982	10,383
2B	4,724	6,425	9,495	11,763	12,235
2C	5,584	7,594	11,224	13,904	14,463
2D	6,299	8,567	12,661	15,685	16,314
3A	6,729	9,219	13,929	17,697	18,505
3B	7,445	10,200	15,411	19,580	20,474
4A	8,161	11,181	16,893	21,463	22,443
4B	8,876	12,160	18,373	23,344	24,409
5A	10,022	13,730	20,746	26,358	27,561
5B	11,167	15,299	23,116	29,369	30,709
6A	11,740	16,084	24,302	30,876	32,285
6B	13,171	18,044	27,264	34,640	36,220
7	15,175	20,790	31,412	39,910	41,731
8	21,761	29,813	45,045	57,231	59,843

3. Standard Claims-Made Program – Area 6

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,947	13,528	19,993	24,768	25,763
3A	10,625	14,556	21,994	27,944	29,219
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

3. Standard Claims-Made Program – Area 6

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,069	5,534	8,179	10,132	10,539
1B	5,425	7,378	10,904	13,508	14,051
1C	6,375	8,670	12,814	15,874	16,511
1D	6,944	9,444	13,957	17,291	17,985
2A	7,595	10,329	15,266	18,912	19,671
2B	8,951	12,173	17,992	22,288	23,183
2C	10,580	14,389	21,266	26,344	27,402
2D	11,936	16,233	23,991	29,721	30,914
3A	12,749	17,466	26,390	33,530	35,060
3B	14,106	19,325	29,199	37,099	38,792
4A	15,462	21,183	32,006	40,665	42,521
4B	16,818	23,041	34,813	44,231	46,250
5A	18,988	26,014	39,305	49,938	52,217
5B	21,158	28,986	43,797	55,646	58,185
6A	22,244	30,474	46,045	58,502	61,171
6B	24,956	34,190	51,659	65,634	68,629
7	28,753	39,392	59,519	75,620	79,071
8	41,232	56,488	85,350	108,440	113,388

3. Standard Claims-Made Program – Area 6

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,295	5,841	8,633	10,695	11,124
1B	5,727	7,789	11,511	14,260	14,833
1C	6,729	9,151	13,525	16,755	17,428
1D	7,330	9,969	14,733	18,252	18,985
2A	8,017	10,903	16,114	19,962	20,764
2B	9,449	12,851	18,992	23,528	24,473
2C	11,167	15,187	22,446	27,806	28,923
2D	12,599	17,135	25,324	31,372	32,631
3A	13,458	18,437	27,858	35,395	37,010
3B	14,889	20,398	30,820	39,158	40,945
4A	16,321	22,360	33,784	42,924	44,883
4B	17,753	24,322	36,749	46,690	48,821
5A	20,043	27,459	41,489	52,713	55,118
5B	22,334	30,598	46,231	58,738	61,419
6A	23,479	32,166	48,602	61,750	64,567
6B	26,343	36,090	54,530	69,282	72,443
7	30,351	41,581	62,827	79,823	83,465
8	43,522	59,625	90,091	114,463	119,686

3. Standard Claims-Made Program – Area 6

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,521	6,149	9,087	11,257	11,709
1B	6,028	8,198	12,116	15,010	15,613
1C	7,083	9,633	14,237	17,637	18,345
1D	7,716	10,494	15,509	19,213	19,984
2A	8,439	11,477	16,962	21,013	21,857
2B	9,946	13,527	19,991	24,766	25,760
2C	11,755	15,987	23,628	29,270	30,445
2D	13,262	18,036	26,657	33,022	34,349
3A	14,166	19,407	29,324	37,257	38,957
3B	15,673	21,472	32,443	41,220	43,101
4A	17,180	23,537	35,563	45,183	47,245
4B	18,687	25,601	38,682	49,147	51,389
5A	21,098	28,904	43,673	55,488	58,020
5B	23,509	32,207	48,664	61,829	64,650
6A	24,715	33,860	51,160	65,000	67,966
6B	27,729	37,989	57,399	72,927	76,255
7	31,948	43,769	66,132	84,023	87,857
8	45,813	62,764	94,833	120,488	125,986

~~g. Area 7~~

3. Standard Claims-Made Program – Area 7

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	933	1,269	1,875	2,323	2,416
1B	1,243	1,690	2,498	3,095	3,219
1C	1,461	1,987	2,937	3,638	3,784
1D	1,591	2,164	3,198	3,962	4,121
2A	1,740	2,366	3,497	4,333	4,507
2B	2,052	2,791	4,125	5,109	5,315
2C	2,424	3,297	4,872	6,036	6,278
2D	2,735	3,720	5,497	6,810	7,084
3A	2,922	4,003	6,049	7,685	8,036
3B	3,233	4,429	6,692	8,503	8,891
4A	3,543	4,854	7,334	9,318	9,743
4B	3,854	5,280	7,978	10,136	10,599
5A	4,352	5,962	9,009	11,446	11,968
5B	4,849	6,643	10,037	12,753	13,335
6A	5,097	6,983	10,551	13,405	14,017
6B	5,719	7,835	11,838	15,041	15,727
7	6,589	9,027	13,639	17,329	18,120
8	9,449	12,945	19,559	24,851	25,985

3. Standard Claims-Made Program – Area 7

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,611	2,191	3,238	4,011	4,172
1B	2,147	2,920	4,315	5,346	5,561
1C	2,523	3,431	5,071	6,282	6,535
1D	2,749	3,739	5,525	6,845	7,120
2A	3,006	4,088	6,042	7,485	7,786
2B	3,544	4,820	7,123	8,825	9,179
2C	4,188	5,696	8,418	10,428	10,847
2D	4,724	6,425	9,495	11,763	12,235
3A	5,046	6,913	10,445	13,271	13,877
3B	5,584	7,650	11,559	14,686	15,356
4A	6,120	8,384	12,668	16,096	16,830
4B	6,657	9,120	13,780	17,508	18,307
5A	7,516	10,297	15,558	19,767	20,669
5B	8,375	11,474	17,336	22,026	23,031
6A	8,805	12,063	18,226	23,157	24,214
6B	9,879	13,534	20,450	25,982	27,167
7	11,381	15,592	23,559	29,932	31,298
8	16,321	22,360	33,784	42,924	44,883

3. Standard Claims-Made Program – Area 7

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,543	3,458	5,111	6,332	6,586
1B	3,391	4,612	6,816	8,444	8,783
1C	3,984	5,418	8,008	9,920	10,319
1D	4,340	5,902	8,723	10,807	11,241
2A	4,747	6,456	9,541	11,820	12,295
2B	5,595	7,609	11,246	13,932	14,491
2C	6,612	8,992	13,290	16,464	17,125
2D	7,460	10,146	14,995	18,575	19,321
3A	7,968	10,916	16,494	20,956	21,912
3B	8,816	12,078	18,249	23,186	24,244
4A	9,664	13,240	20,004	25,416	26,576
4B	10,511	14,400	21,758	27,644	28,905
5A	11,868	16,259	24,567	31,213	32,637
5B	13,224	18,117	27,374	34,779	36,366
6A	13,902	19,046	28,777	36,562	38,231
6B	15,598	21,369	32,288	41,023	42,895
7	17,971	24,620	37,200	47,264	49,420
8	25,770	35,305	53,344	67,775	70,868

3. Standard Claims-Made Program – Area 7

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,052	4,151	6,135	7,599	7,905
1B	4,069	5,534	8,179	10,132	10,539
1C	4,781	6,502	9,610	11,905	12,383
1D	5,208	7,083	10,468	12,968	13,489
2A	5,696	7,747	11,449	14,183	14,753
2B	6,714	9,131	13,495	16,718	17,389
2C	7,934	10,790	15,947	19,756	20,549
2D	8,951	12,173	17,992	22,288	23,183
3A	9,562	13,100	19,793	25,148	26,296
3B	10,580	14,495	21,901	27,825	29,095
4A	11,597	15,888	24,006	30,500	31,892
4B	12,614	17,281	26,111	33,175	34,689
5A	14,242	19,512	29,481	37,456	39,166
5B	15,869	21,741	32,849	41,735	43,640
6A	16,682	22,854	34,532	43,874	45,876
6B	18,717	25,642	38,744	49,226	51,472
7	21,565	29,544	44,640	56,716	59,304
8	30,924	42,366	64,013	81,330	85,041

3. Standard Claims-Made Program – Area 7

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,295	5,841	8,633	10,695	11,124
1C	5,046	6,863	10,142	12,565	13,069
1D	5,498	7,477	11,051	13,690	14,240
2A	6,013	8,178	12,086	14,972	15,574
2B	7,087	9,638	14,245	17,647	18,355
2C	8,375	11,390	16,834	20,854	21,691
2D	9,449	12,851	18,992	23,528	24,473
3A	10,093	13,827	20,893	26,545	27,756
3B	11,167	15,299	23,116	29,369	30,709
4A	12,241	16,770	25,339	32,194	33,663
4B	13,314	18,240	27,560	35,016	36,614
5A	15,033	20,595	31,118	39,537	41,341
5B	16,750	22,948	34,673	44,053	46,063
6A	17,609	24,124	36,451	46,312	48,425
6B	19,757	27,067	40,897	51,961	54,332
7	22,763	31,185	47,119	59,867	62,598
8	32,642	44,720	67,569	85,848	89,766

3. Standard Claims-Made Program – Area 7

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

~~h. Area 8~~

3. Standard Claims-Made Program – Area 8

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,036	1,409	2,082	2,580	2,683
1B	1,381	1,878	2,776	3,439	3,577
1C	1,623	2,207	3,262	4,041	4,204
1D	1,768	2,404	3,554	4,402	4,579
2A	1,934	2,630	3,887	4,816	5,009
2B	2,279	3,099	4,581	5,675	5,903
2C	2,694	3,664	5,415	6,708	6,977
2D	3,039	4,133	6,108	7,567	7,871
3A	3,246	4,447	6,719	8,537	8,927
3B	3,592	4,921	7,435	9,447	9,878
4A	3,937	5,394	8,150	10,354	10,827
4B	4,282	5,866	8,864	11,262	11,776
5A	4,835	6,624	10,008	12,716	13,296
5B	5,387	7,380	11,151	14,168	14,814
6A	5,663	7,758	11,722	14,894	15,573
6B	6,354	8,705	13,153	16,711	17,474
7	7,321	10,030	15,154	19,254	20,133
8	10,498	14,382	21,731	27,610	28,870

3. Standard Claims-Made Program – Area 8

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,789	2,433	3,596	4,455	4,634
1B	2,386	3,245	4,796	5,941	6,180
1C	2,803	3,812	5,634	6,979	7,260
1D	3,054	4,153	6,139	7,604	7,910
2A	3,340	4,542	6,713	8,317	8,651
2B	3,937	5,354	7,913	9,803	10,197
2C	4,653	6,328	9,353	11,586	12,051
2D	5,249	7,139	10,550	13,070	13,595
3A	5,607	7,682	11,606	14,746	15,419
3B	6,204	8,499	12,842	16,317	17,061
4A	6,800	9,316	14,076	17,884	18,700
4B	7,396	10,133	15,310	19,451	20,339
5A	8,351	11,441	17,287	21,963	22,965
5B	9,305	12,748	19,261	24,472	25,589
6A	9,782	13,401	20,249	25,727	26,901
6B	10,975	15,036	22,718	28,864	30,181
7	12,645	17,324	26,175	33,256	34,774
8	18,133	24,842	37,535	47,690	49,866

3. Standard Claims-Made Program – Area 8

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,825	3,842	5,678	7,034	7,317
1B	3,767	5,123	7,572	9,380	9,757
1C	4,427	6,021	8,898	11,023	11,466
1D	4,822	6,558	9,692	12,007	12,489
2A	5,274	7,173	10,601	13,132	13,660
2B	6,216	8,454	12,494	15,478	16,099
2C	7,346	9,991	14,765	18,292	19,026
2D	8,288	11,272	16,659	20,637	21,466
3A	8,853	12,129	18,326	23,283	24,346
3B	9,795	13,419	20,276	25,761	26,936
4A	10,737	14,710	22,226	28,238	29,527
4B	11,678	15,999	24,173	30,713	32,115
5A	13,186	18,065	27,295	34,679	36,262
5B	14,693	20,129	30,415	38,643	40,406
6A	15,446	21,161	31,973	40,623	42,477
6B	17,330	23,742	35,873	45,578	47,658
7	19,967	27,355	41,332	52,513	54,909
8	28,631	39,224	59,266	75,300	78,735

3. Standard Claims-Made Program – Area 8

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,390	4,610	6,814	8,441	8,780
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,786	7,869	11,630	14,407	14,986
2A	6,329	8,607	12,721	15,759	16,392
2B	7,459	10,144	14,993	18,573	19,319
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,754	16,103	24,331	30,913	32,324
4A	12,884	17,651	26,670	33,885	35,431
4B	14,014	19,199	29,009	36,857	38,539
5A	15,823	21,678	32,754	41,614	43,513
5B	17,631	24,154	36,496	46,370	48,485
6A	18,535	25,393	38,367	48,747	50,971
6B	20,795	28,489	43,046	54,691	57,186
7	23,960	32,825	49,597	63,015	65,890
8	34,358	47,070	71,121	90,362	94,485

3. Standard Claims-Made Program – Area 8

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,792	20,265	30,619	38,903	40,678
5A	16,702	22,882	34,573	43,926	45,931
5B	18,611	25,497	38,525	48,947	51,180
6A	19,564	26,803	40,497	51,453	53,801
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

3. Standard Claims-Made Program – Area 8

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,767	5,123	7,572	9,380	9,757
1B	5,023	6,831	10,096	12,507	13,010
1C	5,902	8,027	11,863	14,696	15,286
1D	6,429	8,743	12,922	16,008	16,651
2A	7,032	9,564	14,134	17,510	18,213
2B	8,288	11,272	16,659	20,637	21,466
2C	9,795	13,321	19,688	24,390	25,369
2D	11,051	15,029	22,213	27,517	28,622
3A	11,804	16,171	24,434	31,045	32,461
3B	13,060	17,892	27,034	34,348	35,915
4A	14,316	19,613	29,634	37,651	39,369
4B	15,571	21,332	32,232	40,952	42,820
5A	17,581	24,086	36,393	46,238	48,348
5B	19,590	26,838	40,551	51,522	53,873
6A	20,594	28,214	42,630	54,162	56,634
6B	23,106	31,655	47,829	60,769	63,542
7	26,622	36,472	55,108	70,016	73,211
8	38,175	52,300	79,022	100,400	104,981

3. Standard Claims-Made Program – Area 9

0 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,140	1,550	2,291	2,839	2,953
1B	1,519	2,066	3,053	3,782	3,934
1C	1,785	2,428	3,588	4,445	4,623
1D	1,945	2,645	3,909	4,843	5,038
2A	2,127	2,893	4,275	5,296	5,509
2B	2,507	3,410	5,039	6,242	6,493
2C	2,963	4,030	5,956	7,378	7,674
2D	3,343	4,546	6,719	8,324	8,658
3A	3,571	4,892	7,392	9,392	9,820
3B	3,950	5,412	8,177	10,389	10,863
4A	4,330	5,932	8,963	11,388	11,908
4B	4,710	6,453	9,750	12,387	12,953
5A	5,318	7,286	11,008	13,986	14,625
5B	5,926	8,119	12,267	15,585	16,297
6A	6,230	8,535	12,896	16,385	17,133
6B	6,989	9,575	14,467	18,381	19,220
7	8,053	11,033	16,670	21,179	22,146
8	11,547	15,819	23,902	30,369	31,754

3. Standard Claims-Made Program – Area 9

1 Year Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,968	2,676	3,956	4,900	5,097
1B	2,624	3,569	5,274	6,534	6,796
1C	3,084	4,194	6,199	7,679	7,988
1D	3,359	4,568	6,752	8,364	8,700
2A	3,674	4,997	7,385	9,148	9,516
2B	4,330	5,889	8,703	10,782	11,215
2C	5,118	6,960	10,287	12,744	13,256
2D	5,774	7,853	11,606	14,377	14,955
3A	6,167	8,449	12,766	16,219	16,959
3B	6,823	9,348	14,124	17,944	18,763
4A	7,479	10,246	15,482	19,670	20,567
4B	8,136	11,146	16,842	21,398	22,374
5A	9,186	12,585	19,015	24,159	25,262
5B	10,235	14,022	21,186	26,918	28,146
6A	10,760	14,741	22,273	28,299	29,590
6B	12,072	16,539	24,989	31,749	33,198
7	13,909	19,055	28,792	36,581	38,250
8	19,945	27,325	41,286	52,455	54,849

3. Standard Claims-Made Program – Area 9

2 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,108	4,227	6,247	7,739	8,050
1B	4,144	5,636	8,329	10,319	10,733
1C	4,869	6,622	9,787	12,124	12,611
1D	5,304	7,213	10,661	13,207	13,737
2A	5,801	7,889	11,660	14,444	15,025
2B	6,837	9,298	13,742	17,024	17,708
2C	8,081	10,990	16,243	20,122	20,930
2D	9,116	12,398	18,323	22,699	23,610
3A	9,738	13,341	20,158	25,611	26,780
3B	10,774	14,760	22,302	28,336	29,629
4A	11,810	16,180	24,447	31,060	32,478
4B	12,846	17,599	26,591	33,785	35,327
5A	14,504	19,870	30,023	38,146	39,886
5B	16,161	22,141	33,453	42,503	44,443
6A	16,990	23,276	35,169	44,684	46,723
6B	19,061	26,114	39,456	50,130	52,418
7	21,962	30,088	45,461	57,760	60,396
8	31,493	43,145	65,191	82,827	86,606

3. Standard Claims-Made Program – Area 9

3 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,730	5,073	7,497	9,288	9,661
1B	4,973	6,763	9,996	12,383	12,880
1C	5,843	7,946	11,744	14,549	15,133
1D	6,365	8,656	12,794	15,849	16,485
2A	6,962	9,468	13,994	17,335	18,032
2B	8,204	11,157	16,490	20,428	21,248
2C	9,697	13,188	19,491	24,146	25,115
2D	10,940	14,878	21,989	27,241	28,335
3A	11,686	16,010	24,190	30,734	32,137
3B	12,929	17,713	26,763	34,003	35,555
4A	14,171	19,414	29,334	37,270	38,970
4B	15,415	21,119	31,909	40,541	42,391
5A	17,404	23,843	36,026	45,773	47,861
5B	19,393	26,568	40,144	51,004	53,331
6A	20,388	27,932	42,203	53,620	56,067
6B	22,874	31,337	47,349	60,159	62,904
7	26,355	36,106	54,555	69,314	72,476
8	37,791	51,774	78,227	99,390	103,925

3. Standard Claims-Made Program – Area 9

4 Years Since Retroactive Date

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,937	5,354	7,913	9,803	10,197
1B	5,249	7,139	10,550	13,070	13,595
1C	6,167	8,387	12,396	15,356	15,973
1D	6,718	9,136	13,503	16,728	17,400
2A	7,348	9,993	14,769	18,297	19,031
2B	8,660	11,778	17,407	21,563	22,429
2C	10,235	13,920	20,572	25,485	26,509
2D	11,547	15,704	23,209	28,752	29,907
3A	12,335	16,899	25,533	32,441	33,921
3B	13,647	18,696	28,249	35,892	37,529
4A	14,959	20,494	30,965	39,342	41,137
4B	16,272	22,293	33,683	42,795	44,748
5A	18,371	25,168	38,028	48,316	50,520
5B	20,471	28,045	42,375	53,839	56,295
6A	21,520	29,482	44,546	56,598	59,180
6B	24,144	33,077	49,978	63,499	66,396
7	27,819	38,112	57,585	73,164	76,502
8	39,891	54,651	82,574	104,913	109,700

3. Standard Claims-Made Program – Area 9

Mature

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,144	5,636	8,329	10,319	10,733
1B	5,525	7,514	11,105	13,757	14,310
1C	6,492	8,829	13,049	16,165	16,814
1D	7,072	9,618	14,215	17,609	18,316
2A	7,735	10,520	15,547	19,260	20,034
2B	9,116	12,398	18,323	22,699	23,610
2C	10,774	14,653	21,656	26,827	27,905
2D	12,155	16,531	24,432	30,266	31,481
3A	12,984	17,788	26,877	34,148	35,706
3B	14,365	19,680	29,736	37,780	39,504
4A	15,746	21,572	32,594	41,412	43,302
4B	17,128	23,465	35,455	45,047	47,102
5A	19,338	26,493	40,030	50,859	53,180
5B	21,548	29,521	44,604	56,671	59,257
6A	22,653	31,035	46,892	59,577	62,296
6B	25,415	34,819	52,609	66,841	69,891
7	29,283	40,118	60,616	77,014	80,528
8	41,990	57,526	86,919	110,434	115,473

3. Increased Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

4. Excess Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
1M/1M xs 1M/3M	1.270	1.300	1.300
2M/2M xs 1M/3M	1.430	1.480	1.480
3M/3M xs 1M/3M	1.560	1.620	1.620
4M/4M xs 1M/3M	1.670	1.740	1.740

Note: For aggregate limits not listed above, refer to company.

5. Extended Reporting Period Coverage Factors

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.700
4 OR MORE	1.820

6. Shared Limits Modification

Modification
Up to 25%

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Physician & Surgeons	$250

D. **Premium Modifications**

1. **Part Time Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

3. **Locum Tenens**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

4. **Temporary Staffing Agency Rating**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **New Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

6. **Physician Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

7. **Physicians Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

8. **Physicians Military Leave of Absence Credit**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification -50% / +50%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

10. **Risk Management**
(Occurrence, & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

11. **Claim Free Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 8	10%
8 but less than 10	15%
10 or more	20%

12. **Deductible Credits**
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non-Discretionary Debit Rating Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Claim Threshold	Points
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

Schedule B:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code. ***Refer to the Classification Translation Table – Specialty Description to ISO Code at the end of this section.***

16. **Small Group & Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Convertible Coverage Rating Plan**

NOT AVAILABLE

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

20. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
$250,000

~~**NOT AVAILABLE**~~

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

25. **Membership Credit**
(Occurrence & Standard Claims Made Programs)

Credit
5%

26. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max AvailableCredit
50%

27. **Quarterly Installment Option**
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

28. **Convertible Plus / Nose Rating Plan**
(Occurrence Program)

A healthcare provider that is currently insured under a claims-made policy form may be eligible for Convertible / Nose coverage, subject to underwriting guidelines. This coverage will provide nose coverage to healthcare providers that seek to convert to an occurrence policy form. The rating for such coverage is based upon the insureds standard mature claims made rate times the factor identified in the table below.

Years Retroactive Date Precedes Policy Inception Date	Factor
1	.75
2	1.08
3	1.18
4 or More	1.25

The applicable premium under this plan shall be in addition to the healthcare provider's standard occurrence premium and shall be paid to the Company over an installment period.

In the event the insured cancels the occurrence coverage, within the first five years subsequent to the issuance of the product, for reasons other than non-renewal, death, total and permanent disability or permanent retirement, additional premium shall be due and payable. Additional premium shall be calculated at the Company's filed rate for an extension contract endorsement at the time the Convertible Plus Claims Made coverage is issued. Any unpaid balance between this amount and any payments made prior to the cancellation date is due sixty (60) days from the date of cancellation.

The rating under this rule is subject to applicable Part-Time and Schedule Rating modifications.

*****Classification Translation Table – Specialty Description to ISO Code**

	Speciality Code	MD	DO	Class
Allergy	39	80254	84254	1A
Cardiology (Including Swan-Ganz)	33	80255	84255	2A
Dermatology	31	80256	84256	1A
Family/General Practice	19	80420	84420	1C
Aerospace	19	80230	84230	1A
Forensic Medicine	36	80240	84240	1A
Geriatrics	32	80243	84243	1B
Nuclear Medicine	37	80262	84262	1A
Nutrition	32	80248	84248	1A
Occupational Medicine	19	80233	84233	1A
Physiatry	19	80235	84235	1A
Public Health	19	80236	84236	1A
Gynecology	15	80244	84244	1B
Internal Medicine	32	80257	84257	1D
Diabetes	32	80237	84237	2A
Endocrinology	32	80238	84238	1B
Gastroenterology	32	80241	84241	2B
Hematology / Oncology	32	80245	84245	2A
Infectious Disease	32	80246	84246	2B
Nephrology	32	80260	84260	1C
Pharmacology	32	80234	84234	1B
Preventative Medicine	32	80231	84231	1A
Rheumatology	32	80252	84252	1C
Neonatology	34	80471	84471	2B
Neurology	40	80261	84261	2B
Ophthalmology	16	80263	84263	1A
Otolaryngology	23	80265	84265	1B
Otology	23	80264	84264	1B
Larynogology	23	80258	84258	1B

	Speciality Code	MD	DO	Class
Rhinology	23	80247	84247	1B
Pathology	36	80266	84266	1B
Pediatrics	34	80267	84267	1C
Psychiatry - Inc. Child	35	80249	84249	1B
Hypnosis	35	80232	84232	1B
Psychoanalysis	35	80250	84250	1B
Psychosomatic	35	80251	84251	1B
Pulmonary Disease	38	80269	84269	2C
Radiology - Diagnostic	37	80253	84253	2B
Urgent Care	26	80102	84102	2A
Retired Physician	XX	80179	84179	
Physician - N.O.C.	19	80268	84268	1B
Surgical Specialist Performing No Surgery, But Still Practicing In That Speciality		80268	84268	1B
Cardiology (Right Heart Cath. Only)	33	80281	84281	2C
Dermatology	31	80282	84282	1B
Family/General Practice	19	80421	84421	2C
Geriatrics	32	80276	84276	2B
Physicians - N.O.C.	XX	80294	84294	2B
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80274	84274	2C
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279	84279	2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287	84287	2B
Neurology	40	80288	84288	3A
Ophthalmology	16	80289	84289	1C
Otorhinolaryngology	23	80291	84291	2B
Otology	23	80290	84290	2B
Laryngology	23	80285	84285	2B
Rhinology	23	80270	84270	2B

	Speciality Code	MD	DO	Class
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Psychiatry - Inc. Shock Therapy	35	80431	84431	2B
Radiology - Diagnostic	37	80280	84280	2D
Radiology - Teleradiology	90	80280	84280	2D
Radiology - Therapy	37	80425	84425	2B
Radiology - Teleradiology	90	80425	84425	2B
Pain Management	19, 30, 40	80295	84295	2A
Hospitalist	32	80296	84296	1D
Surgical Specialist Performing Minor Surgery On Their Own Patients While Practicing In That Speciality:		80294	84294	2B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Radiation Therapy	XX	80425	84425	2B
Radiopaque Dye Injection	XX	80449	84449	2D
Radiology - incld. Mammography	37	80472	84472	2D
Radiology - Teleradiology	90	80472	84472	2D
Shock Therapy	XX	80431	84431	2B
Physicians Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients - Not Primarily Engaged In Major Surgery:				
Dermatology	31	80282	84282	1B
Family/General Practice	19	80117	84117	3B
Geriatrics	19	80105	84105	3B
Physicians - N.O.C.	19	80294		
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Diabetes	32	80271		
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80104	84104	3A
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279		2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287		2B
Neurology	40	80288	84288	3A
Otorhinolaryngology	23	80291	84291	2B

	Speciality Code	MD	DO	Class
Otology	23	80290		2B
Laryngology	23	80285		2B
Rhinology	23	80270		2B
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Emergency Medicine (No Major Surg)	25	80102	84102	4A
Surgical Specialists:				
Ophthalmology	16	80114	84114	1D
Colon and Rectal	24	80115	84115	3B
Emergency Medicine (Incl. Major Surg)	25	80157	84157	4B
Surgical Specialist Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients While Practicing In That Speciality, But Not Primarily Engaged In Major Surgery:		80117	84117	3B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Acupuncture	XX	80437	84437	3A
Cardiology (Incl. Left Heart Cath.)	33	80422	84422	3A
Internal Medicine (Incl. Left Heart Cath.)	32	80422	84422	3A
Urology	17	80145	84145	3A
Fam./Gen. Practice - incl. deliveries	29	80273	84273	3A
Anesthesiology	30	80151	84151	2A
Abdominal	10	80166	84166	6B
Cosmetic	10, 15, 16, 20, 23, 31	80136	84136	~~54~~A
General - N.O.C.	10	80143	84143	6B
Otorhinolaryngology	23	80159	84159	3A
Otology	23	80158	84158	3A
Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	4A
Head and Neck	13	80170	84170	4A
Obstetrics/Gynecology	15	80153	84153	6B
Obstetrics	15	80168	84168	6B
Gynecology	18	80167	84167	4A
Plastic - N.O.C.	20	80156	84156	~~54~~A

	Speciality Code	MD	DO	Class
Cardiovascular	21	80150	84150	5B
Neurological	12	80152	84152	8
Orthopedic (Excl. back)	13	80176	84176	4A
Orthopedic (Incl. back)	13	80154	84154	6A
Thoracic	14	80144	84144	5B
Traumatic	10	80171	84171	7
Vascular	22	80146	84146	5B

MEDICAL PROTECTIVE
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DEC 21 2009

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

November 5, 2009

Gayle Neuman, Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RECEIVED

NOV 09 2009

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 09-IL-135
COMPANY FEIN NO: 35-0506406
ILLINOIS PHYSICIANS & SURGEONS, DENTISTS and ALLIEDS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Revised Class Plans (Allieds only)
Revised Rules

RATE/RULE **COMPREHENSIVE LIABILITY COVERAGE FOR HEALTHCARE PROVIDERS**
Revised General Manual Pages, Section I – V
Revised State Rate Pages, Sections II - V

PROPOSED EFFECTIVE DATE: January 1, 2010

Dear Ms. Neuman:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable to its Illinois Physicians & Surgeons, Dentists, Allied and Comprehensive Liability programs. In addition, the Company is added one new classification in the Allied program. The company requests **January 1, 2010**, as the effective date for this submission.

Please find enclosed the manual pages, required filing forms, actuarial certification, explanatory memo and a self-addressed stamped envelope. Upon completion of your review, would you please stamp the duplicate copy of this submission and return it to us in the envelope provided.

Should you have any questions regarding this filing, please do not hesitate to contact me. Thank you.

Sincerely,

Melissa Millican

Melissa Coker Millican, Paralegal
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.millican@medpro.com

Enclosure(s)

1-0
MEM
RUL

ILLINOIS CERTIFICATION FOR
MEDICAL MALPRACTICE RATES

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

I, Jim D. Kunce, a duly authorized officer of The Medical Protective Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Jim D. Kunce, a duly authorized actuary of The Medical Protective Company am authorized to certify on behalf of The Medical Protective Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

J D K : SVP
Signature and Title of Authorized Insurance Company Officer — 11/5/09 Date

J D K FCAS ; SVP
Signature, Title and Designation of Authorized Actuary — 11/05/09 Date

Insurance Company FEIN 35-0506406 Filing Number 09-IL-135

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's: -Name / E-mail Melissa Millican / melissa.millican@medpro.com

-Direct Telephone and Fax Number Direct: 260-486-0838; Fax: 260-486-0733

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective +0.0 % ; effective 1/1/2010

(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1. Automobile Liability Private Passenger Commercial		
2. Automobile Physical Damage Private Passenger Commercial		
3. Liability Other Than Auto		
4. Burglary and Theft		
5. Glass		
6. Fidelity		
7. Surety		
8. Boiler and Machinery		
9. Fire		
10. Extended Coverage		
11. Inland Marine		
12. Homeowners		
13. Commercial Multi-Peril		
14. Crop Hail		
15. Other Line 11 - Med Mal (Allied) (Line of Insurance)	$ 274,852	+0.0%

Does filing only apply to certain territory (territories) or certain classes? If so, specify: No.

Brief description of filing. (If filing follows rates of an advisory organization, specify organization): The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable to its Illinois Physicians & Surgeons, Dentists, Allied and Comprehensive Liability programs. In addition, the Company is adding one new classification in the Allied program. The company requests January 1, 2010, as the effective date for this submission. There is no rate impact associated with this filing.

*Adjusted to reflect all prior rate changes.
**Change in Company's premium level which will result from application of new rates.

The Medical Protective Company
Name of Company

David Sherman, Associate General Counsel
Official – Title

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STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

PHYSICIANS & SURGEONS
DENTISTS
ALLIED HEALTHCARE PROVIDERS

EXPLANATORY MEMORANDUM

The Medical Protective Company wishes to submit the attached rule filing for its stand-alone Physicians and Surgeons, Dentists, and Allied Healthcare Provider professional liability products and the corresponding Comprehensive Liability Coverage for Health Care Providers programs. The Company requests an effective date of January 1, 2010.

I. RULE REVISIONS – Physicians and Surgeons Program.

Aggregate Credit Rule – The Company wishes to introduce the Aggregate Credit Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude New to Practice, New to Company and Membership Association credits from the cap. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section III. There is no substantive rate impact associated with this rule.

Convertible Plus/Nose Rating Plan - The Company also proposes to introduce an additional rating rule and coverage form for insureds that are currently covered under a claims-made policy form, but desire to convert to an occurrence coverage form. The Convertible Plus / Nose Coverage product will provide nose coverage, as an endorsement to the occurrence policy, to cover extended reporting period exposure for the time the insured was on a claims-made policy form.

The rating for such coverage is outlined in the proposed rating rule that is attached. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section III.

Extension Contract Rating Rule – The Extension Contract Rating Rule is being revised for the Stand Alone Standard Claims Made Program to include discretionary schedule rating modifications in the calculation of the Extension Contract premium. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within General Manual Section I and further defines the differences in calculation methods for Individual Healthcare Professional versus Healthcare Facilities. The changes do not result in a rate impact.

Full Time Equivalency Rating Rule – The Company wishes to revise the Full Time Equivalency Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude Risk Management Credits from the calculation of FTE Credits, as well as clarify the audit provisions and identifies that training and residency programs are not eligible for FTE rating Please refer to the Comprehensive Liability Coverage for Healthcare Providers General Manual Section III for these revisions. There is no substantive rate impact associated with this change.

Non-Discretionary Debit Plan – The Company wishes to revise the Non-Discretionary Debit Plan for the Stand Alone Occurrence and Standard Claims Made Programs to include two newly created ISO codes to Table B. Please refer to Section III of the State Rate Pages for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is no substantive rate impact associated with this change.

Partnership / Corporation Rating Rule -The Company wishes to revise the Partnership Corporation Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to include credit for an optional vicarious liability corporation exposure of a non-insured corporation member. Please refer to Section II of the State Rate Pages for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual page. There is no substantive rate impact associated with this change.

Part Time Practice Rule -_The Company wishes to revise the Part Time Practice Rule for the Occurrence and Standard Claims Made Programs to include the application of Schedule Rating Modifications with Part Time Credits. Please refer to the attached General Manual Section III for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is not a substantive rate impact associated with this change.

Renewal Rating Rule - The Company wishes to revise the Renewal Rating Rule for the Occurrence and Standard Claims Made Programs to hold premium constant from policy term to policy term for accounts which meet a certain premium threshold. Please refer to Section III of the State Rate Pages for the Comprehensive Liability Coverage for Healthcare providers for the applicable premium threshold. There is not a substantive rate impact associated with this change.

II. RULE REVISIONS – Dental Program

Aggregate Credit Rule – The Company wishes to introduce the Aggregate Credit Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude New to Practice and New to Company credits from the cap. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section IV. There is no substantive rate impact associated with this rule.

Botulineum Toxin and Dermal Fillers Rating Rule – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently added Botulineum Toxin and Dermal Fillers Rating Rule which has recently been filed and approved for its Stand Alone Dentist program. Please refer to the attached General Manual Section IV as well as corresponding Section IV of the State Rate Pages. This modification has no rate impact on current insureds.

Dental Board Examination Rule – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised Dental Board Examination Rule revisions which have been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the State Rate Pages for this modification of which has no rate impact on current insureds.

Dental Facility Classification Plan – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently added Dental Facility Classification Plan which has recently been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the General Manual as well as Section IV of the attached State Rate Pages.

Extension Contract Rating Rule – The Extension Contract Rating rule is being revised for the Stand Alone Standard Claims Made Program to include discretionary schedule rating modifications in the calculation of the Extension Contract premium. Additionally, the Comprehensive Liability Coverage for

Healthcare Providers manual page modification can be found within the attached General Manual Section I and further defines the differences in calculation methods for Individual Healthcare Professional versus Healthcare Facilities. The changes do not result in a rate impact.

Full Time Equivalency Rating Rule – The Company wishes to revise the Full Time Equivalency Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude Risk Management Credits from the calculation of FTE Credits, as well as clarify the audit provisions and identifies that training and residency programs are not eligible for FTE rating Please refer to the Comprehensive Liability Coverage for Healthcare Providers General Manual Section IV for these revisions. There is no substantive rate impact associated with this change.

Membership Association Credit Rule – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised Membership Association Credit Rule which has been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the attached State Rate Pages for this modification. There is not a substantive rate impact associated with this change.

Moonlighting Rating Rule – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised Moonlighting Rating Rule which has been filed and approved for its Stand Alone Dentists program. Please refer to the attached General Manual Section IV and Section IV State Rate Pages for the modification. There is not a substantive rate impact associated with this change.

New to Practice Credit – The Company wishes to update the Comprehensive Coverage for Healthcare Providers manual to reflect the recently revised New to Practice Credits which have been filed and approved for its Stand Alone Dentists program. Please refer to Section IV of the attached State Rate Pages for the modification. There is not a substantive rate impact associated with this change.

Part Time Practice Rule - The Company wishes to revise the Part Time Practice Rule for the Occurrence and Standard Claims Made Programs to include the application of Schedule Rating Modifications with Part Time Credits. Additionally, please refer to the attached General Manual Section IV for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is not a substantive rate impact associated with this change.

Renewal Rating Rule - The Company wishes to revise the Renewal Rating Rule for the Occurrence and Standard Claims Made Programs to hold premium constant from policy term to policy term for accounts which meet a certain premium threshold. Please refer to Section IV of the State Rate Pages for the Comprehensive Liability Coverage for Healthcare providers for the applicable premium threshold. There is not a substantive rate impact associated with this change.

Student/Resident Rating Rule – The Company wishes to revise the Comprehensive Coverage for Healthcare Providers program Section IV General Manual and State Rate Pages to include the Student / Resident Rating Rule. This rule has recently been filed and approved for the DDS Stand Alone program and the addition of this rule does not result in a rate impact.

III. RULE REVISIONS – Allied Healthcare Providers Program

Aggregate Credit Rule – The Company wishes to revise the Aggregate Credit Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude New to Practice, New to Company and Membership Association credits from the cap. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section V. There is no substantive rate impact associated with this rule.

Allied Healthcare Providers Class Plan – The Company wishes to revise the Allied Healthcare Providers Class Plan for the Stand Alone Occurrence and Standard Claims Made Programs. The revision consists of adding Anesthesia Assistants as their own speciality under the class plan. Currently Anesthesia Assistants are rated as CRNA's as their exposure is similar. However, the marketplace has begun to distinguish these two healthcare specialties separately and thus the Company is choosing to make that distinction in its classification plan at this time. Additionally, the addition of Anesthesia Assistant has been made to the attached Comprehensive Liability Coverage for Healthcare Providers manual, Section V of the State Rate Pages. There is no rate impact associated with this addition.

Extension Contract Rating Rule – The Extension Contract Rating rule is being revised for the Stand Alone Standard Claims Made Programs to include discretionary schedule rating modifications in the calculation of the Extension Contract premium. Additionally, the Comprehensive Liability Coverage for Healthcare Providers manual page modification can be found within the attached General Manual Section I and further defines the differences in calculation methods for Individual Healthcare Professional versus Healthcare Facilities. The changes do not result in a rate impact.

Full Time Equivalency Rating Rule – The Company wishes to revise the Full Time Equivalency Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to exclude Risk Management Credits from the calculation of FTE Credits, as well as clarify the audit provisions and identifies that training and residency programs are not eligible for FTE rating. Please refer to the Comprehensive Liability Coverage for Healthcare Providers General Manual Section V for these revisions. There is no substantive rate impact associated with this change.

Part Time Practice Rule - The Company wishes to revise the Part Time Practice Rule for the Occurrence and Standard Claims Made Programs to include the application of Schedule Rating Modifications with Part Time Credits. Please refer to the attached General Manual Section V for the modification to the Comprehensive Liability Coverage for Healthcare Providers manual. There is not a substantive rate impact associated with this change.

Renewal Rating Rule - The Company wishes to revise the Renewal Rating Rule for the Occurrence and Standard Claims Made Programs to hold premium constant from policy term to policy term for accounts which meet a certain premium threshold. Please refer to Section V of the State Rate Pages for the Comprehensive Liability Coverage for Healthcare providers for the applicable premium threshold. There is not a substantive rate impact associated with this change.

IV. RULE REVISIONS – Miscellaneous adjustments – Non Premium Bearing.

The Company has conducted a review of the Stand Alone Program (Physician & Surgeon/Dentists/Allied Healthcare Providers) compared to the Comprehensive Coverage for Healthcare Providers program in an effort to achieve consistency with the two product offerings. As such, the following additional revisions are being made to the Comprehensive Coverage for Healthcare Providers State Rate Page manuals to resolve these inconsistencies. They do not result in a rate impact and are typographical in nature.

Section II:

Extended Reporting Period Coverage Factors - The extended reporting period factors for Dentists, years 4 and 5 or more , currently on file for the Company's Stand Alone DDS program are not referenced accurately in the matrix in the State Rate Pages. The factors are being revised to accurately depict the Company's intent with regard to this rating rule.

Policy Writing Minimum Premium – The minimum premium designations currently on file for the Company's Stand Alone DDS programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Schedule Rating – Partnerships & Corporations – The schedule rating designations currently on file for the Company's Stand Alone DDS programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Small Group, Large Group & Temporary Staffing Agency Rating – Corporations – The countrywide designation of these rules is not accurately reflected in the current State Rate Pages. Therefore, the rule title is being changed to add the distinction of 'Small' groups in the title.

Section III –

Small Group & Large Group Rating – The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Section IV:

Policy Writing Minimum Premium – The minimum premium designations currently on file for the Company's Stand Alone DDS programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

New to Company Credit – The New to Practice credit designations currently on file for the Company's Stand Alone DDS programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Schedule Rating – The schedule rating designations currently on file for the Company's Stand Alone MD programs are not referenced accurately in the matrix in the State Rate Pages, in that the per characteristic caps were omitted from the page. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Small Group & Large Group Rating – The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Section V:

Allied Territory Rating Plan – The Allied Territory Rating Plan currently on file for the Company's Stand Alone AHCP programs are not referenced accurately in the matrix in the State Rate Pages. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Schedule Rating – The schedule rating designations currently on file for the Company's Stand Alone AHCP programs are not referenced accurately in the matrix in the State Rate Pages, in the the per characteristic caps were omitted from the page. They are being revised to accurately depict the Company's intent with regard to this rating rule.

Small Group Rating Rule – The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Large Group Rating Rule – The General Manual currently contains rating rules for Small Groups and Large Groups. However, after review of the Company's state rate pages, it was determined that these rules are not adequately reflected in the State Rate Pages as available. Therefore the State Rate Pages are being modified to include references to both rules.

Accelerated Extension Contract Rating – The rule is being updated to 'Available' to align with the Stand Alone Allied Healthcare Providers Program.

Group Rating Rule – This is being removed as it is redundant with the 'Small Group Rating Rule' and 'Large Group Rating Rule.'

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AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION OR DEDUCTIBLE CREDITS.

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CONVERTIBLE PLUS / NOSE RATING PLAN

A HEALTHCARE PROVIDER THAT IS CURRENTLY INSURED UNDER A CLAIMS-MADE POLICY FORM MAY BE ELIGIBLE FOR CONVERTIBLE / NOSE COVERAGE, SUBJECT TO UNDERWRITING GUIDELINES. THIS COVERAGE WILL PROVIDE NOSE COVERAGE TO HEALTHCARE PROVIDERS THAT SEEK TO CONVERT TO AN OCCURRENCE POLICY FORM. THE RATING FOR SUCH COVERAGE IS BASED UPON THE INSUREDS STANDARD MATURE CLAIMS MADE RATE TIMES THE FACTOR IDENTIFIED IN THE TABLE BELOW.

YEARS RETROACTIVE DATE PRECEDES POLICY INCEPTION DATE	FACTOR
1	.75
2	1.08
3	1.18
4 OR MORE	1.25

THE APPLICABLE PREMIUM UNDER THIS PLAN SHALL BE IN ADDITION TO THE HEALTHCARE PROVIDER'S STANDARD OCCURRENCE PREMIUM AND SHALL BE PAID TO THE COMPANY OVER AN INSTALLMENT PERIOD.

IN THE EVENT THE INSURED CANCELS THE OCCURRENCE COVERAGE, WITHIN THE FIRST FIVE YEARS SUBSEQUENT TO THE ISSUANCE OF THE PRODUCT, FOR REASONS OTHER THAN NON-RENEWAL, DEATH, TOTAL AND PERMANENT

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OCCURRENCE PROGRAM

CONVERTIBLE PLUS / NOSE RATING PLAN

DISABILITY OR PERMANENT RETIREMENT, ADDITIONAL PREMIUM SHALL BE DUE AND PAYABLE. ADDITIONAL PREMIUM SHALL BE CALCULATED AT THE COMPANY'S FILED RATE FOR AN EXTENSION CONTRACT ENDORSEMENT AT THE TIME THE CONVERTIBLE PLUS CLAIMS MADE COVERAGE IS ISSUED. ANY UNPAID BALANCE BETWEEN THIS AMOUNT AND ANY PAYMENTS MADE PRIOR TO THE CANCELLATION DATE IS DUE SIXTY (60) DAYS FROM THE DATE OF CANCELLATION.

THE RATING UNDER THIS RULE IS SUBJECT TO APPLICABLE PART-TIME AND SCHEDULE RATING MODIFICATIONS.

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OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-PHYSICIAN GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL PHYSICIAN BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH PHYSICIAN'S NUMBER OF HOURS OF MEDICAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL PHYSICIAN IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER PHYSICIAN RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE PHYSICIAN RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

FOR ANY INSURED WHO IS NOT ELIGIBLE FOR A CREDIT UNDER THE COMPANY'S CLAIM/LOSS FREE CREDIT RULE, POINTS WILL BE ASSIGNED FOR EACH CLAIM:

1) PENDING AGAINST THE INSURED AT THE BEGINNING OF THE CURRENT POLICY PERIOD;
2) PAID ON THE INSURED'S BEHALF DURING THE PAST 5 YEARS; OR
3) CLOSED WITH NO PAYMENT DURING THE PAST 5 YEARS,

PURSUANT TO THE FOLLOWING SCHEDULE:

ASSIGNED CLAIM POINTS	
Claim Threshold	**Points**
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

FOR PROVIDERS WHO HAVE BEEN PRACTICING FOR LESS THAN EIGHT COMPLETE YEARS FROM THEIR INITIAL MEDICAL SCHOOL GRADUATION DATE, THE TOTAL ASSIGNED CLAIM POINTS (AS CALCULATED FROM THE SCHEDULE ABOVE) WILL BE MULTIPLIED BY THE APPLICABLE FACTOR SET FORTH IN THE FOLLOWING SCHEDULE:

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OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 years or more	No factor applied

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY WHO HAVE PENDING CLAIMS OR CLAIMS PAID ON THEIR BEHALF WITHIN THE PAST FIVE YEARS WILL BE ASSIGNED POINTS IN ACCORDANCE WITH COMPANY GUIDELINES.

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NON-DISCRETIONARY DEBIT PLAN

A DEBIT SHALL THEN BE APPLIED TO THE INSURED'S RATE BASED UPON THE FOLLOWING SCHEDULE:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. TABLE A SHALL APPLY TO INSUREDS PRACTICING UNDER ANY OTHER ISO CODE.)

FOR THE PURPOSE OF THIS RULE, A "CLAIM" SHALL NOT INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

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OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

ANY DEBIT REQUIRED UNDER THIS RULE SHALL BE ADDITIVE WITH ANY OTHER DEBITS OR CREDITS APPLICABLE UNDER THE COMPANY'S RATING MANUAL.

THIS NON-DISCRETIONARY DEBIT PLAN SHALL ONLY APPLY TO PROVIDERS WHO MEET THE COMPANY'S GUIDELINES FOR ACCEPTANCE, AND THE COMPANY RETAINS THE RIGHT TO REFUSE TO INSURE ANY INSURED OR APPLICANT BASED UPON THE QUALITATIVE NATURE OF ANY CLAIMS MADE AGAINST THAT INDIVIDUAL OR ENTITY. AS A RESULT, THE FACT THAT THIS RULE PROVIDES (OR DOES NOT PROVIDE) A DEBIT FOR CLAIMS EXPERIENCE IS NOT AN INDICATION THAT THERE IS A RATE AVAILABLE FOR ANY PARTICULAR INSURED OR APPLICANT.

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OCCURRENCE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS AND/OR RISK MANAGEMENT.

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

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/CONTRACTED PHYSICIANS.

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

The

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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION OR DEDUCTIBLE CREDITS.

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STANDARD CLAIMS MADE PROGRAM

EXTENSION CONTRACT RATING

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, NON-DISCRETIONARY DEBIT, DEDUCTIBLE AND SCHEDULE RATING MODIFICATIONS.

PARTNERSHIP / CORPORATION EXTENSION CONTRACT RATING SHALL BE BASED ON THE NUMBER OF SHAREHOLDERS, PARTNERS AND INDEPENDENT CONTRACTORS AT THE INCEPTION DATE OF THE MOST RECENT POLICY.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-PHYSICIAN GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL PHYSICIAN BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH PHYSICIAN'S NUMBER OF HOURS OF MEDICAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL PHYSICIAN IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER PHYSICIAN RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE PHYSICIAN RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

FOR ANY INSURED WHO IS NOT ELIGIBLE FOR A CREDIT UNDER THE COMPANY'S CLAIM/LOSS FREE CREDIT RULE, POINTS WILL BE ASSIGNED FOR EACH CLAIM:

1) PENDING AGAINST THE INSURED AT THE BEGINNING OF THE CURRENT POLICY PERIOD;
2) PAID ON THE INSURED'S BEHALF DURING THE PAST 5 YEARS; OR
3) CLOSED WITH NO PAYMENT DURING THE PAST 5 YEARS,

PURSUANT TO THE FOLLOWING SCHEDULE:

ASSIGNED CLAIM POINTS	
Claim Threshold	**Points**
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

FOR PROVIDERS WHO HAVE BEEN PRACTICING FOR LESS THAN EIGHT COMPLETE YEARS FROM THEIR INITIAL MEDICAL SCHOOL GRADUATION DATE, THE TOTAL ASSIGNED CLAIM POINTS (AS CALCULATED FROM THE SCHEDULE ABOVE) WILL BE MULTIPLIED BY THE APPLICABLE FACTOR SET FORTH IN THE FOLLOWING SCHEDULE:

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 years or more	No factor applied

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY WHO HAVE PENDING CLAIMS OR CLAIMS PAID ON THEIR BEHALF WITHIN THE PAST FIVE YEARS WILL BE ASSIGNED POINTS IN ACCORDANCE WITH COMPANY GUIDELINES.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

A DEBIT SHALL THEN BE APPLIED TO THE INSURED'S RATE BASED UPON THE FOLLOWING SCHEDULE:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. TABLE A SHALL APPLY TO INSUREDS PRACTICING UNDER ANY OTHER ISO CODE.)

FOR THE PURPOSE OF THIS RULE, A "CLAIM" SHALL NOT INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

ANY DEBIT REQUIRED UNDER THIS RULE SHALL BE ADDITIVE WITH ANY OTHER DEBITS OR CREDITS APPLICABLE UNDER THE COMPANY'S RATING MANUAL.

THIS NON-DISCRETIONARY DEBIT PLAN SHALL ONLY APPLY TO PROVIDERS WHO MEET THE COMPANY'S GUIDELINES FOR ACCEPTANCE, AND THE COMPANY RETAINS THE RIGHT TO REFUSE TO INSURE ANY INSURED OR APPLICANT BASED UPON THE QUALITATIVE NATURE OF ANY CLAIMS MADE AGAINST THAT INDIVIDUAL OR ENTITY. AS A RESULT, THE FACT THAT THIS RULE PROVIDES (OR DOES NOT PROVIDE) A DEBIT FOR CLAIMS EXPERIENCE IS NOT AN INDICATION THAT THERE IS A RATE AVAILABLE FOR ANY PARTICULAR INSURED OR APPLICANT.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS AND/OR RISK MANAGEMENT.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE (CON'T)

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,050 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY. IF SO, THE AVERAGE NUMBER OF HOURS IN PRACTICE PER WEEK DURING THE PREVIOUS FIVE POLICY YEARS WILL DETERMINE THE APPLICABLE CREDIT.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

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/CONTRACTED PHYSICIANS.

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STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE (CON'T)

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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DENTISTS

OCCURRENCE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION, MOONLIGHTING OR DEDUCTIBLE CREDITS.

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OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-DENTIST GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL DENTIST BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH DENTIST'S NUMBER OF HOURS OF DENTAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
1,800	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL DENTIST IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER DENTIST RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE DENTIST RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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DENTISTS

OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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DENTISTS

OCCURRENCE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS, AND/OR RISK MANAGEMENT.

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OCCURRENCE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $25,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION, MOONLIGHTING OR DEDUCTIBLE CREDITS.

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STANDARD CLAIMS MADE PROGRAM

EXTENSION CONTRACT RATING

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, NON-DISCRETIONARY DEBIT, DEDUCTIBLE AND SCHEDULE RATING MODIFICATIONS.

PARTNERSHIP / CORPORATION EXTENSION CONTRACT RATING SHALL BE BASED ON THE NUMBER OF SHAREHOLDERS, PARTNERS AND INDEPENDENT CONTRACTORS AT THE INCEPTION DATE OF THE MOST RECENT POLICY.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-DENTIST GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL DENTIST BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH DENTIST'S NUMBER OF HOURS OF DENTAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
1,800	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL DENTIST IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER DENTIST RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE DENTIST RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS, AND/OR RISK MANAGEMENT.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE (CON'T)

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,050 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY. IF SO, THE AVERAGE NUMBER OF HOURS IN PRACTICE PER WEEK DURING THE PREVIOUS FIVE POLICY YEARS WILL DETERMINE THE APPLICABLE CREDIT.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $25,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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ALLIED HEALTHCARE PROVIDERS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS I-A

DENTAL ASSISTANT, DENTAL HYGIENIST.

CLASS I-B

CARDIOLOGY TECHNOLOGIST, CLINICAL LABORATORY TECHNOLOGIST, COUNSELOR, DIETICIAN, ELECTROCARDIOGRAPH TECHNICIAN, ELECTRONEURODIAGNOSTIC TECHNOLOGIST, LICENSED PRACTICING NURSE, MEDICAL LABORATORY TECHNICIAN, MEDICAL (OFFICE) ASSISTANT, MEDICAL RECORDS TECHNICIAN, NUCLEAR MEDICINE TECHNOLOGIST, OPHTHALMOLOGY TECHNICIAN, RESPIRATORY THERAPY ASSISTANT, REGISTERED NURSE.

CLASS II

AUDIOLOGIST/SPEECH PATHOLOGIST, NURSE MIDWIFE ASSISTANT, OCCUPATIONAL THERAPIST ASSISTANT, OPTICIAN, PHYSICAL THERAPY ASSISTANT, RADIATION THERAPY TECHNOLOGIST, SOCIAL WORKER, SURGICAL TECHNICIAN, X-RAY TECHNICIAN.

The

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Fort Wayne, Indiana 46835

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ILLINOIS

ALLIED HEALTHCARE PROVIDERS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS III

OPTOMETRIST, PARAMEDIC/EMT, PHARMACIST, PHYSICAL THERAPIST (NON-OWNER).

CLASS IV

CASE MANAGER, OCCUPATIONAL THERAPIST, PERFUSIONIST, PHYSICAL THERAPIST (OWNER), PSYCHOLOGIST, RESPIRATORY THERAPIST.

CLASS V

NURSE PRACTITIONER (NON-PRESCRIBING), PHYSICIAN'S ASSISTANT (NON-PRESCRIBING).

CLASS VI

NURSE SURGICAL ASSISTANT, PHYSICIAN SURGICAL ASSISTANT.

NURSE PRACTITIONER (PRESCRIBING), PHYSICIAN'S ASSISTANT (PRESCRIBING).

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OCCURRENCE PROGRAM

RATE CLASSES

CLASS VII - A

CERTIFIED REGISTERED NURSE ANESTHETIST, REGISTERED NURSE ANESTHETIST, ANESTHESIA ASSISTANT.

CLASS VII - B

NURSE MIDWIFE.

CLASS VIII - A

PODIATRIST (NO SURGERY).

CLASS VIII - B

PODIATRIST (SURGERY).

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OCCURRENCE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT OR DEDUCTIBLE CREDITS.

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OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR AN ALLIED HEALTHCARE PROVIDER GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL INSURED BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH ALLIED HEALTHCARE PROVIDER'S NUMBER OF HOURS OF PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL ALLIED HEALTHCARE PROVIDER IS .10 (200 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE ALLIED HEALTHCARE RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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FTE* PER POLICY	PREMIUM MODIFICATION
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR PART TIME PRACTICE OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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OCCURRENCE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT AND SCHEDULE RATING MODIFICATIONS.

DUE TO MINIMUM PREMIUM REQUIREMENTS, PART TIME CREDITS ARE AVAILABLE FOR CLASS 4-8B ONLY.

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OCCURRENCE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY AND CLAIMS-MADE STEP WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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ILLINOIS

ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS I-A

DENTAL ASSISTANT, DENTAL HYGIENIST.

CLASS I-B

CARDIOLOGY TECHNOLOGIST, CLINICAL LABORATORY TECHNOLOGIST, COUNSELOR, DIETICIAN, ELECTROCARDIOGRAPH TECHNICIAN, ELECTRONEURODIAGNOSTIC TECHNOLOGIST, LICENSED PRACTICING NURSE, MEDICAL LABORATORY TECHNICIAN, MEDICAL (OFFICE) ASSISTANT, MEDICAL RECORDS TECHNICIAN, NUCLEAR MEDICINE TECHNOLOGIST, OPHTHALMOLOGY TECHNICIAN, RESPIRATORY THERAPY ASSISTANT, REGISTERED NURSE.

CLASS II

AUDIOLOGIST/SPEECH PATHOLOGIST, NURSE MIDWIFE ASSISTANT, OCCUPATIONAL THERAPIST ASSISTANT, OPTICIAN, PHYSICAL THERAPY ASSISTANT, RADIATION THERAPY TECHNOLOGIST, SOCIAL WORKER, SURGICAL TECHNICIAN, X-RAY TECHNICIAN.

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ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS III

OPTOMETRIST, PARAMEDIC/EMT, PHARMACIST, PHYSICAL THERAPIST (NON-OWNER).

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NURSE PRACTITIONER (PRESCRIBING), PHYSICIAN'S ASSISTANT (PRESCRIBING).

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STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS VII - A

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CLASS VII - B

NURSE MIDWIFE.

CLASS VIII - A

PODIATRIST (NO SURGERY).

CLASS VIII - B

PODIATRIST (SURGERY).

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ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

AGGREGATE CREDIT RULE

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STANDARD CLAIMS MADE PROGRAM

EXTENSION CONTRACT RATING

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, DEDUCTIBLE AND SCHEDULE RATING MODIFICATIONS.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL ALLIED HEALTHCARE PROVIDER IS .10 (200 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE ALLIED HEALTHCARE RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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STANDARD CLAIMS MADE PROGRAM

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1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR PART TIME PRACTICE OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE

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AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT AND SCHEDULE RATING MODIFICATIONS.

DUE TO MINIMUM PREMIUM REQUIREMENTS, PART TIME CREDITS ARE AVAILABLE FOR CLASS 4-8B ONLY.

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,050 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY. IF SO, THE AVERAGE NUMBER OF HOURS IN PRACTICE PER WEEK DURING THE PREVIOUS FIVE POLICY YEARS WILL DETERMINE THE APPLICABLE CREDIT.

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ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY AND CLAIMS-MADE STEP WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the following health care providers:

Section

II. Corporations, Partnerships and Associations
III. Physicians and Surgeons
IV. Dentists
V. Health Care Professionals
VI. Health Care Facilities

B. This manual also specifies rules, rates, premiums, classifications and territories for the purpose of providing the following optional associated coverages to health care providers:

Section

VII. General Liability
VIII. Managed Care Entity Liability

II. APPLICATION OF GENERAL RULES

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the respective Section or State Rate Pages.

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

III. 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.

IV. 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.

V. 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.

VI. FACTORS OR MULTIPLIERS

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

VII. 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.

VIII. 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.

C. The Company may waive an additional premium of $100 or less for coverages related to Health Care Facilities. This waiver only applies to cash exchange due on an endorsement effective date.

IX. 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.

X. 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 no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

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.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider and is shown on the appropriate State Rate Pages.

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

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate State Rate Pages.

XII. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. Specific options may be referenced in the State Rate Pages.

XIII. COVERAGE

Coverage may be provided on either an Occurrence or Claims-Made basis, unless noted otherwise in the respective section or State Rate Pages. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Occurrence or Standard Claims-Made, subject to availability and identified on the State Rate Pages.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. INCREASED LIMITS OF LIABILITY

A. Individual Limits of Liability

1. Increased Limits factors shall be those shown as applicable for the respective insureds and be used to develop the applicable premium.

B. Shared Limits of Liability

1. Limits of Liability may be increased on a shared limits basis excess of an individual limit per insured.

2. The rate for the shared excess limits shall be computed in the following manner:

a. The rate for the individual limit of liability and the total limit of liability shall be calculated in accordance with the State Rate Pages. The total limit of liability is the sum of the individual per occurrence limit and the shared per occurrence limit.

b. The initial shared limits rate is the difference between the total limits rate and the individual limits rate.

c. The initial shared limits rate may be modified subject to the restrictions identified on the State Rate Pages, based on the following objective considerations:

i. The number and distribution by classification of insureds.

ii. The amount of the shared limit and its relationship to the size and distribution of the group.

iii. The amount of the individual limit (attachment point) underlying the shared limit.

3. The minimum individual limit over which a shared excess limit may be provided is identified on the State Rate Pages.

4. Requests for total limits of liability (the sum of the individual per health care occurrence limit and the shared excess per health care occurrence limit) that exceed the maximum limit of liability identified on the State Rate Pages shall be referred to the Company and (a) rated.

XVI. 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.

XVII. EXTENDED REPORTING PERIOD COVERAGE (Claims-Made Coverage only)

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. Premium must be paid, in accordance with state statutes, promptly when due.

D. For exposures rated in Section VI – Healthcare Facilities, Section VII – General Liability or Section VIII – Managed Care Entity Liability, the premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims made rate, applicable to the expiring policy, and subject to Experience, Part Time and Schedule Rating Modifications.

E. For exposures rated in Section III – Physicians & Surgeons, Section IV – Dentists or Section V – Healthcare Professionals, the premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims

made rate, applicable to the expiring policy, and subject to Part Time, Non - Discretionary Debit and Schedule Rating Modifications. Deductible Credits may or may not apply to a groups Extension Contract, at the Insureds option.

F. For exposures rated in Section III – Physicians & Surgeons, Section IV – Dentists or Section V – Healthcare Professionals the Partnership / Corporation Extension Contract Rating shall be based on the number of shareholders, partners and independent contractors at the inception date of the most recent policy.

XVIII. LARGE GROUP PRACTICE

A. Physicians organized in a Large Group practice may be collectively rated.

B. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

C. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, Risk Management, or Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

D. Locum Tenens Group Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

E. For Individual insureds within the group, Extension Contract Rating premium is calculated by multiplying the mature allocated premium times the applicable claims made tail factor.

F. Refer to the State Rate Pages for availability.

XIX. SMALL GROUP PRACTICE

Any group practice consisting of two or more healthcare providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Group's Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

   The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

   The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insureds based upon applicable underwriting criteria.

   For Individual insureds within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.

2. Refer to the applicable State Rate Page for availability.

XX. MEMBERSHIP IN QUALIFIED ASSOCIATIONS

1. The unique characteristics of medical/dental practices and their membership in qualified professional associations shall make them eligible for premium modifications in addition to those available to all other groups.

2. Members of a qualified medical/dental group professional association shall be eligible for additional premium modifications.

   A. Membership Credit

      1. A premium credit, identified on the State Rate Pages, shall be given to those insureds whose group is a member of a qualified association.
      2. A Qualified Association may include State Medical or Dental Societies.

B. Renewal Rate Rule

1. If the group practice generates a manual premium in excess the amount identified in the State Rate Pages, the Company may, in consideration of the underlying risk, hold the next renewal rate(s) for the individual policyholder(s) constant, subject to underwriting approval. However, changes in classification, limits of liability, claims-made step, claim free credit and non-discretionary credits will be applied in the usual manner.

2. Only one consecutive renewal may receive application of this rule. The group practice may again qualify for this rule after the payment of one renewal premium based upon currently filed rates.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

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

1. Professional Corporations, Partnerships and Associations

2. Miscellaneous Entities

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering outpatient 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. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates (or premium per FTE/OPV rated policy) of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated on the State Rate Pages.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any modifications presented on the State Rate Pages.

3. 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.

4. The premium for professional corporations, partnerships and associations may be subject to premium caps or flat rates as indicated on the State Rate Pages and may be reduced or eliminated as part of credits provided to multi-physician practices.

5. The premium otherwise determined for the partnership or corporation may be discounted should the insured elect to exclude the vicarious liability associated with the partners', shareholders' and employed/contracted physicians' professional services. Refer to the State Rate pages for the available credit.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy or FTE/OPV rated policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

C. The premium for other entities shall be referred to the Home Office for the determination of premium and filing with the state insurance department.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgicare Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center
   f. Home Health Agency
   g. Nursing Home
   h. Physical Fitness Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 on the State Rate Pages, 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 on the State Rate Pages.

B. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Credits shall be available, subject to underwriting guidelines.

b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

3. Large Group & Temporary Staffing Agency Rating - Corporations

A. Corporation Coverage for Temporary Staffing Agencies or Large Group practices may be collectively rated.

B. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

C. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence, or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

D. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

E. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

F. Refer to the State Rate Pages for availability.

4. Small Group Rating Rule

Any group practice consisting of two or more healthcare providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

A. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

B. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

C. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insured's based upon applicable underwriting criteria.

D. For Individual insured's within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.

E. Refer to the applicable state rate page for availability.

A. **Classification**

1. As defined by state statutes and formed for the purpose of rendering medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists – All Other Dental Specialties	5%	Available
Dentists – Oral Surgeons	1%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

c. The premium otherwise determined for the partnership or corporation may be discounted 50% should the insured elect to exclude the vicarious liability associated with the partners', shareholders' and employed/contracted physicians' professional services.

2. **Miscellaneous Entities**

NOT AVAILABLE

3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.900	1.150	1.200
5 or more	1.820	1.900	1.200	1.250

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$50
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 50%
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

2. **Deductible Credits**
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

3. **Self-Insured Retention Credits**

NOT AVAILABLE

4. **Small Group, Large Group & Temporary Staffing Agency Rating – Corporations**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

5. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Premium Threshold
Physicians & Surgeons	$250,000
Dentists	$25,000
Allied Health Care Providers	$250,000

6. **Quarterly Installment Option**
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, shown on the State Rate Pages, in accordance with each physician's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons

1. Each medical practitioner is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part-Time Physicians

1. Any insured who is determined not to be working on a full time basis will be considered a part-time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part-time practitioner is identified on the State Rate Pages.

2. A Part-Time Practitioner may include any classification identified in the class plan, as well as those practitioners who are moonlighting or teaching. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part-time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part-time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except risk management, schedule rating modifications and/or membership association credits.

C. 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.

      Note: Do not confuse a physician in a fellowship training program with a fellow, for example, of American College of Surgeons.

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.

   a. 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. Refer to the Company to determine the applicable credit.

3. Coverage is available for a physician's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program. The applicable physician class for moonlighting activities, as identified in the class plan, will be utilized to determine the rate. If no such classification is identified, the applicable premium will be computed as follows.

   a. The premium will be based upon the equivalent medical specialty rate and the average number of hours the insured practices per week.

   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 except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

D. Locum Tenens Physician –Physicians Substituting for MPCo Insured Physicians

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.

E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agency Coverage is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. 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 reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

G. 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.

   a. 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. Refer to the Company to determine the applicable credit.

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 except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

H. Physician's Leave of Absence

1. A physician who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

   - The birth of insured's newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
   - To care for a spouse, child or parent who has a serious health condition.
   - To care for insured's own health condition which prevents insured from working.
   - Time to enhance the insured's education or other reason while not practicing.

   This credit is not available to an insured's leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

I. Physicians Military Leave of Absence

A physician who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 policy may be modified in accordance with a maximum modification indicated on the State Rate Pages, 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 on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit provided on the State Rate Pages.

   a. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

   b. Insureds converting coverage to The Medical Protective Company, shall qualify for credit at the policy inception date in accordance with the Company's guidelines.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Credits shall be available, subject to underwriting guidelines.

b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

E. Experience Rating

1. A group practice, consisting of a specified number of 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. Paid losses
   e. Projected incurred but not reported losses
   f. Cause of such losses
   g. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

F. Non-Discretionary Debit Plan

For any insured who is not eligible for a credit under the company's claim/loss free credit rule, points will be assigned for each claim pursuant to Schedule A, found in the State Rate Pages, for the following:

- Pending against the insured at the beginning of the current policy period; or
- Paid on the insured's behalf during the past 5 years; or
- Closed with no payment during the past 5 years.

For providers who have been practicing for less than eight complete years from their initial medical school graduation date, the total assigned claim points (as calculated from the Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 years or more	No factor applied

Insureds with less than one year of experience shall be assumed to have one year of experience. Insureds converting coverage to The Medical Protective Company who have pending claims or claims paid on their behalf within the past five years will be assigned points in accordance with Company guidelines.

A debit shall then be applied the insured's rate based upon Schedule B, found in the State Rate Pages.

For the purpose of this rule, a "claim" shall not include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

Any Debit required under this rule shall be additive with any other debits or credits applicable under the Company's rating manual.

This non-discretionary debit plan shall only apply to providers who meet the Company's Guidelines for acceptance, and the Company retains the right to refuse to insure any insured or applicant based upon the qualitative nature of any claims made against that individual or entity. As a result, the fact that this rule provides (or does not provide) a debit for claims experience is not an indication that there is a rate available for any particular insured or applicant.

G. Large Group Rating

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims-made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

6. Refer to the State Rate Pages for availability.

H. Small Group Rating Rule

Any group practice consisting of two or more physician providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Group's Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be performed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate fee agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insureds based upon applicable underwriting criteria.

4. For Individual insureds within the group, the extension contract premium will be per the filed Extension Contract Rating Rule.

5. Refer to the applicable State Rate Page for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Convertible Coverage Rating Plan

1. Insureds shall be provided the option, subject to underwriting guidelines, to convert from Standard Claims-Made to Occurrence coverage. The insured shall be eligible for conversion after the following conditions have been met:

a. Payment to the Company of the applicable premium for a minimum of three annual claims-made policies.

b. Achieve three years of continuous claims-made coverage under this plan with no losses attributed to the insured. (A loss shall be a culpable loss. A claim under this plan shall not be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.)

2. At the time the aforementioned conditions are met, and the insured has purchased Occurrence coverage, the Company will issue Extended Reporting Period Coverage, covering professional services subsequent to the retroactive date and prior to the expiration of the claims-made policy, and will waive any premium that would normally be due for such coverage.

3. Should the insured be unable to meet the conditions for conversion, the insured may elect to purchase the Extended Reporting Period Coverage, subject to policy provisions. Refer to the Extended Reporting Period rule to determine the applicable premium.

4. The applicable premium under this plan is presented on the State Rate Pages.

5. No other modifications are to apply concurrent with this rule except membership association, risk management and schedule rating modifications.

B. Enhanced Claims-Made

1. Insureds shall be provided the option, subject to underwriting guidelines, to purchase Claims-Made coverage under the Enhanced rating structure.

2. The Enhanced Claims-Made base rate is developed as a percentage of the applicable Occurrence rate. The applicable percentage is identified on the State Rate Pages.

3. The Enhanced Claims-Made base rate is subject to Claim Free Credits in accordance with the schedule provided on the State Rate Pages. The application of the credits shall be consistent with the criteria identified in V(C) of this section of the manual.

C. Slot Rating

1. Coverage for group practices is available, at the Company's option, 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 cannot be used in conjunction with this rating rule.

D. Full-time Equivalency Rating

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

2,500 - Group Practice
2,100 - Residency Programs

2. For group practices, the minimum average FTE assigned to any individual physician is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Training/Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per physician rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the physician rates.

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

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

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

- The table value is determined by rounding the actual FTE per policy using the .5 rounding rule.

6. Premium modifications for claim free, new to practice, part time practice, or risk management cannot be used in conjunction with this rating rule.

E. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on an out-patient visit (OPV) basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of out-patient visits equivalent to a physician year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable medical specialty rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new physician, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

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 an 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 or permanent retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

   a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

   b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than one year and/or will not attain the required number of years of continuous claims-made coverage at the time of retirement.

   c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

   d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

   e. The insured otherwise meets the requirements as set forth in the policy for a free extension contract.

   f. Refer to the State Rate Pages for availability.

G. Deferred Premium Payment Plan.

1. The Company will, subject to applicable guidelines, offer the insured various premium payment options. The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

H. Aggregate Credit Rule.

The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, New to Company, New to Practice, Membership Association, Risk Management or Deductible Credits.

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Physician & Surgeons	$250

D. **Premium Modifications**

1. **Part Time Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

3. **Locum Tenens**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

4. **Temporary Staffing Agency Rating**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **New Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

6. **Physician Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

7. **Physicians Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

8. **Physicians Military Leave of Absence Credit**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification -50%/+50%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

10. **Risk Management**
(Occurrence, & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

11. **Claim Free Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 8	10%
8 but less than 10	15%
10 or more	20%

12. **Deductible Credits**
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non-Discretionary Debit Rating Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Claim Threshold	Points
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

Schedule B:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code. ***Refer to the Classification Translation Table – Specialty Description to ISO Code at the end of this section.***

16. **Small Group & Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Convertible Coverage Rating Plan**

NOT AVAILABLE

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

20. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
$250,000

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

25. **Membership Credit**
(Occurrence & Standard Claims Made Programs)

Credit
5%

26. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max AvailableCredit
50%

27. **Quarterly Installment Option**
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

*****Classification Translation Table – Specialty Description to ISO Code**

	Speciality Code	MD	DO	Class
Allergy	39	80254	84254	1A
Cardiology (Including Swan-Ganz)	33	80255	84255	2A
Dermatology	31	80256	84256	1A
Family/General Practice	19	80420	84420	1C
Aerospace	19	80230	84230	1A
Forensic Medicine	36	80240	84240	1A
Geriatrics	32	80243	84243	1B
Nuclear Medicine	37	80262	84262	1A
Nutrition	32	80248	84248	1A
Occupational Medicine	19	80233	84233	1A
Physiatry	19	80235	84235	1A
Public Health	19	80236	84236	1A
Gynecology	15	80244	84244	1B
Internal Medicine	32	80257	84257	1D
Diabetes	32	80237	84237	2A
Endocrinology	32	80238	84238	1B
Gastroenterology	32	80241	84241	2B
Hematology / Oncology	32	80245	84245	2A
Infectious Disease	32	80246	84246	2B
Nephrology	32	80260	84260	1C
Pharmacology	32	80234	84234	1B
Preventative Medicine	32	80231	84231	1A
Rheumatology	32	80252	84252	1C
Neonatology	34	80471	84471	2B
Neurology	40	80261	84261	2B
Ophthalmology	16	80263	84263	1A
Otolaryngology	23	80265	84265	1B
Otology	23	80264	84264	1B
Larynogology	23	80258	84258	1B

	Speciality Code	MD	DO	Class
Rhinology	23	80247	84247	1B
Pathology	36	80266	84266	1B
Pediatrics	34	80267	84267	1C
Psychiatry - Inc. Child	35	80249	84249	1B
Hypnosis	35	80232	84232	1B
Psychoanalysis	35	80250	84250	1B
Psychosomatic	35	80251	84251	1B
Pulmonary Disease	38	80269	84269	2C
Radiology - Diagnostic	37	80253	84253	2B
Urgent Care	26	80102	84102	2A
Retired Physician	XX	80179	84179	
Physician - N.O.C.	19	80268	84268	1B
Surgical Specialist Performing No Surgery, But Still Practicing In That Speciality		80268	84268	1B
Cardiology (Right Heart Cath. Only)	33	80281	84281	2C
Dermatology	31	80282	84282	1B
Family/General Practice	19	80421	84421	2C
Geriatrics	32	80276	84276	2B
Physicians - N.O.C.	XX	80294	84294	2B
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80274	84274	2C
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279	84279	2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287	84287	2B
Neurology	40	80288	84288	3A
Ophthalmology	16	80289	84289	1C
Otorhinolaryngology	23	80291	84291	2B
Otology	23	80290	84290	2B
Laryngology	23	80285	84285	2B
Rhinology	23	80270	84270	2B

	Speciality Code	MD	DO	Class
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Psychiatry - Inc. Shock Therapy	35	80431	84431	2B
Radiology - Diagnostic	37	80280	84280	2D
Radiology - Teleradiology	90	80280	84280	2D
Radiology - Therapy	37	80425	84425	2B
Radiology - Teleradiology	90	80425	84425	2B
Pain Management	19, 30, 40	80295	84295	2A
Hospitalist	32	80296	84296	1D
Surgical Specialist Performing Minor Surgery On Their Own Patients While Practicing In That Speciality:		80294	84294	2B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Radiation Therapy	XX	80425	84425	2B
Radiopaque Dye Injection	XX	80449	84449	2D
Radiology - incld. Mammography	37	80472	84472	2D
Radiology - Teleradiology	90	80472	84472	2D
Shock Therapy	XX	80431	84431	2B
Physicians Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients - Not Primarily Engaged In Major Surgery:				
Dermatology	31	80282	84282	1B
Family/General Practice	19	80117	84117	3B
Geriatrics	19	80105	84105	3B
Physicians - N.O.C.	19	80294		
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Diabetes	32	80271		
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80104	84104	3A
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279		2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287		2B
Neurology	40	80288	84288	3A
Otorhinolaryngology	23	80291	84291	2B

	Speciality Code	MD	DO	Class
Otology	23	80290		2B
Laryngology	23	80285		2B
Rhinology	23	80270		2B
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Emergency Medicine (No Major Surg)	25	80102	84102	4A
Surgical Specialists:				
Ophthalmology	16	80114	84114	1D
Colon and Rectal	24	80115	84115	3B
Emergency Medicine (Incl. Major Surg)	25	80157	84157	4B
Surgical Specialist Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients While Practicing In That Speciality, But Not Primarily Engaged In Major Surgery:		80117	84117	3B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Acupuncture	XX	80437	84437	3A
Cardiology (Incl. Left Heart Cath.)	33	80422	84422	3A
Internal Medicine (Incl. Left Heart Cath.)	32	80422	84422	3A
Urology	17	80145	84145	3A
Fam./Gen. Practice - incl. deliveries	29	80273	84273	3A
Anesthesiology	30	80151	84151	2A
Abdominal	10	80166	84166	6B
Cosmetic	10, 15, 16, 20, 23, 31	80136	84136	5A
General - N.O.C.	10	80143	84143	6B
Otorhinolaryngology	23	80159	84159	3A
Otology	23	80158	84158	3A
Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	4A
Head and Neck	13	80170	84170	4A
Obstetrics/Gynecology	15	80153	84153	6B
Obstetrics	15	80168	84168	6B
Gynecology	18	80167	84167	4A
Plastic - N.O.C.	20	80156	84156	5A

	Speciality Code	MD	DO	Class
Cardiovascular	21	80150	84150	5B
Neurological	12	80152	84152	8
Orthopedic (Excl. back)	13	80176	84176	4A
Orthopedic (Incl. back)	13	80154	84154	6A
Thoracic	14	80144	84144	5B
Traumatic	10	80171	84171	7
Vascular	22	80146	84146	5B

28. **Convertible Plus / Nose Rating Plan**
(Occurrence Program)

A healthcare provider that is currently insured under a claims-made policy form may be eligible for Convertible / Nose coverage, subject to underwriting guidelines. This coverage will provide nose coverage to healthcare providers that seek to convert to an occurrence policy form. The rating for such coverage is based upon the insureds standard mature claims made rate times the factor identified in the table below.

Years Retroactive Date Precedes Policy Inception Date	Factor
1	.75
2	1.08
3	1.18
4 or More	1.25

The applicable premium under this plan shall be in addition to the healthcare provider's standard occurrence premium and shall be paid to the Company over an installment period.

In the event the insured cancels the occurrence coverage, within the first five years subsequent to the issuance of the product, for reasons other than non-renewal, death, total and permanent disability or permanent retirement, additional premium shall be due and payable. Additional premium shall be calculated at the Company's filed rate for an extension contract endorsement at the time the Convertible Plus Claims Made coverage is issued. Any unpaid balance between this amount and any payments made prior to the cancellation date is due sixty (60) days from the date of cancellation.

The rating under this rule is subject to applicable Part-Time and Schedule Rating modifications.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Dentists.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per dentist, shown on the State Rate Pages, in accordance with each dentist's classification and class plan designation.

IV. CLASSIFICATIONS

A. Dentists

1. Each dental practitioner is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part Time Dentists

1. Any insured who is determined not to be working on a full time basis will be considered a part time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner is identified on the State Rate Pages.

2. A Part Time Practitioner may include any classification identified in the class plan as well as those practitioners who are moonlighting or teaching. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except risk management, membership association credits and/or schedule rating modifications.

C. Dentists in Training

1. Coverage is available for activities directly related to a dentist's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Dental students are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

2. Coverage is available for insureds moonlighting activities while in a residency or fellowship program conducted thru any dental school or hospital.

   a. A credit will apply to the insureds premium pursuant to the Company's guidelines for acceptance.

   b. No other credits may apply with this rule.

   c. Refer to the State Rate Pages for the applicable credit.

3. Coverage is available to dental students for activities directly related to their licensing.

   a. Coverage is available to dental students, on a short-term basis, for services rendered by the student during a dental externship prior to graduation and/or during the dental board exam pursuant to the student s professional licensing.

   b. The coverage for dental students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages, and are not subject to the minimum premium rule. The premium shall be applied to the insured's first annual policy if coverage is purchased within one year of the successful completion of the dental board exam.

4. Restricted Coverage is available for Dental Students and Residents. No other credits, debits or minimum premium rules shall apply with this rating program except for Schedule Rating Modifications. Refer to the State Rate Pages for the appropriate premium.

D. Locum Tenens Dentists

1. Coverage for a dentist substituting for an insured dentist will be limited to cover only professional services rendered on behalf of the insured dentist for the specified time period. Locum Tenens will share in the insured dentist's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens dentist must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

E. New Dentist

1. A "new" dentist shall be a dentist 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 dental specialty;

   c. Fulfillment of a military obligation in remuneration for dental school tuition;

   d. Dental school or specialty training program.

2. To qualify for the 1st year 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 reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

F. New to Company Dentists

1. An insured may be eligible for a New to Company credit pursuant to the following guidelines:

   i. Never insured with the Company, or
   ii. Previously insured with the Company more than 3 years ago.

2. Credits shall apply to the insureds first, second and third year consecutive years of coverage. All other credits will apply to the reduced rate.

3. This credit is not subject to the Aggregate Credit Rule and subject to underwriting guidelines. Only one request for this three year credit program will be granted to an eligible insured during any period of time insured by the company.

4. Please refer to the state rate pages for availability and the appropriate credit for this program.

G. Dentist 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.

   a. Faculty members are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for teaching activities related to an accredited training program. Refer to the Company to determine the applicable credit.

2. Coverage is available for the private practice of a dentist 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 dentist 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 except risk management and membership credits.

d. The applicable percentages are presented on the State Rate Pages.

H. Dentist's Leave of Absence

1. A dentist who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

- The birth of insureds newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
- To care for a spouse, child or parent who has a serious health condition.
- To care for insureds own health condition which prevents insured from working.
- Time to enhance the insureds education or other reason while not practicing.

This credit is not available to an insureds leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

I. Dentist Military Leave of Absence

A Dentist who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 policy may be modified in accordance with a maximum modification indicated on the State Rate Pages, 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 on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved for by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit on the schedule provided on the State Rate Pages.

    a. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

    b. Insureds converting coverage to The Medical Protective Company, shall qualify for credit at the policy inception date in accordance with the Company's guidelines.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

    a. Credits shall be available, subject to underwriting guidelines.

    b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

    c. Deductibles can only be revised at policy renewal.

    d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

        i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

        ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

        iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

    a. SIR's shall be offered to qualified insureds.

    b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

E. Experience Rating

1. A group practice, consisting of a specified number of insureds, may receive a credit/debit based on the claim history. The claim 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. Paid losses
e. Projected incurred but not reported losses
f. Cause of such losses
g. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

F. Non-Discretionary Debit Plan

For any insured who is not eligible for a credit under the Company's claim/loss free credit rule, points will be assigned for each claim, pursuant to Schedule A, found in the State Rate Pages, for the following:

- Pending against the insured at the beginning of the current policy period; or
- Paid on the insured's behalf during the past 5 years; or
- Closed with no payment during the past 5 years.

For providers who have been practicing for less than five complete years from their initial dental school graduation date, the total assigned claim points (as calculated from Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 2 years	5.00
At least 2 years but less than 3 years	2.50
At least 3 years but less than 4 years	1.666
At least 4 years but less than 5 years	1.25
5 years or more	No factor applied

Insureds with less than one year of experience shall be assumed to have one year of experience. Insureds converting coverage to The Medical Protective Company who have pending claims or claims paid on their behalf within the past five years, will be assigned points in accordance with Company guidelines.

A debit shall then be applied to the insured's policy based upon Schedule B, found in the State Rate Pages.

For the purpose of this rule, a "claim" shall not include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

Any debit required under this rule shall be additive with any other debits or credits applicable under the Company's rating manual.

This non-discretionary debit plan shall only apply to providers who meet the Company's guidelines for acceptance, and the company retains the right to refuse to insure any insured or applicant based upon the qualitative nature of any claims made against that individual or entity. As a result, the fact that this rule provides (or does not provide) a debit for claims experience is not an indication that there is a rate available for any particular insured or applicant.

G. Small Group Rating Rule

Any group practice consisting of two or more dentists may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insureds based upon applicable underwriting criteria.

4. For Individual insured's within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.

5. Refer to the applicable State Rate Page for availability.

H. Botulinum Toxin and Dermal Fillers Rating Rule.

1. A debit shall apply in addition to the existing filed rate and in recognition of the unique risk characteristics of Dentists, or groups of Dentists, who administer Botulinum Toxin and Dermal Filler procedures

2. The following outlines the debit category which applies to specific dental specialists that perform Botulinum Toxin and Dermal Fillers procedures:

Debit A: General Dentists, Orthodontists, Pediatric Dentists, Periodontists, Prosthodontists, Endodontists, or Host Dentists unless classified under debit B & C.

Debit B: Any dentists performing Minor Surgical Procedures or Implants and oral pathologists.

Debit C: Any dentist performing major surgical procedures.

3. Approval for participation in this rating rule is subject to underwriting guidelines.

4. Refer to the applicable state rate page for availability.

I. Dental Facility Classification Plan

1. A debit shall apply in addition to the existing filed rate for insureds, or groups of insureds, who practice in or with dental facilities as such non-standard dental practices which are not contemplated in the filed rate structure.

2. Placement into the Dental Facility Classification plan will be determined by the company's underwriting rules and guidelines.

3. Refer to the applicable state rate pages for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Convertible Coverage Rating Plan

1. Insureds shall be provided the option, subject to underwriting guidelines, to convert from Standard Claims Made to Occurrence coverage. The insured shall be eligible for conversion after the following conditions have been met:

   a. Payment to the Company of the applicable premium for a minimum of three annual claims made policies.

   b. Achieve three years of continuous claims made coverage under this plan with no claims attributed to the insured. (A claim shall be a culpable loss. A claim under this plan shall not be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.)

2. At the time the aforementioned conditions are met, and the insured has purchased Occurrence coverage, the Company will issue Extended Reporting Period Coverage, covering professional services subsequent to the retroactive date and prior to the expiration of the claims made policy, and will waive any premium that would normally be due for such extension.

3. Should the insured be unable to meet the conditions for conversion, the insured may elect to purchase the Extended Reporting Period Coverage, subject to policy provisions. Refer to the Extended Reporting Period Rule to determine the applicable premium.

4. The applicable premium under this plan is presented on the State Rate Pages.

5. No other modifications are to apply concurrent with this rule except Membership Association, Risk Management, New to Company and Schedule Rating modifications.

B. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual dentist 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 dentist, part time, moonlighting, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

C. Full-Time Equivalency Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each dentist's number of hours of dental practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
1,800 - Residency Programs

2. For group practices, the minimum average FTE assigned to individual dentists is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Training/Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per dentist rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the dental rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.

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

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

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

* The table value is determined by rounding the actual FTE per policy using the .5 rounding rule. Policies with an FTE of 1 will receive the

6. Premium modifications for new to practice, part time, claim free credit or risk management credit cannot be used in conjunction with this rating rule.

D. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available at the Company's option, on an out-patient visit (OPV) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual dentist limit basis.

2. The number of out-patient visits equivalent to a dentist year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable dental specialty rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new dentist, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

E. Requirements for Waiver of Premium for Extended Reporting Period Coverage for Standard Claims Made Program.

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 disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

3. The Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

   a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

   b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than one year and/or will not attain the required number of years of continuous claims-made coverage at the time of retirement.

   c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

   d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

   e. The insured otherwise meets the requirements as set forth in the policy for a free extension contract.

   f. Refer to the State Rate Pages for availability.

F. Deferred Premium Payment Plan.

1. The Company will, subject to applicable guidelines, offer the insured various premium payment options. The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

G. Aggregate Credit Rule.

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

   This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, Risk Management, New to Company, New to Practice, Membership Association, Moonlighting or Deductible Credits.

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Dentists	$50

D. **Premium Modifications**

1. **Part Time Dentists**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Dentists in Training**

a. Training Activities
(Occurrence & Standard Claims Made Programs)

The Dentist's rate shall be determined by the insured's classification and limit of liability as present on the manual rate tables, subject to any applicable credit determined by the Company to be commensurate with the exposure.

b. Moonlighting Activities
(Occurrence & Standard Claims Made Programs)

Credit
75%

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	No Charge

d. Student / Resident Rating Rule
(Occurrence Program)

Type	Premium
Students	$35 per student
Residents	$50 per resident

3. **Locum Tenens**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

4. **New Dentists**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	75%
2nd	50%
3rd	25%

5. **New to Company Credit**

Program	Credit
Standard Claims Made	35%
Occurrence	35%

6. **Dentist Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

7. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

8. **Dentists Military Leave of Absence Credit**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification - 50% / + 50%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

10. **Risk Management**
(Occurrence & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

11. **Claim Free Credit**
(Occurrence & Standard Claims Made Programs)

Years Claim Free	Credit
3 but less than 5	5%
5 but less than 8	10%
8 or more	15%

12. **Deductible Credits**
(Occurrence & Standard Claims Made Program)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non Discretionary Debit Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Claim Threshold	Points
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

Schedule B:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	25%	0%
4	25%	25%
5	50%	40%
6	50%	40%
7	200%	50%
8	500%	200%
9	700%	500%
10+	800%	700%

For the purposes of this schedule, Table B shall apply to all insureds practicing in the following ISO Codes: 80201 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

16. **Small Group & Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Botulinum Toxin and Dermal Fillers Rating Rule**
(Occurrence & Standard Claims Made Programs)

DEBIT A	DEBIT B	DEBIT C
50%	40%	25%

18. **Dental Facility Classification Plan**
(Occurrence & Standard Claims Made Programs)

Debit
60%

19. **Convertible Coverage Rating Plan**
(Standard Claims Made Program)

The applicable premium under this plan shall be equal to 100% of the manual premium that would otherwise be derived for the insured under the Occurrence Program.

20. **Slot Rating**
(Standard Claims Made Program)

AVAILABLE

21. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
$25,000

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

25. **Accelerated Extension Contract Rating**
(Standard Claims Made Program)

AVAILABLE

26. **Membership Credit**
(Occurrence & Standard Claims Made Programs)

Credit
up to 25%

27. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max Available Credit
50%

28. **Quarterly Installment Option**

(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

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Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Allied Health Care Providers.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per provider, shown on the State Rate Pages, in accordance with each provider's classification and class plan designation.

IV. CLASSIFICATIONS

A. Allied Health Care Providers

1. Each provider is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part Time Allied Health Care Providers

1. Any insured who is determined not to be working on a full time basis will be considered a part time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner is identified on the State Rate Pages.

2. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except risk management credit and/or schedule rating modifications.

C. Dental Hygienist Training

1. Coverage is available for activities directly related to a hygienist's training program. The coverage will not apply to any professional services rendered after the training is complete.

2. Coverage is available to students for activities directly related to their licensing.

   a. Coverage is available to students, on a short-term basis, for services rendered by the student during a dental hygiene externship prior to graduation and/or during the dental hygiene board exam pursuant to the student's professional licensing.

   b. The coverage for students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages. The premium shall be applied to the insured's first annual policy if coverage is purchased within one year of the successful completion of the dental hygiene board exam.

D. Locum Tenens Allied Health Care Providers subsitituting for MPCo Insureds

1. Coverage for an allied health care provider substituting for an insured allied health care provider will be limited to cover only professional services rendered on behalf of the insured allied health care provider for the specified time period. Locum Tenens will share in the insured allied health care provider's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens allied health care provider must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agencies is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. Allied Health Care Provider's Leave of Absence

1. An Allied Healthcare Provider who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

   - The birth of insureds newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
   - To care for a spouse, child or parent who has a serious health condition.
   - To care for insureds own health condition which prevents insured from working.

- Time to enhance the insureds education or other reason while not practicing.

This credit is not available to an insureds leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

G. Allied Healthcare Providers Military Leave of Absence.

A Provider who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 on the State Rate Pages, 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 on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved for by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of therequired documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule and value of the credits.

C. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Credits shall be available, subject to underwriting guidelines.

   b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

D. Experience Rating

1. A group practice, consisting of a specified number of insureds, may receive a credit/debit based on the claim history. The claim 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. Paid losses
e. Projected incurred but not reported losses
f. Cause of such losses
g. Nature of practice

1. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

2. The application of this modification precludes the use of all other rules based upon loss experience criteria.

E. Large Group Rating.

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

6. Refer to the State Rate Pages for availability.

F. Small Group Rating Rule

Any group practice consisting of two or more healthcare providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Group's Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insureds based upon applicable underwriting criteria.

4. For Individual insureds within the group, the extension contract premium will be calculated per the Filed Extension Contract Rating Rule.

5. Refer to the applicable State Rate Page for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual practitioner 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 part time or risk management credit cannot be used in conjunction with this rating rule.

B. Full Time Equivalency Rating

Coverage for an Allied Healthcare provider group is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual insured basis. Coverage is provided on an individual limit or shared limit basis. Full time equivalency is based on each allied healthcare provider's number of hours of practice per year. The definition of one FTE is based on the following number of hours per year:

2,000	Group Practice
1,800	Training/Residency Programs

For group practices, the minimum average FTE assigned to any individual Allied Healthcare provider is .10 (200 Hours), subject to a total FTE per policy of no less than 1.0. Training/residency programs (and other similar programs) are not subject to the group practice minimums.

The premium developed by applying the applicable Allied Healthcare rate to the corresponding FTE will be adjusted to reflect loss cost considerations recognized in the standard rates.

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

FTE* Per Policy	Premium Modification
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

* The table value is determined by rounding the actual FTE per policy using the .50 rounding rule.

Premium modification for Part Time Practice or Risk Management cannot be used in conjunction with this rating rule.

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

C. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on an out-patient visit (OPV) basis rather than on an individual practitioner basis. Coverage is provided on a shared or individual practitioner limit basis.

2. The number of out-patient visits equivalent to a practitioner year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 3 visits per hour and a maximum rate of 6 visits per hour.

3. The applicable classification rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

D. 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 disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. For an insured, classified as 4B and above, the Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

   a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

   b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than one year and/or will not attain the required number of years of continuous claims-made coverage at the time of retirement.

   c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

   d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

   e. The insured otherwise meets the requirements as set forth in the policy for a free extension contract.

   f. Refer to the State Rate Pages for availability.

E. Deferred Premium Payment Plan

1. The Company will, subject to applicable guidelines, offer the insured various premium payment options. The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

F. Aggregate Credit Rule

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

   This rule does not apply to Deductible Credits, Part Time Practice, Leave of Absence, Military Leave of Absence, or Risk Management Credits.

A. Classifications

1. Applicable to the Occurrence and Standard Claims Made Programs.

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

CLASS I-A

Dental Assistant, Dental Hygienist.

CLASS I-B

Cardiology Technologist, Clinical Laboratory Technologist, Counselor, Dietician, Electrocardiograph Technician, Electroneurodiagnostic Technologist, Licensed Practicing Nurse, Medical Laboratory Technician, Medical (Office) Assistant, Medical Records Technician, Nuclear Medicine Technologist, Ophthalmology Technician, Respiratory Therapy Assistant, Registered Nurse.

CLASS II

Audiologist/Speech Pathologist, Nurse Midwife Assistant, Occupational Therapist Assistant, Optician, Physical Therapy Assistant, Radiation Therapy Technologist, Social Worker, Surgical Technician, X-Ray Technician.

CLASS III

Optometrist, Paramedic/EMT, Pharmacist, Physical Therapist (Non-Owner).

CLASS IV

Case Manager, Occupational Therapist, Perfusionist, Physical Therapist (Owner), Psychologist, Respiratory Therapist.

CLASS V

Nurse Practitioner (Non-prescribing), Physician's Assistant (Non-prescribing).

CLASS VI

Nurse Surgical Assistant, Physician Surgical Assistant.
Nurse Practitioner (Prescribing), Physician's Assistant (Prescribing).

CLASS VII-A

Certified Registered Nurse Anesthetist, Registered Nurse Anesthetist, Anesthesia Assistant.

CLASS VII-B

Nurse Midwife.

CLASS VIII-A

Podiatrist (No Surgery)

CLASS VIII-B

Podiatrist (Surgery).

B. Manual Rates

1. Territory Definitions

Refer to Program Type for the Territory definition and description.

2. Occurrence Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. Class 1A base rates are calculated as a percentage of the Dentists Statewide 100/300 Limits Occurrence rate.
b. Classes 1B-4 base rates are calculated as a percentage of the Physicians & Surgeons Territory 2 (Rest of State) 100/300 Limits Occurrence rate.
c. Classes 5 –8B base rates are calculated as a percentage of the Physicians & Surgeons 100/300 Limits occurrence rate for the appropriate territory.
d. Rates for higher that 100/300 limits are calculated by applying the Allied Healthcare Provider increased limit factors to the base rate.

3. Standard Claims Made Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. The Mature Standard Claims Made rate for Class 1A is 0.925 of the corresponding Allied Health Care Provider Occurrence rate.
b. The Mature Standard Claims Made rate for Classes 1B-8B is 0.900 of the corresponding Allied Health Care Provider Occurrence Rate.
c. Class 1A base rates are calculated as a percentage of the Dentists Territory (Rest of State) 100/300 Limits Occurrence rate.
d. Classes 1B-4 base rates are calculated as a percentage of the Physicians & Surgeons Territory (Rest of State) 100/300 Limits Occurrence rate.
e. Classes 5 –8B base rates are calculated as a percentage of the Physicians & Surgeons 100/300 Limits occurrence rate for the appropriate territory.
f. Allied Health Care Provider Claims Made Factors may be applied to the Mature Standard Claims Made base rate for the applicable year of claims made coverage.
g. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

4. Increased Limits Factors

Limits	Classes 1A-5	Classes 6-8B
100/300	1.000	1.000
200/600	1.220	1.260
500/1000	1.460	1.630
1000/1000	1.750	1.940
1000/3000	1.800	2.000
2000/2000	2.050	2.410
2000/4000	2.120	2.480
3000/3000	2.220	2.680
3000/5000	2.290	2.750

A minimum of 1000/3000 underlying limits required in order to purchase shared excess limits.

5. Extended Reporting Period Coverage Factors

Years Retro. Date Precedes Expiration Date	Classes 1A-4	Classes 5-8B
1	0.750	0.700
2	1.000	1.000
3	1.100	1.150
4	1.150	1.200
5 or more	1.200	1.250

a. Factor applies to Mature Claims-Made Allied Health Care Provider rate.

6. Claims Made Factors

Years Since Retroactive Date	Class 1A-4	Classes 5-8B
0	0.60	0.45
1	0.80	0.70
2	0.90	0.85
3	0.95	0.90
4 or More	1.00	1.00

7. Shared Limits Modification

Modification
Up to 25%

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Allied Health Care Provider	$50

D. Premium Modifications

1. Part Time Allied Health Care Provider

(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-10	515	50%
11-20	1050	30%

Part Time Credits are available for AHCP Classes 4-8B Only.

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. Dental Hygienist in Training

NOT AVAILABLE

3. Locum Tenens

NOT AVAILABLE

4. Temporary Staffing Agency Rating Coverage

(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. Leave of Absence

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

6. Military Leave of Absence

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

7. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification -50% / +50%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

8. **Risk Management**
(Occurrence & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

9. **Deductible Credits**
(Occurrence & Standard Claims Made Program)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

10. **Self-Insured Retention Credits**

NOT AVAILABLE

11. **Experience Rating**

NOT AVAILABLE

12. **Small Group Rating Rule**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

13. **Large Group Rating Rule**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

14. **Slot Rating**
(Standard Claims Made Program)

AVAILABLE

15. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

16. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Accelerated Extension Contract Rating**
(Standard Claims Made Program)

AVAILABLE

18. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max Available Credit
50%

19. **Quarterly Installment Option**

(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

4 PAY - 25% down, 3 equal quarterly payments thereafter

If manual premium is over $150,000

25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

20. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
$250,000

21. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

STRIKE THRU COMPARISON DOCUMENTS

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AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION OR DEDUCTIBLE CREDITS.

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CONVERTIBLE PLUS / NOSE RATING PLAN

A HEALTHCARE PROVIDER THAT IS CURRENTLY INSURED UNDER A CLAIMS-MADE POLICY FORM MAY BE ELIGIBLE FOR CONVERTIBLE / NOSE COVERAGE, SUBJECT TO UNDERWRITING GUIDELINES. THIS COVERAGE WILL PROVIDE NOSE COVERAGE TO HEALTHCARE PROVIDERS THAT SEEK TO CONVERT TO AN OCCURRENCE POLICY FORM. THE RATING FOR SUCH COVERAGE IS BASED UPON THE INSUREDS STANDARD MATURE CLAIMS MADE RATE TIMES THE FACTOR IDENTIFIED IN THE TABLE BELOW.

YEARS RETROACTIVE DATE PRECEDES POLICY INCEPTION DATE	FACTOR
1	.75
2	1.08
3	1.18
4 OR MORE	1.25

THE APPLICABLE PREMIUM UNDER THIS PLAN SHALL BE IN ADDITION TO THE HEALTHCARE PROVIDER'S STANDARD OCCURRENCE PREMIUM AND SHALL BE PAID TO THE COMPANY OVER AN INSTALLMENT PERIOD.

IN THE EVENT THE INSURED CANCELS THE OCCURRENCE COVERAGE, WITHIN THE FIRST FIVE YEARS SUBSEQUENT TO THE ISSUANCE OF THE PRODUCT, FOR REASONS OTHER THAN NON-RENEWAL, DEATH, TOTAL AND PERMANENT

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CONVERTIBLE PLUS / NOSE RATING PLAN

DISABILITY OR PERMANENT RETIREMENT, ADDITIONAL PREMIUM SHALL BE DUE AND PAYABLE. ADDITIONAL PREMIUM SHALL BE CALCULATED AT THE COMPANY'S FILED RATE FOR AN EXTENSION CONTRACT ENDORSEMENT AT THE TIME THE CONVERTIBLE PLUS CLAIMS MADE COVERAGE IS ISSUED. ANY UNPAID BALANCE BETWEEN THIS AMOUNT AND ANY PAYMENTS MADE PRIOR TO THE CANCELLATION DATE IS DUE SIXTY (60) DAYS FROM THE DATE OF CANCELLATION.

THE RATING UNDER THIS RULE IS SUBJECT TO APPLICABLE PART-TIME AND SCHEDULE RATING MODIFICATIONS.

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FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-PHYSICIAN GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL PHYSICIAN BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH PHYSICIAN'S NUMBER OF HOURS OF MEDICAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL PHYSICIAN IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER PHYSICIAN RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE PHYSICIAN RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR ~~LOSS FREE~~ RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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NON-DISCRETIONARY DEBIT PLAN

FOR ANY INSURED WHO IS NOT ELIGIBLE FOR A CREDIT UNDER THE COMPANY'S CLAIM/LOSS FREE CREDIT RULE, POINTS WILL BE ASSIGNED FOR EACH CLAIM:

1) PENDING AGAINST THE INSURED AT THE BEGINNING OF THE CURRENT POLICY PERIOD;
2) PAID ON THE INSURED'S BEHALF DURING THE PAST 5 YEARS; OR
3) CLOSED WITH NO PAYMENT DURING THE PAST 5 YEARS,

PURSUANT TO THE FOLLOWING SCHEDULE:

ASSIGNED CLAIM POINTS	
Claim Threshold	**Points**
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

FOR PROVIDERS WHO HAVE BEEN PRACTICING FOR LESS THAN EIGHT COMPLETE YEARS FROM THEIR INITIAL MEDICAL SCHOOL GRADUATION DATE, THE TOTAL ASSIGNED CLAIM POINTS (AS CALCULATED FROM THE SCHEDULE ABOVE) WILL BE MULTIPLIED BY THE APPLICABLE FACTOR SET FORTH IN THE FOLLOWING SCHEDULE:

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NON-DISCRETIONARY DEBIT PLAN

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 years or more	No factor applied

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY WHO HAVE PENDING CLAIMS OR CLAIMS PAID ON THEIR BEHALF WITHIN THE PAST FIVE YEARS WILL BE ASSIGNED POINTS IN ACCORDANCE WITH COMPANY GUIDELINES.

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OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

A DEBIT SHALL THEN BE APPLIED TO THE INSURED'S RATE BASED UPON THE FOLLOWING SCHEDULE:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. TABLE A SHALL APPLY TO INSUREDS PRACTICING UNDER ANY OTHER ISO CODE.)

FOR THE PURPOSE OF THIS RULE, A "CLAIM" SHALL NOT INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

The

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ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

ANY DEBIT REQUIRED UNDER THIS RULE SHALL BE ADDITIVE WITH ANY OTHER DEBITS OR CREDITS APPLICABLE UNDER THE COMPANY'S RATING MANUAL.

THIS NON-DISCRETIONARY DEBIT PLAN SHALL ONLY APPLY TO PROVIDERS WHO MEET THE COMPANY'S GUIDELINES FOR ACCEPTANCE, AND THE COMPANY RETAINS THE RIGHT TO REFUSE TO INSURE ANY INSURED OR APPLICANT BASED UPON THE QUALITATIVE NATURE OF ANY CLAIMS MADE AGAINST THAT INDIVIDUAL OR ENTITY. AS A RESULT, THE FACT THAT THIS RULE PROVIDES (OR DOES NOT PROVIDE) A DEBIT FOR CLAIMS EXPERIENCE IS NOT AN INDICATION THAT THERE IS A RATE AVAILABLE FOR ANY PARTICULAR INSURED OR APPLICANT.

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OCCURRENCE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS AND/OR RISK MANAGEMENT.

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OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

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/CONTRACTED PHYSICIANS.

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

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OCCURRENCE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING ~~APPROVAL~~ REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, ~~LOSS/~~CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION OR DEDUCTIBLE CREDITS.

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STANDARD CLAIMS MADE PROGRAM

EXTENSION CONTRACT RATING

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, NON-DISCRETIONARY DEBIT, DEDUCTIBLE AND SCHEDULE RATING ~~DEBITS~~ MODIFICATIONS.

PARTNERSHIP / CORPORATION EXTENSION CONTRACT RATING SHALL BE BASED ON THE NUMBER OF SHAREHOLDERS, PARTNERS AND INDEPENDENT CONTRACTORS AT THE INCEPTION DATE OF THE MOST RECENT POLICY.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-PHYSICIAN GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL PHYSICIAN BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH PHYSICIAN'S NUMBER OF HOURS OF MEDICAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL PHYSICIAN IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER PHYSICIAN RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE PHYSICIAN RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR ~~LOSS FREE~~ RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

FOR ANY INSURED WHO IS NOT ELIGIBLE FOR A CREDIT UNDER THE COMPANY'S CLAIM/LOSS FREE CREDIT RULE, POINTS WILL BE ASSIGNED FOR EACH CLAIM:

1) PENDING AGAINST THE INSURED AT THE BEGINNING OF THE CURRENT POLICY PERIOD;
2) PAID ON THE INSURED'S BEHALF DURING THE PAST 5 YEARS; OR
3) CLOSED WITH NO PAYMENT DURING THE PAST 5 YEARS,

PURSUANT TO THE FOLLOWING SCHEDULE:

ASSIGNED CLAIM POINTS	
Claim Threshold	**Points**
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

FOR PROVIDERS WHO HAVE BEEN PRACTICING FOR LESS THAN EIGHT COMPLETE YEARS FROM THEIR INITIAL MEDICAL SCHOOL GRADUATION DATE, THE TOTAL ASSIGNED CLAIM POINTS (AS CALCULATED FROM THE SCHEDULE ABOVE) WILL BE MULTIPLIED BY THE APPLICABLE FACTOR SET FORTH IN THE FOLLOWING SCHEDULE:

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 years or more	No factor applied

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY WHO HAVE PENDING CLAIMS OR CLAIMS PAID ON THEIR BEHALF WITHIN THE PAST FIVE YEARS WILL BE ASSIGNED POINTS IN ACCORDANCE WITH COMPANY GUIDELINES.

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

A DEBIT SHALL THEN BE APPLIED TO THE INSURED'S RATE BASED UPON THE FOLLOWING SCHEDULE:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. TABLE A SHALL APPLY TO INSUREDS PRACTICING UNDER ANY OTHER ISO CODE.)

FOR THE PURPOSE OF THIS RULE, A "CLAIM" SHALL NOT INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

ANY DEBIT REQUIRED UNDER THIS RULE SHALL BE ADDITIVE WITH ANY OTHER DEBITS OR CREDITS APPLICABLE UNDER THE COMPANY'S RATING MANUAL.

THIS NON-DISCRETIONARY DEBIT PLAN SHALL ONLY APPLY TO PROVIDERS WHO MEET THE COMPANY'S GUIDELINES FOR ACCEPTANCE, AND THE COMPANY RETAINS THE RIGHT TO REFUSE TO INSURE ANY INSURED OR APPLICANT BASED UPON THE QUALITATIVE NATURE OF ANY CLAIMS MADE AGAINST THAT INDIVIDUAL OR ENTITY. AS A RESULT, THE FACT THAT THIS RULE PROVIDES (OR DOES NOT PROVIDE) A DEBIT FOR CLAIMS EXPERIENCE IS NOT AN INDICATION THAT THERE IS A RATE AVAILABLE FOR ANY PARTICULAR INSURED OR APPLICANT.

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STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS AND/OR RISK MANAGEMENT.

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STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE (CON'T)

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,050 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY. IF SO, THE AVERAGE NUMBER OF HOURS IN PRACTICE PER WEEK DURING THE PREVIOUS FIVE POLICY YEARS WILL DETERMINE THE APPLICABLE CREDIT.

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STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

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/CONTRACTED PHYSICIANS.

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STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE (CON'T)

THE PREMIUM OTHERWISE DETERMINED FOR THE PARTNERSHIP OR CORPORATION MAY BE DISCOUNTED 50% SHOULD THE INSURED ELECT TO EXCLUDE THE VICARIOUS LIABILITY ASSOCIATED WITH THE PARTNERS', SHAREHOLDERS' AND EMPLOYED/CONTRACTED PHYSICIANS' PROFESSIONAL SERVICES.

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STANDARD CLAIMS MADE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING ~~APPROVAL~~ REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, ~~LOSS/~~CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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DENTISTS

OCCURRENCE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION, MOONLIGHTING OR DEDUCTIBLE CREDITS.

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OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-DENTIST GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL DENTIST BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH DENTIST'S NUMBER OF HOURS OF DENTAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
1,800	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL DENTIST IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER DENTIST RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE DENTIST RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR ~~CLAIM FREE~~ RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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OCCURRENCE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS, AND/OR RISK MANAGEMENT.

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RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $25,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING ~~APPROVAL~~ REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, ~~LOSS/~~CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION, MOONLIGHTING OR DEDUCTIBLE CREDITS.

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EXTENSION CONTRACT RATING

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, NON-DISCRETIONARY DEBIT, DEDUCTIBLE AND SCHEDULE RATING ~~DEBITS~~ MODIFICATIONS.

PARTNERSHIP / CORPORATION EXTENSION CONTRACT RATING SHALL BE BASED ON THE NUMBER OF SHAREHOLDERS, PARTNERS AND INDEPENDENT CONTRACTORS AT THE INCEPTION DATE OF THE MOST RECENT POLICY.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-DENTIST GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL DENTIST BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH DENTIST'S NUMBER OF HOURS OF DENTAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
1,800	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL DENTIST IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER DENTIST RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE DENTIST RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

The
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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR ~~CLAIM FREE~~ RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS, AND/OR RISK MANAGEMENT.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE (CON'T)

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,050 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY. IF SO, THE AVERAGE NUMBER OF HOURS IN PRACTICE PER WEEK DURING THE PREVIOUS FIVE POLICY YEARS WILL DETERMINE THE APPLICABLE CREDIT.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $25,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING ~~APPROVAL~~ REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, ~~LOSS/~~CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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ALLIED HEALTHCARE PROVIDERS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS I-A

DENTAL ASSISTANT, DENTAL HYGIENIST.

CLASS I-B

CARDIOLOGY TECHNOLOGIST, CLINICAL LABORATORY TECHNOLOGIST, COUNSELOR, DIETICIAN, ELECTROCARDIOGRAPH TECHNICIAN, ELECTRONEURODIAGNOSTIC TECHNOLOGIST, LICENSED PRACTICING NURSE, MEDICAL LABORATORY TECHNICIAN, MEDICAL (OFFICE) ASSISTANT, MEDICAL RECORDS TECHNICIAN, NUCLEAR MEDICINE TECHNOLOGIST, OPHTHALMOLOGY TECHNICIAN, RESPIRATORY THERAPY ASSISTANT, REGISTERED NURSE.

CLASS II

AUDIOLOGIST/SPEECH PATHOLOGIST, NURSE MIDWIFE ASSISTANT, OCCUPATIONAL THERAPIST ASSISTANT, OPTICIAN, PHYSICAL THERAPY ASSISTANT, RADIATION THERAPY TECHNOLOGIST, SOCIAL WORKER, SURGICAL TECHNICIAN, X-RAY TECHNICIAN.

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ALLIED HEALTHCARE PROVIDERS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS III

OPTOMETRIST, PARAMEDIC/EMT, PHARMACIST, PHYSICAL THERAPIST (NON-OWNER).

CLASS IV

CASE MANAGER, OCCUPATIONAL THERAPIST, PERFUSIONIST, PHYSICAL THERAPIST (OWNER), PSYCHOLOGIST, RESPIRATORY THERAPIST.

CLASS V

NURSE PRACTITIONER (NON-PRESCRIBING), PHYSICIAN'S ASSISTANT (NON-PRESCRIBING).

CLASS VI

NURSE SURGICAL ASSISTANT, PHYSICIAN SURGICAL ASSISTANT.

NURSE PRACTITIONER (PRESCRIBING), PHYSICIAN'S ASSISTANT (PRESCRIBING).

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ALLIED HEALTHCARE PROVIDERS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS VII - A

CERTIFIED REGISTERED NURSE ANESTHETIST, REGISTERED NURSE ANESTHETIST, ANESTHESIA ASSISTANT.

CLASS VII - B

NURSE MIDWIFE.

CLASS VIII - A

PODIATRIST (NO SURGERY).

CLASS VIII - B

PODIATRIST (SURGERY).

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OCCURRENCE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT OR DEDUCTIBLE CREDITS.

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2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL ALLIED HEALTHCARE PROVIDER IS .10 (200 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE ALLIED HEALTHCARE RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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FTE* PER POLICY	PREMIUM MODIFICATION
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

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NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT AND SCHEDULE RATING MODIFICATIONS.

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RENEWAL RATING RULE

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ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

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DENTAL ASSISTANT, DENTAL HYGIENIST.

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NURSE SURGICAL ASSISTANT, PHYSICIAN SURGICAL ASSISTANT.

NURSE PRACTITIONER (PRESCRIBING), PHYSICIAN'S ASSISTANT (PRESCRIBING).

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RATE CLASSES

CLASS VII - A

CERTIFIED REGISTERED NURSE ANESTHETIST, REGISTERED NURSE ANESTHETIST, ANESTHESIA ASSISTANT.

CLASS VII - B

NURSE MIDWIFE.

CLASS VIII - A

PODIATRIST (NO SURGERY).

CLASS VIII - B

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STANDARD CLAIMS MADE PROGRAM

EXTENSION CONTRACT RATING

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, DEDUCTIBLE AND SCHEDULE RATING MODIFICATIONS.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL ALLIED HEALTHCARE PROVIDER IS .10 (200 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE ALLIED HEALTHCARE RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

FTE* PER POLICY	PREMIUM MODIFICATION
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR PART TIME PRACTICE OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

FTE POLICIES MAY BE ~~ARE~~ SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY ~~WILL~~ BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT AND SCHEDULE RATING MODIFICATIONS.

DUE TO MINIMUM PREMIUM REQUIREMENTS, PART TIME CREDITS ARE AVAILABLE FOR CLASS 4-8B ONLY.

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,050 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY. IF SO, THE AVERAGE NUMBER OF HOURS IN PRACTICE PER WEEK DURING THE PREVIOUS FIVE POLICY YEARS WILL DETERMINE THE APPLICABLE CREDIT.

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STANDARD CLAIMS MADE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF $250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING ~~APPROVAL~~ REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, ~~LOSS/~~CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

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ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

A. **Classification**

1. As defined by state statutes and formed for the purpose of rendering medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists – All Other Dental Specialties	5%	Available
Dentists – Oral Surgeons	1%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

c. The premium otherwise determined for the partnership or corporation may be discounted 50% should the insured elect to exclude the vicarious liability associated with the partners', shareholders' and employed/contracted physicians' professional services.

2. **Miscellaneous Entities**

NOT AVAILABLE

3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.900~~750~~	1.150	1.200
5 or more	1.820	1.900~~750~~	1.200	1.250

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$50~~25~~
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 50%~~35%~~
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

2. **Deductible Credits**
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

3. **Self-Insured Retention Credits**

NOT AVAILABLE

4. **Small Group, Large Group & Temporary Staffing Agency Rating – Corporations**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

5. Renewal Rate Rule
(Occurrence & Standard Claims Made Programs)

Specialty Type	Premium Threshold
Physicians & Surgeons	$250,000
Dentists	$25,000
Allied Health Care Providers	$250,000

~~5.~~6. Quarterly Installment Option
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Physician & Surgeons	$250

D. **Premium Modifications**

1. **Part Time Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

3. **Locum Tenens**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

4. **Temporary Staffing Agency Rating**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **New Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

6. **Physician Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

7. **Physicians Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

8. **Physicians Military Leave of Absence Credit**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification -50% / +50%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

10. **Risk Management**
(Occurrence, & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

11. **Claim Free Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 8	10%
8 but less than 10	15%
10 or more	20%

12. **Deductible Credits**
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non-Discretionary Debit Rating Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Claim Threshold	Points
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

Schedule B:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80136, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84136, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code. ***Refer to the Classification Translation Table – Specialty Description to ISO Code at the end of this section.***

16. **Small Group & Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Convertible Coverage Rating Plan**

NOT AVAILABLE

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

20. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
$250,000

~~**NOT AVAILABLE**~~

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

25. **Membership Credit**
(Occurrence & Standard Claims Made Programs)

Credit
5%

26. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max AvailableCredit
50%

27. **Quarterly Installment Option**
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

*****Classification Translation Table – Specialty Description to ISO Code**

	Speciality Code	MD	DO	Class
Allergy	39	80254	84254	1A
Cardiology (Including Swan-Ganz)	33	80255	84255	2A
Dermatology	31	80256	84256	1A
Family/General Practice	19	80420	84420	1C
Aerospace	19	80230	84230	1A
Forensic Medicine	36	80240	84240	1A
Geriatrics	32	80243	84243	1B
Nuclear Medicine	37	80262	84262	1A
Nutrition	32	80248	84248	1A
Occupational Medicine	19	80233	84233	1A
Physiatry	19	80235	84235	1A
Public Health	19	80236	84236	1A
Gynecology	15	80244	84244	1B
Internal Medicine	32	80257	84257	1D
Diabetes	32	80237	84237	2A
Endocrinology	32	80238	84238	1B
Gastroenterology	32	80241	84241	2B
Hematology / Oncology	32	80245	84245	2A
Infectious Disease	32	80246	84246	2B
Nephrology	32	80260	84260	1C
Pharmacology	32	80234	84234	1B
Preventative Medicine	32	80231	84231	1A
Rheumatology	32	80252	84252	1C
Neonatology	34	80471	84471	2B
Neurology	40	80261	84261	2B
Ophthalmology	16	80263	84263	1A
Otolaryngology	23	80265	84265	1B
Otology	23	80264	84264	1B
Larynogology	23	80258	84258	1B

	Speciality Code	MD	DO	Class
Rhinology	23	80247	84247	1B
Pathology	36	80266	84266	1B
Pediatrics	34	80267	84267	1C
Psychiatry - Inc. Child	35	80249	84249	1B
Hypnosis	35	80232	84232	1B
Psychoanalysis	35	80250	84250	1B
Psychosomatic	35	80251	84251	1B
Pulmonary Disease	38	80269	84269	2C
Radiology - Diagnostic	37	80253	84253	2B
Urgent Care	26	80102	84102	2A
Retired Physician	XX	80179	84179	
Physician - N.O.C.	19	80268	84268	1B
Surgical Specialist Performing No Surgery, But Still Practicing In That Speciality		80268	84268	1B
Cardiology (Right Heart Cath. Only)	33	80281	84281	2C
Dermatology	31	80282	84282	1B
Family/General Practice	19	80421	84421	2C
Geriatrics	32	80276	84276	2B
Physicians - N.O.C.	XX	80294	84294	2B
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80274	84274	2C
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279	84279	2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287	84287	2B
Neurology	40	80288	84288	3A
Ophthalmology	16	80289	84289	1C
Otorhinolaryngology	23	80291	84291	2B
Otology	23	80290	84290	2B
Laryngology	23	80285	84285	2B
Rhinology	23	80270	84270	2B

	Speciality Code	MD	DO	Class
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Psychiatry - Inc. Shock Therapy	35	80431	84431	2B
Radiology - Diagnostic	37	80280	84280	2D
Radiology - Teleradiology	90	80280	84280	2D
Radiology - Therapy	37	80425	84425	2B
Radiology - Teleradiology	90	80425	84425	2B
Pain Management	19, 30, 40	80295	84295	2A
Hospitalist	32	80296	84296	1D
Surgical Specialist Performing Minor Surgery On Their Own Patients While Practicing In That Speciality:		80294	84294	2B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Radiation Therapy	XX	80425	84425	2B
Radiopaque Dye Injection	XX	80449	84449	2D
Radiology - incld. Mammography	37	80472	84472	2D
Radiology - Teleradiology	90	80472	84472	2D
Shock Therapy	XX	80431	84431	2B
Physicians Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients - Not Primarily Engaged In Major Surgery:				
Dermatology	31	80282	84282	1B
Family/General Practice	19	80117	84117	3B
Geriatrics	19	80105	84105	3B
Physicians - N.O.C.	19	80294		
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Diabetes	32	80271		
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80104	84104	3A
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279		2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287		2B
Neurology	40	80288	84288	3A
Otorhinolaryngology	23	80291	84291	2B

	Speciality Code	MD	DO	Class
Otology	23	80290		2B
Laryngology	23	80285		2B
Rhinology	23	80270		2B
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Emergency Medicine (No Major Surg)	25	80102	84102	4A
Surgical Specialists:				
Ophthalmology	16	80114	84114	1D
Colon and Rectal	24	80115	84115	3B
Emergency Medicine (Incl. Major Surg)	25	80157	84157	4B
Surgical Specialist Performing Major Surgery Or Assisting In Major Surgery On Other Than Their Own Patients While Practicing In That Speciality, But Not Primarily Engaged In Major Surgery:		80117	84117	3B
Physicians And Surgical Specialist Performing The Following Procedures (Xx = Code For Speciality)				
Acupuncture	XX	80437	84437	3A
Cardiology (Incl. Left Heart Cath.)	33	80422	84422	3A
Internal Medicine (Incl. Left Heart Cath.)	32	80422	84422	3A
Urology	17	80145	84145	3A
Fam./Gen. Practice - incl. deliveries	29	80273	84273	3A
Anesthesiology	30	80151	84151	2A
Abdominal	10	80166	84166	6B
Cosmetic	10, 15, 16, 20, 23, 31	80136	84136	5A
General - N.O.C.	10	80143	84143	6B
Otorhinolaryngology	23	80159	84159	3A
Otology	23	80158	84158	3A
Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	4A
Head and Neck	13	80170	84170	4A
Obstetrics/Gynecology	15	80153	84153	6B
Obstetrics	15	80168	84168	6B
Gynecology	18	80167	84167	4A
Plastic - N.O.C.	20	80156	84156	5A

	Speciality Code	MD	DO	Class
Cardiovascular	21	80150	84150	5B
Neurological	12	80152	84152	8
Orthopedic (Excl. back)	13	80176	84176	4A
Orthopedic (Incl. back)	13	80154	84154	6A
Thoracic	14	80144	84144	5B
Traumatic	10	80171	84171	7
Vascular	22	80146	84146	5B

28. **Convertible Plus / Nose Rating Plan**
(Occurrence Program)

A healthcare provider that is currently insured under a claims-made policy form may be eligible for Convertible / Nose coverage, subject to underwriting guidelines. This coverage will provide nose coverage to healthcare providers that seek to convert to an occurrence policy form. The rating for such coverage is based upon the insureds standard mature claims made rate times the factor identified in the table below.

Years Retroactive Date Precedes Policy Inception Date	Factor
1	.75
2	1.08
3	1.18
4 or More	1.25

The applicable premium under this plan shall be in addition to the healthcare provider's standard occurrence premium and shall be paid to the Company over an installment period.

In the event the insured cancels the occurrence coverage, within the first five years subsequent to the issuance of the product, for reasons other than non-renewal, death, total and permanent disability or permanent retirement, additional premium shall be due and payable. Additional premium shall be calculated at the Company's filed rate for an extension contract endorsement at the time the Convertible Plus Claims Made coverage is issued. Any unpaid balance between this amount and any payments made prior to the cancellation date is due sixty (60) days from the date of cancellation.

The rating under this rule is subject to applicable Part-Time and Schedule Rating modifications.

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Dentists	~~$100~~50

D. **Premium Modifications**

1. **Part Time Dentists**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Dentists in Training**

a. Training Activities
(Occurrence & Standard Claims Made Programs)

The Dentist's rate shall be determined by the insured's classification and limit of liability as present on the manual rate tables, subject to any applicable credit determined by the Company to be commensurate with the exposure.

b. Moonlighting Activities

~~**NOT AVAILABLE**~~
(Occurrence & Standard Claims Made Programs)

Credit
75%

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	~~$25~~No Charge

d. Student / Resident Rating Rule
(Occurrence Program)

Type	Premium
Students	$35 per student
Residents	$50 per resident

3. **Locum Tenens**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

4. **New Dentists**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	~~60%~~75%
2nd	~~40%~~50%
3rd	~~20%~~25%

5. **New to Company Credit**

Program	Credit
Standard Claims Made	~~25%~~35%
Occurrence	~~25%~~35%

6. **Dentist Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

7. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

8. **Dentists Military Leave of Absence Credit**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification -50% / + 50%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

10. **Risk Management**

(Occurrence & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

11. **Claim Free Credit**
(Occurrence & Standard Claims Made Programs)

Years Claim Free	Credit
3 but less than 5	5%
5 but less than 8	10%
8 or more	15%

12. **Deductible Credits**
(Occurrence & Standard Claims Made Program)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non Discretionary Debit Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Claim Threshold	Points
Pending claim	1
Loss payment of $0 to $49,999	1
Loss payment of $50,000 to $99,999	2
Loss payment of $100,000 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

Schedule B:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	25%	0%
4	25%	25%
5	50%	40%
6	50%	40%
7	200%	50%
8	500%	200%
9	700%	500%
10+	800%	700%

For the purposes of this schedule, Table B shall apply to all insureds practicing in the following ISO Codes: 80201 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

16. **Small Group & Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Botulinum Toxin and Dermal Fillers Rating Rule**

(Occurrence & Standard Claims Made Programs)

DEBIT A	DEBIT B	DEBIT C
50%	40%	25%

18. **Dental Facility Classification Plan**
(Occurrence & Standard Claims Made Programs)

Debit
60%

~~16.~~19. **Convertible Coverage Rating Plan**
(Standard Claims Made Program)

The applicable premium under this plan shall be equal to 100% of the manual premium that would otherwise be derived for the insured under the Occurrence Program.

~~17.~~20. **Slot Rating**
(Standard Claims Made Program)

AVAILABLE

~~18.~~21. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

~~19.~~22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

~~20~~23. **Renewal Rate Rule**
~~(Occurrence & Standard Claims Made Programs)~~

~~**AVAILABLE**~~

Premium Threshold
$25,000

~~21. **Deferred Premium Payment Plan**~~
(Occurrence & Standard Claims Made Programs)

~~**Refer to Quarterly Installment Option rule..**~~

~~22. **Accelerated Extension Contract Rating**~~

~~(Standard Claims Made Program)~~

~~**AVAILABLE**~~

~~23. **Membership Credit**~~
~~(Occurrence & Standard Claims Made Programs)~~

~~Credit~~
~~5%~~

~~**24. Aggregate Credit Rule**~~

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

25. **Accelerated Extension Contract Rating**
(Standard Claims Made Program)

AVAILABLE

26. **Membership Credit**
(Occurrence & Standard Claims Made Programs)

Credit
~~5%~~up to 25%

27. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max Available Credit
50%

28. **Quarterly Installment Option**

(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

If manual premium is over $150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

A. Classifications

1. Applicable to the Occurrence and Standard Claims Made Programs.

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

CLASS I-A

Dental Assistant, Dental Hygienist.

CLASS I-B

Cardiology Technologist, Clinical Laboratory Technologist, Counselor, Dietician, Electrocardiograph Technician, Electroneurodiagnostic Technologist, Licensed Practicing Nurse, Medical Laboratory Technician, Medical (Office) Assistant, Medical Records Technician, Nuclear Medicine Technologist, Ophthalmology Technician, Respiratory Therapy Assistant, Registered Nurse.

CLASS II

Audiologist/Speech Pathologist, Nurse Midwife Assistant, Occupational Therapist Assistant, Optician, Physical Therapy Assistant, Radiation Therapy Technologist, Social Worker, Surgical Technician, X-Ray Technician.

CLASS III

Optometrist, Paramedic/EMT, Pharmacist, Physical Therapist (Non-Owner).

CLASS IV

Case Manager, Occupational Therapist, Perfusionist, Physical Therapist (Owner), Psychologist, Respiratory Therapist.

CLASS V

Nurse Practitioner (Non-prescribing), Physician's Assistant (Non-prescribing).

CLASS VI

Nurse Surgical Assistant, Physician Surgical Assistant.
Nurse Practitioner (Prescribing), Physician's Assistant (Prescribing).

CLASS VII-A

Certified Registered Nurse Anesthetist, Registered Nurse Anesthetist, Anesthesia Assistant.

CLASS VII-B

Nurse Midwife.

CLASS VIII-A

Podiatrist (No Surgery)

CLASS VIII-B

Podiatrist (Surgery).

B. Manual Rates

1. Territory Definitions

Refer to Program Type for the Territory definition and description.

2. Occurrence Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. Class 1A base rates are calculated as a percentage of the Dentists Statewide 100/300 Limits Occurrence rate.

b. Classes 1B-4 base rates are calculated as a percentage of the Physicians & Surgeons Territory 2 (Rest of State) 100/300 Limits Occurrence rate.

c. Classes 5 –8B base rates are calculated as a percentage of the Physicians & Surgeons 100/300 Limits occurrence rate for the appropriate territory.

~~a.~~d. Rates for ~~limits~~ higher ~~than~~that 100/300 limits are calculated by applying the Allied ~~Health Care~~Healthcare Provider increased limit factors to the base rate.

3. Standard Claims Made Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. The Mature Standard Claims Made rate for Class 1A is 0.~~920~~925 of the corresponding Allied Health Care Provider Occurrence rate.

b. The Mature Standard Claims Made rate for Classes 1B-8B is 0.900 of the corresponding Allied Health Care Provider Occurrence Rate.

c. Class 1A base rates are calculated as a percentage of the Dentists Territory (Rest of State) 100/300 Limits Occurrence rate.

d. Classes 1B-4 base rates are calculated as a percentage of the Physicians & Surgeons Territory (Rest of State) 100/300 Limits Occurrence rate.

e. Classes 5 –8B base rates are calculated as a percentage of the Physicians & Surgeons 100/300 Limits occurrence rate for the appropriate territory.

~~b.~~f. Allied Health Care Provider Claims Made Factors may be applied to the Mature Standard Claims Made base rate for the applicable year of claims made coverage.

~~c.~~g. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

4. Increased Limits Factors

Limits	Classes 1A-5	Classes 6-8B
100/300	1.000	1.000
200/600	1.220	1.260
500/1000	1.460	1.630
1000/1000	1.750	1.940
1000/3000	1.800	2.000
2000/2000	2.050	2.410
2000/4000	2.120	2.480
3000/3000	2.220	2.680
3000/5000	2.290	2.750

A minimum of 1000/3000 underlying limits required in order to purchase shared excess limits.

5. Extended Reporting Period Coverage Factors

Years Retro. Date Precedes Expiration Date	Classes 1A-4	Classes 5-8B
1	0.750	0.700
2	1.000	1.000
3	1.100	1.150
4	1.150	1.200
5 or more	1.200	1.250

a. Factor applies to Mature Claims-Made Allied Health Care Provider rate.

6. Claims Made Factors

Years Since Retroactive Date	Class 1A-4	Classes 5-8B
0	0.60	0.45
1	0.80	0.70
2	0.90	0.85
3	0.95	0.90
4 or More	1.00	1.00

7. Shared Limits Modification

Modification
Up to 25%

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Allied Health Care Provider	$50

D. **Premium Modifications**

1. **Part Time Allied Health Care Provider**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-10	515	50%
11-20	1050	30%

Part Time Credits are available for AHCP Classes 4-8B Only.

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Dental Hygienist in Training**

NOT AVAILABLE

3. **Locum Tenens**

NOT AVAILABLE

4. **Temporary Staffing Agency Rating Coverage**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

6. **Military Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

7. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification -50% / +50%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

8. **Risk Management**
(Occurrence & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

9. **Deductible Credits**
(Occurrence & Standard Claims Made Program)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

10. **Self-Insured Retention Credits**

NOT AVAILABLE

11. **Experience Rating**

NOT AVAILABLE

12. **Small Group Rating Rule**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

13. **Large Group Rating Rule**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

14. **Slot Rating**
(Standard Claims Made Program)

AVAILABLE

15. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

16. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Accelerated Extension Contract Rating**
(Standard Claims Made Program)

~~**NOT** **AVAILABLE**~~

~~17~~18. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max Available Credit
50%

~~18. **Group Rating Rule**~~
~~(Occurrence & Standard Claims Made Programs)~~

~~**AVAILABLE**~~

19. **Quarterly Installment Option**

(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

4 PAY - 25% down, 3 equal quarterly payments thereafter

If manual premium is over $150,000

25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of $100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

20. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
$250,000

21. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the following health care providers:

Section

II. Corporations, Partnerships and Associations
III. Physicians and Surgeons
IV. Dentists
V. ~~Allied~~ Health Care ~~Providers~~Professionals
VI. Health Care Facilities

B. This manual also specifies rules, rates, premiums, classifications and territories for the purpose of providing the following optional associated coverages to health care providers:

Section

VII. General Liability
VIII. Managed Care Entity Liability
~~IX. Pollution Liability~~

II. APPLICATION OF GENERAL RULES

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the respective Section or State Rate Pages.

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

III. 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.

IV. 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.

V. 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.

VI. FACTORS OR MULTIPLIERS

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

VII. 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.

VIII. 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.

C. The Company may waive an additional premium of $100 or less for coverages related to ~~Healthcare facilities.~~Health Care Facilities. This waiver only applies to cash exchange due on an endorsement effective date.

IX. 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.

X. 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 no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

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.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider and is shown on the appropriate State Rate Pages.

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

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate State Rate Pages.

XII. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. Specific options may be referenced in the State Rate Pages.

XIII. COVERAGE

Coverage may be provided on either an Occurrence or Claims-Made basis, unless noted otherwise in the respective section or State Rate Pages. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Occurrence or Standard Claims-Made, subject to availability and identified on the State Rate Pages.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. INCREASED LIMITS OF LIABILITY

A. Individual Limits of Liability

1. Increased Limits factors shall be those shown as applicable for the respective insureds and be used to develop the applicable premium.

B. Shared Limits of Liability

1. Limits of Liability may be increased on a shared limits basis excess of an individual limit per insured.

2. The rate for the shared excess limits shall be computed in the following manner:

a. The rate for the individual limit of liability and the total limit of liability shall be calculated in accordance with the State Rate Pages. The total limit of liability is the sum of the individual per occurrence limit and the shared per occurrence limit.

b. The initial shared limits rate is the difference between the total limits rate and the individual limits rate-.

c. The initial shared limits rate may be modified subject to the restrictions identified on the State Rate Pages, based on the following objective considerations:

i. The number and distribution by classification of insureds.

ii. The amount of the shared limit and its relationship to the size and distribution of the group.

iii. The amount of the individual limit (attachment point) underlying the shared limit.

3. The minimum individual limit over which a shared excess limit may be provided is identified on the State Rate Pages.

4. Requests for total limits of liability (the sum of the individual per health care occurrence limit and the shared excess per health care occurrence limit) that exceed the maximum limit of liability identified on the State Rate Pages shall be referred to the Company and (a) rated.

XVI. 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.

XVII. EXTENDED REPORTING PERIOD COVERAGE (Claims-Made Coverage only)

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 must be paid, in accordance with state statutes, promptly when due.

D. For exposures rated in Section VI – Healthcare Facilities, Section VII – General Liability or Section VIII – Managed Care Entity Liability, the premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims made rate, applicable to the expiring policy, and subject to Experience, Part Time and Schedule Rating Modifications.

E. For exposures rated in Section III – Physicians & Surgeons, Section IV – Dentists or Section V – Healthcare Professionals, the premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims made rate, applicable to the expiring policy, and subject to Part Time, Non - Discretionary Debit and Schedule Rating ~~Debits.~~Modifications. Deductible Credits may or may not apply to a groups Extension Contract, at the Insureds option.

~~D. Premium must be paid, in accordance with state statutes, promptly when due.~~

~~E.~~ F. For exposures rated in Section III – Physicians & Surgeons, Section IV – Dentists or Section V – Healthcare Professionals the Partnership / Corporation Extension Contract Rating shall be based on the number of shareholders, partners and independent contractors at the inception date of the most recent policy.

XVIII. LARGE GROUP PRACTICE

A. Physicians organized in a Large Group practice may be collectively rated.

B. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

C. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, Risk Management, or Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

D. Locum Tenens Group Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

E. For Individual insureds within the group, Extension Contract Rating premium is calculated by multiplying the mature allocated premium times the applicable claims made tail factor.

F. Refer to the State Rate Pages for availability.

XIX. SMALL GROUP PRACTICE

Any group practice consisting of two or more healthcare providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

_____The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.;

_____The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insured's based upon applicable underwriting criteria.

_____For Individual insured's within the group, the extension contract premium will be _____calculated per the filed Extension Contract Rating Rule.

~~5~~2. Refer to the applicable state rate page for availability.

XX. MEMBERSHIP IN QUALIFIED ASSOCIATIONS

~~A~~1. The unique characteristics of medical/dental practices and their membership in qualified professional associations shall make them eligible for premium modifications in addition to those available to all other groups.

~~B~~

2. Members of a qualified medical/dental group professional association shall be eligible for additional premium modifications.

~~1~~A. Membership Credit

~~a.~~1. A premium credit, identified on the State Rate Pages, shall be given to those insureds whose group is a member of a qualified association.

~~b.~~2. A Qualified Association may include State Medical or Dental Societies.

~~2~~B. Renewal Rate Rule

~~a~~1. If the group practice generates a manual premium in excess ~~of~~ ~~$50,000~~the amount identified in the State Rate Pages, the Company may, in consideration of the underlying risk, hold the next renewal rate(s) for the individual policyholder(s) constant, subject to underwriting approval. However, changes in classification, limits of liability, claims-made step ~~and loss~~, claim free credit and non-discretionary credits will be applied in the usual manner.

~~b~~2. Only one consecutive renewal may receive application of this rule. The group practice may again qualify for this rule after the payment of one renewal premium based upon currently filed rates.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

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

1. Professional Corporations, Partnerships and Associations

2. Miscellaneous Entities

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering outpatient 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. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates (or premium per FTE/OPV rated policy) of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated on the State Rate Pages.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any modifications presented on the State Rate Pages.

3. 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.

4. The premium for professional corporations, partnerships and associations may be subject to premium caps or flat rates as indicated on the State Rate Pages and may be reduced or eliminated as part of credits provided to multi-physician practices.

5. The premium otherwise determined for the partnership or corporation may be discounted should the insured elect to exclude the vicarious liability associated with the partners', shareholders' and employed/contracted physicians' professional services. Refer to the State Rate pages for the available credit.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy or FTE/OPV rated policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

C. The premium for other entities shall be referred to the Home Office for the determination of premium and filing with the state insurance department.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgicare Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center
   f. Home Health Agency
   g. Nursing Home
   h. Physical Fitness Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 on the State Rate Pages, 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 on the State Rate Pages.

B. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Credits shall be available, subject to underwriting guidelines.

b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

3. Large Group & ~~Locum Tenens Group~~Temporary Staffing Agency Rating - Corporations

A. Corporation Coverage for ~~Locum Tenens Groups~~Temporary Staffing Agencies or Large Group ~~practicese~~practices may be collectively rated.

B. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

C. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence, or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

D. ~~Locum Tenens Group~~Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

E. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

F. ~~F.~~ Refer to the State Rate Pages for availability.

4. Small Group Rating Rule

Any group practice consisting of two or more healthcare providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

A. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

B. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

C. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insured's based upon applicable underwriting criteria.

D. For Individual insured's within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.

E. Refer to the applicable state rate page for availability.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, shown on the State Rate Pages, in accordance with each physician's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons

1. Each medical practitioner is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part-Time Physicians

1. Any insured who is determined not to be working on a full time basis will be considered a part-time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part-time practitioner is identified on the State Rate Pages.

2. A Part-Time Practitioner may include any classification identified in the class plan, as well as those practitioners who are moonlighting or teaching. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part-time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part-time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except risk management, schedule rating modifications and membership association credits.

C. 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.

      Note: Do not confuse a physician in a fellowship training program with a fellow, for example, of American College of Surgeons.

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.

   a. 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. Refer to the Company to determine the applicable credit.

3. Coverage is available for a physician's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program. The applicable physician class for moonlighting activities, as identified in the class plan, will be utilized to determine the rate. If no such classification is identified, the applicable premium will be computed as follows.

   a. The premium will be based upon the equivalent medical specialty rate and the average number of hours the insured practices per week.

   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 except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

D. Locum Tenens Physician –Physicians Substituting for MPCo Insured Physicians

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.

E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agency Coverage is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. 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 reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

G. 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.

   a. 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. Refer to the Company to determine the applicable credit.

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 except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

H. Physician's Leave of Absence

1. A physician who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

   - The birth of insured's newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
   - To care for a spouse, child or parent who has a serious health condition.
   - To care for insured's own health condition which prevents insured from working.
   - Time to enhance the insured's education or other reason while not practicing.

   This credit is not available to an insured's leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

I. Physicians Military Leave of Absence

A physician who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 policy may be modified in accordance with a maximum modification indicated on the State Rate Pages, 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 on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit provided on the State Rate Pages.

   a. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

   b. Insureds converting coverage to The Medical Protective Company, shall qualify for credit at the policy inception date in accordance with the Company's guidelines.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Credits shall be available, subject to underwriting guidelines.

b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

E. Experience Rating

1. A group practice, consisting of a specified number of 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. Paid losses
   e. Projected incurred but not reported losses
   f. Cause of such losses
   g. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

F. Non-Discretionary Debit Plan

For any insured who is not eligible for a credit under the company's claim/loss free credit rule, points will be assigned for each claim pursuant to Schedule A, found in the State Rate Pages, for the following:

- Pending against the insured at the beginning of the current policy period; or
- Paid on the insured's behalf during the past 5 years; or
- Closed with no payment during the past 5 years.

For providers who have been practicing for less than eight complete years from their initial medical school graduation date, the total assigned claim points (as calculated from the Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 years or more	No factor applied

Insureds with less than one year of experience shall be assumed to have one year of experience. Insureds converting coverage to The Medical Protective Company who have pending claims or claims paid on their behalf within the past five years will be assigned points in accordance with Company guidelines.

A debit shall then be applied the insured's rate based upon Schedule B, found in the State Rate Pages.

For the purpose of this rule, a "claim" shall not include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

Any Debit required under this rule shall be additive with any other debits or credits applicable under the Company's rating manual.

This non-discretionary debit plan shall only apply to providers who meet the Company's Guidelines for acceptance, and the Company retains the right to refuse to insure any insured or applicant based upon the qualitative nature of any claims made against that individual or entity. As a result, the fact that this rule provides (or does not provide) a debit for claims experience is not an indication that there is a rate available for any particular insured or applicant.

G. Large Group Rating

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims-made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

6. Refer to the State Rate Pages for availability.

H. Small Group Rating Rule

Any group practice consisting of two or more physician providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Group's Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be performed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate fee agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insureds based upon applicable underwriting criteria.

4. For Individual insureds within the group, the extension contract premium will be per the filed Extension Contract Rating Rule.

5. Refer to the applicable state rate page for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Convertible Coverage Rating Plan

1. Insureds shall be provided the option, subject to underwriting guidelines, to convert from Standard Claims-Made to Occurrence coverage. The insured shall be eligible for conversion after the following conditions have been met:

a. Payment to the Company of the applicable premium for a minimum of three annual claims-made policies.

b. Achieve three years of continuous claims-made coverage under this plan with no losses attributed to the insured. (A loss shall be a culpable loss. A claim under this plan shall not be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.)

2. At the time the aforementioned conditions are met, and the insured has purchased Occurrence coverage, the Company will issue Extended Reporting Period Coverage, covering professional services subsequent to the retroactive date and prior to the expiration of the claims-made policy, and will waive any premium that would normally be due for such coverage.

3. Should the insured be unable to meet the conditions for conversion, the insured may elect to purchase the Extended Reporting Period Coverage, subject to policy provisions. Refer to the Extended Reporting Period rule to determine the applicable premium.

4. The applicable premium under this plan is presented on the State Rate Pages.

5. No other modifications are to apply concurrent with this rule except membership association, risk management and schedule rating modifications.

B. Enhanced Claims-Made

1. Insureds shall be provided the option, subject to underwriting guidelines, to purchase Claims-Made coverage under the Enhanced rating structure.

2. The Enhanced Claims-Made base rate is developed as a percentage of the applicable Occurrence rate. The applicable percentage is identified on the State Rate Pages.

3. The Enhanced Claims-Made base rate is subject to Claim Free Credits in accordance with the schedule provided on the State Rate Pages. The application of the credits shall be consistent with the criteria identified in V(C) of this section of the manual.

C. Slot Rating

1. Coverage for group practices is available, at the Company's option, 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 cannot be used in conjunction with this rating rule.

D. Full-time Equivalency Rating

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

2,500 - Group Practice
2,100 - Residency Programs

2. For group practices, the minimum average FTE assigned to any individual physician is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Training/Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per physician rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the physician rates.

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

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

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

- The table value is determined by rounding the actual FTE per policy using the .5 rounding rule.

~~5~~6. Premium modifications for ~~new physician~~claim free, new to practice, part time~~, moonlighting, teaching, loss free credit~~ practice, or ~~other similar credit~~risk management cannot be used in conjunction with this rating rule.

E. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on an out-patient visit (OPV) basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of out-patient visits equivalent to a physician year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable medical specialty rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new physician, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

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 an Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

~~1.~~2. Upon termination of coverage under this policy by reason of total disability or permanent retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

~~2.~~3. The Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than one year and/or will not attain the required number of years of continuous claims-made coverage at the time of retirement.

c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

e. The insured otherwise meets the requirements as set forth in the policy for a free extension contract.

f. Refer to the State Rate Pages for availability.

G. Deferred Premium Payment Plan.

1. The Company will, subject to applicable guidelines, offer the insured various premium payment options. The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments.

Other fees may apply.

H. Aggregate Credit Rule.

~~1.~~ The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, New to Company, New to Practice, Membership Association, Risk Management or Deductible Credits.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Dentists.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per dentist, shown on the State Rate Pages, in accordance with each dentist's classification and class plan designation.

IV. CLASSIFICATIONS

A. Dentists

1. Each dental practitioner is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part Time Dentists

1. Any insured who is determined not to be working on a full time basis will be considered a part time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner is identified on the State Rate Pages.

2. A Part Time Practitioner may include any classification identified in the class plan as well as those practitioners who are moonlighting or teaching. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except risk management ~~and~~, membership association credits and/or schedule rating modifications.

C. Dentists in Training

1. Coverage is available for activities directly related to a dentist's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Dental students are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

2. Coverage is available for ~~a dentist's "~~insureds moonlighting~~"~~ activities~~. The coverage will not apply to any aspect of the insured's training~~ while in a residency or fellowship program conducted thru any dental school or hospital.

   a. ~~The premium will be based upon the equivalent dental specialty rate and the average number of hours the insured practices per week~~A credit will apply to the insureds premium pursuant to the Company's guidelines for acceptance.

   ~~b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~

b. ~~c.~~ No other credits ~~are to~~may apply ~~concurrent~~ with this rule ~~except risk management and membership credits~~.

c. ~~d. The applicable modifications applicable~~Refer to the ~~manual rates are presented on the~~ State Rate Pages~~.~~ for the applicable credit.

3. Coverage is available to dental students for activities directly related to their licensing.

   a. Coverage is available to dental students, on a short-term basis, for services rendered by the student during a dental externship prior to graduation and/or during the dental board exam pursuant to the student s professional licensing.

   b. The coverage for dental students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages, and are not subject to the minimum premium rule. The premium shall be applied to the insured's first annual policy if coverage is purchased within one year of the successful completion of the dental board exam.

4. Restricted Coverage is available for Dental Students and Residents. No other credits, debits or minimum premium rules shall apply with this rating program except for Schedule Rating Modifications. Refer to the State Rate Pages for the appropriate premium.

D. Locum Tenens Dentists

1. Coverage for a dentist substituting for an insured dentist will be limited to cover only professional services rendered on behalf of the insured dentist for the specified time period. Locum Tenens will share in the insured dentist's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens dentist must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

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E. New Dentist

1. A "new" dentist shall be a dentist 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 dental specialty;

   c. Fulfillment of a military obligation in remuneration for dental school tuition;

   d. Dental school or specialty training program.

2. To qualify for the 1st year 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 reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

F. New to Company Dentists

1. An insured may be eligible for a New to Company credit pursuant to the following guidelines:

   i. Never insured with the Company, or
   ii. Previously insured with the Company more than 3 years ago.

2. Credits shall apply to the insureds first, second and third year consecutive years of coverage. All other credits will apply to the reduced rate.

3. This credit is not subject to the Aggregate Credit Rule and subject to underwriting guidelines. Only one request for this three year credit program will be granted to an eligible insured during any period of time insured by the company.

4. Please refer to the state rate pages for availability and the appropriate credit for this program.

G. Dentist 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.

a. Faculty members are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for teaching activities related to an accredited training program. Refer to the Company to determine the applicable credit.

2. Coverage is available for the private practice of a dentist 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 dentist 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 except risk management and membership credits.

d. The applicable percentages are presented on the State Rate Pages.

H. Dentist's Leave of Absence

1. A dentist who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

- The birth of insureds newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
- To care for a spouse, child or parent who has a serious health condition.
- To care for insureds own health condition which prevents insured from working.
- Time to enhance the insureds education or other reason while not practicing.

This credit is not available to an insureds leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

I. Dentist Military Leave of Absence

A Dentist who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 policy may be modified in accordance with a maximum modification indicated on the State Rate Pages, 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 on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved for by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit on the schedule provided on the State Rate Pages.

    a. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

    b. Insureds converting coverage to The Medical Protective Company, shall qualify for credit at the policy inception date in accordance with the Company's guidelines.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

    a. Credits shall be available, subject to underwriting guidelines.

    b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

    c. Deductibles can only be revised at policy renewal.

    d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

        i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

        ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

        iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

    a. SIR's shall be offered to qualified insureds.

    b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

E. Experience Rating

1. A group practice, consisting of a specified number of insureds, may receive a credit/debit based on the claim history. The claim 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. Paid losses
e. Projected incurred but not reported losses
f. Cause of such losses
g. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

F. Non-Discretionary Debit Plan

For any insured who is not eligible for a credit under the Company's claim/loss free credit rule, points will be assigned for each claim, pursuant to Schedule A, found in the State Rate Pages, for the following:

- Pending against the insured at the beginning of the current policy period; or
- Paid on the insured's behalf during the past 5 years; or
- Closed with no payment during the past 5 years.

For providers who have been practicing for less than five complete years from their initial dental school graduation date, the total assigned claim points (as calculated from Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 2 years	5.00
At least 2 years but less than 3 years	2.50
At least 3 years but less than 4 years	1.666
At least 4 years but less than 5 years	1.25
5 years or more	No factor applied

Insureds with less than one year of experience shall be assumed to have one year of experience. Insureds converting coverage to The Medical Protective Company who have pending claims or claims paid on their behalf within the past five years, will be assigned points in accordance with Company guidelines.

A debit shall then be applied to the insured's policy based upon Schedule B, found in the State Rate Pages.

For the purpose of this rule, a "claim" shall not include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

Any debit required under this rule shall be additive with any other debits or credits applicable under the Company's rating manual.

This non-discretionary debit plan shall only apply to providers who meet the Company's guidelines for acceptance, and the company retains the right to refuse to insure any insured or applicant based upon the qualitative nature of any claims made against that individual or entity. As a result, the fact that this rule provides (or does not provide) a debit for claims experience is not an indication that there is a rate available for any particular insured or applicant.

G. Small Group Rating Rule

Any group practice consisting of two or more dentists may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insured's based upon applicable underwriting criteria.

4. For Individual insured's within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.

5. Refer to the applicable state rate page for availability.

G. Botulinum Toxin and Dermal Fillers Rating Rule

1. A debit shall apply in addition to the existing filed rate and in recognition of the unique risk characteristics of Dentists, or groups of Dentists, who administer Botulinum Toxin and Dermal Filler procedures

2. The following outlines the debit category which applies to specific dental specialists that perform Botulinum Toxin and Dermal Fillers procedures:

Debit A: General Dentists, Orthodontists, Pediatric Dentists, Periodontists, Prosthodontists, Endodontists, or Host Dentists unless classified under debit B & C.

Debit B: Any dentists performing Minor Surgical Procedures or Implants and oral pathologists.

Debit C: Any dentist performing major surgical procedures.

3. Approval for participation in this rating rule is subject to underwriting guidelines.

4. Refer to the applicable state rate page for availability.

H. Dental Facility Classification Plan

1. A debit shall apply in addition to the existing filed rate for insureds, or groups of insureds, who practice in or with dental facilities as such non-standard dental practices which are not contemplated in the filed rate structure.

2. Placement into the Dental Facility Classification plan will be determined by the company's underwriting rules and guidelines.

3. Refer to the applicable state rate pages for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Convertible Coverage Rating Plan

1. Insureds shall be provided the option, subject to underwriting guidelines, to convert from Standard Claims Made to Occurrence coverage. The insured shall be eligible for conversion after the following conditions have been met:

   a. Payment to the Company of the applicable premium for a minimum of three annual claims made policies.

   b. Achieve three years of continuous claims made coverage under this plan with no claims attributed to the insured. (A claim shall be a culpable loss. A claim under this plan shall not be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.)

2. At the time the aforementioned conditions are met, and the insured has purchased Occurrence coverage, the Company will issue Extended Reporting Period Coverage, covering professional services subsequent to the retroactive date and prior to the expiration of the claims made policy, and will waive any premium that would normally be due for such extension.

3. Should the insured be unable to meet the conditions for conversion, the insured may elect to purchase the Extended Reporting Period Coverage, subject to policy provisions. Refer to the Extended Reporting Period Rule to determine the applicable premium.

4. The applicable premium under this plan is presented on the State Rate Pages.

5. No other modifications are to apply concurrent with this rule except ~~membership association, risk management~~Membership Association, Risk Management, New to Company and ~~schedule rating~~Schedule Rating modifications.

B. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual dentist 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 dentist, part time, moonlighting, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

C. Full-Time Equivalency Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each dentist's number of hours of dental practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
1,800 - Residency Programs

2. For group practices, the minimum average FTE assigned to individual dentists is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Training/Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per dentist rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the dental rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.

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

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

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

* The table value is determined by rounding the actual FTE per policy using the .5 rounding rule. Policies with an FTE of 1 will receive the premium modification regardless of shared or individual limits.

6. Premium modifications for new ~~dentist~~to practice, part time, ~~moonlighting, teaching,~~ claim free credit or ~~other similar~~risk management credit cannot be used in conjunction with this rating rule.

D. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available at the Company's option, on an out-patient visit (OPV) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual dentist limit basis.

2. The number of out-patient visits equivalent to a dentist year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable dental specialty rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new dentist, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

E. Requirements for Waiver of Premium for Extended Reporting Period Coverage for Standard Claims Made Program.

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 disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

3. The Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

   a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

   b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than one year and/or will not attain the required number of years of continuous claims-made coverage at the time of retirement.

   c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

   d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

   e. The insured otherwise meets the requirements as set forth in the policy for a free extension contract.

   f. Refer to the State Rate Pages for availability.

F. Deferred Premium Payment Plan.

1. The Company ~~may, at its discretion~~will, subject to applicable guidelines, offer the insured various premium payment options. ~~For determination and eligibility, refer to the State Rate Pages.~~ The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

G. Aggregate Credit Rule.

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

   This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, Risk Management, New to Company, New to Practice, Membership Association, Moonlighting or Deductible Credits.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Allied Health Care Providers.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per provider, shown on the State Rate Pages, in accordance with each provider's classification and class plan designation.

IV. CLASSIFICATIONS

A. Allied Health Care Providers

1. Each provider is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part Time Allied Health Care Providers

1. Any insured who is determined not to be working on a full time basis will be considered a part time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner is identified on the State Rate Pages.

2. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except ~~the~~ risk management credit and schedule rating modifications.

C. Dental Hygienist Training

1. Coverage is available for activities directly related to a hygienist's training program. The coverage will not apply to any professional services rendered after the training is complete.

2. Coverage is available to students for activities directly related to their licensing.

   a. Coverage is available to students, on a short-term basis, for services rendered by the student during a dental hygiene externship prior to graduation and/or during the dental hygiene board exam pursuant to the student's professional licensing.

   b. The coverage for students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages. The premium shall be applied to the insured's first annual policy if coverage is purchased within one year of the successful completion of the dental hygiene board exam.

D. Locum Tenens Allied Health Care Providers subsitituting for MPCo Insureds

1. Coverage for an allied health care provider substituting for an insured allied health care provider will be limited to cover only professional services rendered on behalf of the insured allied health care provider for the specified time period. Locum Tenens will share in the insured allied health care provider's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens allied health care provider must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agencies is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. Allied Health Care Provider's Leave of Absence

1. An Allied Healthcare Provider who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

   - The birth of insureds newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
   - To care for a spouse, child or parent who has a serious health condition.
   - To care for insureds own health condition which prevents insured from working.

- Time to enhance the insureds education or other reason while not practicing.

This credit is not available to an insureds leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

G. Allied Healthcare Providers Military Leave of Absence

A Provider who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. 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 on the State Rate Pages, 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 on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved for by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Credits shall be available, subject to underwriting guidelines.

b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

D. Experience Rating

1. A group practice, consisting of a specified number of insureds, may receive a credit/debit based on the claim history. The claim 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. Paid losses
e. Projected incurred but not reported losses
f. Cause of such losses
g. Nature of practice

1. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

2. The application of this modification precludes the use of all other rules based upon loss experience criteria.

E. Large Group Rating

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, -Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

6. Refer to the State Rate Pages for availability.

F. Small Group Rating Rule

Any group practice consisting of two or more healthcare providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insured's based upon applicable underwriting criteria.

4. For Individual insured's within the group, the extension contract premium will be calculated per the Filed Extension Contract Rating Rule.

5. Refer to the applicable state rate page for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual practitioner 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 part time or risk management credit cannot be used in conjunction with this rating rule.

B. Full Time Equivalency Rating

Coverage for an Allied Healthcare provider group is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual insured basis. Coverage is provided on an individual limit or shared limit basis. Full time equivalency is based on each allied healthcare provider's number of hours of practice per year. The definition of one FTE is based on the following number of hours per year:

2,000	Group Practice
1,800	Training/Residency Programs

For group practices, the minimum average FTE assigned to any individual Allied Healthcare provider is .10 (200 Hours), subject to a total FTE per policy of no less than 1.0. Training/residency programs (and other similar programs) are not subject to the group practice minimums.

The premium developed by applying the applicable Allied Healthcare rate to the corresponding FTE will be adjusted to reflect loss cost considerations recognized in the standard rates.

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

FTE* Per Policy	Premium Modification
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

* The table value is determined by rounding the actual FTE per policy using the .50 rounding rule.

Premium modification Part Time Practice or Risk Management cannot be used in conjunction with this rating rule.

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

C. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on an out-patient visit (OPV) basis rather than on an individual practitioner basis. Coverage is provided on a shared or individual practitioner limit basis.

2. The number of out-patient visits equivalent to a practitioner year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 3 visits per hour and a maximum rate of 6 visits per hour.

3. The applicable classification rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

D. 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 disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. For an insured, classified as 4B and above, the Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than one year and/or will not attain the required number of years of continuous claims-made coverage at the time of retirement.

c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

e. The insured otherwise meets the requirements as set forth in the policy for a free extension contract.

f. Refer to the State Rate Pages for availability.

E. Deferred Premium Payment Plan

1. The Company will, subject to applicable guidelines, offer the insured various premium payment options. The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

E.F. Aggregate Credit Rule.

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

   This rule does not apply to Deductible Credits, Part Time Practice, Leave of Absence, Military Leave of Absence, or Risk Management Credits.