

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Filing at a Glance

Company: ProAssurance Casualty Company
Product Name: Ascension Health Risk Purchasing Group, Inc.
State: Illinois
TOI: 11.2 Med Mal-Claims Made Only
Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations
Filing Type: Rate/Rule
Date Submitted: 06/20/2012
SERFF Tr Num: PCWA-128495383
SERFF Status: Closed-Filed
State Tr Num: PCWA-128495383
State Status:
Co Tr Num: IL-AHRPG-0712-RR

Effective Date 07/01/2012
Requested (New):
Effective Date 07/01/2012
Requested (Renewal):
Author(s): LaQuita Goodwin
Reviewer(s): Gayle Neuman (primary), Neetha Mamoottile, Caryn Carmean
Disposition Date: 01/08/2013
Disposition Status: Filed
Effective Date (New): 07/01/2012
Effective Date (Renewal): 07/01/2012

State Filing Description:
 to actuarial unit 11/30/12

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

General Information

Project Name: Initial Filing of Rates, Rules and Forms Status of Filing in Domicile: Not Filed
 Project Number: Domicile Status Comments: None
 Reference Organization: None Reference Number:
 Reference Title: Advisory Org. Circular:
 Filing Status Changed: 01/08/2013
 State Status Changed: Deemer Date:
 Created By: LaQuita Goodwin Submitted By: LaQuita Goodwin
 Corresponding Filing Tracking Number: PCWA-128495382

Filing Description:

I submit, for your review and approval, the initial filing of the rates, rules and forms for policies written through the Ascension Health Risk Purchasing Group's Program, underwritten by ProAssurance Casualty Company. I request the effective date of July 1, 2012 for this filing submission.

The attached underwriting manual contains the rates and rules for health care providers written through this purchasing group. While most of the rules mirror the ones currently on file for ProAssurance Casualty Company, some of them were modified to be specific to the Ascension Program. The forms are being submitted under separate cover.

If you have any questions during the review process, please contact me.

Thank you.

Company and Contact

Filing Contact Information

LaQuita Goodwin, Compliance Specialist lgoodwin@proassurance.com
 100 Brookwood Place 205-877-4426 [Phone]
 Birmingham, AL 35209 205-414-2887 [FAX]

Filing Company Information

ProAssurance Casualty Company	CoCode: 38954	State of Domicile: Michigan
100 Brookwood Place	Group Code: 2698	Company Type: Property & Casualty
Birmingham, AL 35209	Group Name: ProAssurance	State ID Number: 12
(205) 877-4426 ext. [Phone]	FEIN Number: 38-2317569	

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State Specific

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
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Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm):
Acknowledged

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

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

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

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

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

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

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	01/08/2013	01/08/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Caryn Carmean	11/30/2012	11/30/2012
Pending Industry Response	Gayle Neuman	11/20/2012	11/20/2012
Pending Industry Response	Gayle Neuman	09/10/2012	09/10/2012
Pending Industry Response	Gayle Neuman	08/23/2012	08/23/2012

Response Letters

Responded By	Created On	Date Submitted
LaQuita Goodwin	11/30/2012	11/30/2012
LaQuita Goodwin	11/29/2012	11/29/2012
LaQuita Goodwin	09/21/2012	09/21/2012
LaQuita Goodwin	09/10/2012	09/10/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Effective Date	Note To Reviewer	LaQuita Goodwin	01/08/2013	01/08/2013
effective date	Note To Filer	Gayle Neuman	01/07/2013	01/07/2013
Actuarial Review Complete	Reviewer Note	Caryn Carmean	01/07/2013	

SERFF Tracking #:

PCWA-128495383

State Tracking #:

PCWA-128495383

Company Tracking #:

IL-AHRPG-0712-RR

State:

Illinois

Filing Company:

ProAssurance Casualty Company

TOI/Sub-TOI:

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

Product Name:

Ascension Health Risk Purchasing Group, Inc.

Project Name/Number:

Initial Filing of Rates, Rules and Forms/

Disposition

Disposition Date: 01/08/2013

Effective Date (New): 07/01/2012

Effective Date (Renewal): 07/01/2012

Status: Filed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Explanatory Memorandum		No
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Rate (revised)	Underwriting Manual		Yes
Rate	Underwriting Manual		Yes

State: Illinois **Filing Company:** ProAssurance Casualty Company
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Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/30/2012
Submitted Date	11/30/2012
Respond By Date	12/14/2012

Dear LaQuita Goodwin,

Introduction:

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

Objection 1

- Manual (Supporting Document)

Comments: Provide Actuarial support for rate and factors filed.

Caryn Carmean
217-524-5420

Conclusion:

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

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

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

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

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

Sincerely,

Caryn Carmean

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/20/2012
Submitted Date	11/20/2012
Respond By Date	11/30/2012

Dear LaQuita Goodwin,

Introduction:

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

The last response did not address the issue about the paragraph on "Removal from the State". If a doctor moves most of his business out of state, the company can nonrenew the business but it is not a reason for a mid term cancellation of the coverage. Please address.

Conclusion:

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

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

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

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

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

Sincerely,

Gayle Neuman

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/10/2012
Submitted Date	09/10/2012
Respond By Date	09/17/2012

Dear LaQuita Goodwin,

Introduction:

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

Lake County is listed on page 36 in territory 1 and on page 39 in territory 4. The county can only be listed in one territory.

In regard to the "removal from the state" issue, if a manufacturer previously made cotton balls but now produced dynamite - that is an increase in risk. A doctor who changes from family practice to neurosurgery is an increase in risk. A doctor who simply moves his practice location is a territory change. ProAssurance can add a territory for "out of state" and asses the rate necessary for such risk. But this is not an increase in risk.

Conclusion:

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

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

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

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

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

Sincerely,

Gayle Neuman

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/23/2012
Submitted Date	08/23/2012
Respond By Date	09/06/2012

Dear LaQuita Goodwin,

Introduction:

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

1. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?
2. On page 4 under II. Cancellations, C. Removal from the State, a policy could be nonrenewed for this reason but it is not a reason for mid-term cancellation.
3. On page 15 under X. Rate Change Amelioration, please explain how this affects the insured after the first year. Do they get a 25% credit the first year and then pay the 30% starting the next year? Wouldn't the underwriter already have considered factors like training, experience, and longevity when issuing the policy to the insured?
4. On page 20 under C. Self-Insured Retentions, have the company filed a coverage form/policy that provides excess coverage? Are the rates in this manual the same rates that would apply to an excess policy?
5. On page 21 under VIII. Large Group Credit, explain how this credit would not duplicate a credit for claim experience under the Scheduled Rating Program (on page 18) or the Claims Free Credit Program (on page 24).
6. On page 36, I believe Lake County is mistakenly listed as a county in Territory 1.

Conclusion:

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

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

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

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

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

Sincerely,

Gayle Neuman

SERFF Tracking #:

PCWA-128495383

State Tracking #:

PCWA-128495383

Company Tracking #:

IL-AHRPG-0712-RR

State:

Illinois

Filing Company:

ProAssurance Casualty Company

TOI/Sub-TOI:

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

Product Name:

Ascension Health Risk Purchasing Group, Inc.

Project Name/Number:

Initial Filing of Rates, Rules and Forms/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/30/2012
Submitted Date	11/30/2012

Dear Gayle Neuman,

Introduction:

The response to your 11/30/2012 objection is below.

Response 1

Comments:

The Actuarial Support, which was inadvertently omitted, is attached.

Related Objection 1

Applies To:

- Manual (Supporting Document)

Comments: Provide Actuarial support for rate and factors filed.

Caryn Carmean

217-524-5420

Changed Items:

SERFF Tracking #:

PCWA-128495383

State Tracking #:

PCWA-128495383

Company Tracking #:

IL-AHRPG-0712-RR

State:

Illinois

Filing Company:

ProAssurance Casualty Company

TOI/Sub-TOI:

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

Product Name:

Ascension Health Risk Purchasing Group, Inc.

Project Name/Number:

Initial Filing of Rates, Rules and Forms/

Supporting Document Schedule Item Changes

Satisfied - Item:

Explanatory Memorandum

Comments:

Attachment(s):

Explanatory Memorandum.pdf

Rts_IL_Asc_PSD_04012012.pdf

Previous Version

Satisfied - Item:

Explanatory Memorandum

Comments:

Attachment(s):

Explanatory Memorandum.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please let me know if you have any other questions or concerns. Thank you.

Sincerely,

LaQuita Goodwin

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/29/2012
Submitted Date	11/29/2012

Dear Gayle Neuman,

Introduction:

Please find our legal counsel's response to your 11/20/2012 objection below.

Response 1

Comments:

Illinois law recognizes an insurers ability to cancel a policy based on a measurable increase in the risk. We have been writing policies in Illinois for many years, and we have a good understanding of the medical and legal environment and the nature of the risk we are taking on when we insure an Illinois physician. If that physician then moves out of state and practices more than ¾ of the time outside of Illinois, the risk we are insuring has changed dramatically. We should not be required to continue insuring a physician when the risk has materially changed because of the physicians new practice environment, and cancellation in this circumstance accords with state law.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please contact me if you have any other questions or concerns. Thank you.

Sincerely,

LaQuita Goodwin

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 09/21/2012
 Submitted Date 09/21/2012

Dear Gayle Neuman,

Introduction:

The response to your 9/10/2012 objection follows below.

Response 1

Comments:

I failed to attached the correct manual with the corrected Territory. Lake County is properly reflected in the attached manual.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Item No.	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #	Date Submitted
1	Underwriting Manual	Entire Manual	New		09/21/2012 By: LaQuita Goodwin
<i>Previous Version</i>					
1	<i>Underwriting Manual</i>	<i>Entire Manual</i>	<i>New</i>		<i>06/20/2012 By: LaQuita Goodwin</i>

Conclusion:

Please let me know if you have any other questions or concerns. Thank you.

Sincerely,

LaQuita Goodwin

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/10/2012
Submitted Date	09/10/2012

Dear Gayle Neuman,

Introduction:

Please find following the responses, as prepared by the Acturial Department, to your 8/23/2012 objections.

Response 1

Comments:

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

1. ProAssurance subscribes to the Independent Statistical Service for the reporting of statistics.

2. Illinois law recognizes an insurers ability to cancel a policy based on a measurable increase in the risk. We have been writing policies in Illinois for many years, and we have a good understanding of the medical and legal environment and the nature of the risk we are taking on when we insure an Illinois physician. If that physician then moves out of state and practices more than ¾ of the time outside of Illinois, the risk we are insuring has changed dramatically. We should not be required to continue insuring a physician when the risk has materially changed because of the physicians new practice environment, and cancellation in this circumstance accords with state law.

3. You are correct in stating that the underwriter already has considered factors like training, experience, and longevity when issuing the policy to the insured. The Rate Change Amelioration credit is only utilized when a rate change is implemented that impacts a single specialty. For example, assume that a rate submission was filed, and approved. In that submission, an overall 10% rate change was being implemented. In addition, a specialty plan change was being implemented such that a specific specialty was being moved from Class 1 to Class 2. The compound impact of the overall rate change and the class plan change could imply a rate impact to an insured in this specialty of 50%.

Given the magnitude of the impact of these two revisions (rate change and specialty/class assignment change), we would apply the Rate Change Amelioration Credit for this insured. The goal would be to spread out effect of the rate change over the course of two renewals, to lessen the single year impact on the insureds rate.

4. Yes, form PRA-HCP-252 08 05, Self Insured Retention Endorsement, was filed with your department under Company Filing Number IL0406, effective 10/1/2006. The rates shown in the manual, modified by the factors shown on Page 20, are the same rates that would apply to a policy that provided coverage in excess of an SIR.

5. The Claims Free Credit Program applies only to the claims status of the individual physician. The purpose of the Large Group Credit is to reflect the additional underwriting information that can be derived from the loss experience of a large group. Take for example a group of 10 family practice, no surgery, physicians. Individually, each of these physicians would have to be claims free for 10 years before they would qualify for a claims free credit (keeping in mind, the expectation is that a family practice physician will have a claim every 10 years). For a Large Group of family practice physicians, we would expect a claim every [0.10 x Number of Physicians in Group] years. For our example group, we would expect one claim every year, on average.

Now, if we have insured this group for 5 years and the group has remained claim free, the individual members would not yet qualify for a Claims Free Credit, even though the group has developed 50 physician-years of claims-free experience. The purpose of the Large Group Credit, which offers a 10% credit to groups with a five year incurred loss and Allocated Loss Adjustment Expense (ALAE) ratio less than 25%, is to provide an objective standard by which to reward those groups who, as a group, are showing a better than average, or expected, loss ratio. In other words, the groups experience is such that they have demonstrated better than average, or expected, claims result.

6. I've verified that Lake County is listed in Territory 4 throughout the entire manual.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

If you have any other questions or concerns, please let me know.

Thank you.

Sincerely,

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
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LaQuita Goodwin

State: Illinois **Filing Company:** ProAssurance Casualty Company
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Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Note To Reviewer

Created By:

LaQuita Goodwin on 01/08/2013 10:29 AM

Last Edited By:

Gayle Neuman

Submitted On:

01/08/2013 10:33 AM

Subject:

Effective Date

Comments:

This filing was implemented on 7/1/2012 and we would still like to keep this same effective date.

Thank you.

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Note To Filer

Created By:

Gayle Neuman on 01/07/2013 03:13 PM

Last Edited By:

Gayle Neuman

Submitted On:

01/08/2013 10:33 AM

Subject:

effective date

Comments:

The Department of Insurance has completed its review of this filing. Originally, ProAssurance Casualty requested the filing be effective June 20, 2012. Was the filing put in effect on June 20, 2012 or do you wish to have a different effective date? Your prompt response is appreciated.

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Reviewer Note

Created By:

Caryn Carmean on 01/07/2013 12:09 PM

Last Edited By:

Gayle Neuman

Submitted On:

01/08/2013 10:33 AM

Subject:

Actuarial Review Complete

Comments:

Neetha and I are done with our actuarial review.

SERFF Tracking #:

PCWA-128495383

State Tracking #:

PCWA-128495383

Company Tracking #:

IL-AHRPG-0712-RR

State:

Illinois

Filing Company:

ProAssurance Casualty Company

TOI/Sub-TOI:

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

Product Name:

Ascension Health Risk Purchasing Group, Inc.

Project Name/Number:

Initial Filing of Rates, Rules and Forms/

Rate/Rule Schedule

Item No.	Schedule Item Status	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing Number	Attachments
1		Underwriting Manual	Entire Manual	New		Ascension Illinois Manual eff 7-1-2012.pdf

ILLINOIS MANUAL
for
Ascension Health Risk Purchasing Group, Inc.

Healthcare Professionals
Underwriting Rules and Rates



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SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance through the Ascension Health Risk Purchasing Group, Inc., underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

- A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500. If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date. For any transaction producing under \$25 in premium, the Company may waive the premium.
- B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Policies developing annualized, \$1,000,000/\$3,000,000 limits mature claims-made manual premium of \$50,000 or more for (a) rating.
- C. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving \$.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

- A. By the Company: The earned premium shall be determined on a "pro rata" basis.
- B. By the Insured: The earned premium shall be determined on a "short rate" basis.
- C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, subject to proper notice.

III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One
 - a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
 - b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
 - c. No interest or installment charges;
 - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
 - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.
2. Quarterly Installment Option Two – (35/25/25/15)
 - a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
 - b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
 - c. No interest or installment charges;
 - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
 - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.
3. Annual Payment Plan – The premium must be paid in full prior to the inception date of the policy. A discount for this payment option is available (see Item VIII, Annual Premium Payment Discount, of Section 4, Professional Liability Discounts).
4. Semi-Annual Payment Plan – 60% of the premium must be paid prior to the policy inception date and one installment of 40% is due six months after inception.
5. Nine Payment Plan – 20% down and eight consecutive monthly installments of 10% each. This plan requires that the policyholder participate in the Electronic Payment Plan in which premiums are automatically deducted from the policyholder's bank account.

No finance charges or fees apply to these payment plans. The option to pay premium on other than the Annual Payment Plan may be withdrawn by the Company if the insured has failed to make premium payments when due.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

SPECIALTY CODES AND DESCRIPTIONS

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

<u>Specialty</u>	Industry Class Code		
	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-
<i>Endocrinology</i>	80238	-	-

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

Industry Class Code

<u>Specialty</u>	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420 - -	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
<i>Infectious Disease</i>	80246	-	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

*refer to Classification and/or Rating Modifications & Procedures Section for further definition

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

<u>Specialty</u>	<u>Industry Class Code</u>		
	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A) - -	- - -	80475(B)-basic procedures 80475(C)-intermediate procedures 80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Surgical Consultation – Office Only	80477(A)	80477(B)	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

**For rating purposes, include Neonatology in this risk class.

***See Internal Medicine – Minor Surgery.

SECTION 3

**CLASSIFICATION AND/OR RATING MODIFICATIONS
AND PROCEDURES**

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

- A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.
- B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.
- C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.
- D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

- A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:
 - a. First year resident - 25% of the appropriate specialty classification rate
 - b. Second year resident - 50% of the appropriate specialty classification rate
 - c. Third year resident - 75% of the appropriate specialty classification rate
 - d. Fellows and interns - 85% of the appropriate specialty classification rate
- B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).
- C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

<u>Classification</u>	<u>Rating Criteria:</u>
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. PART-TIME AND SEMI-RETIRED INSUREDS

The Part-Time Discount is available to insureds.

- A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
- B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
- C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
- D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor or Dentist Discount are not eligible for the Part-Time Discount. This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. Paramedicals covered on an individual basis, not sharing limits, are eligible for the same part-time program, discounts and rules that apply to physicians.

The available discounts are:

<u>TYPE</u>	<u>Class</u>	<u>Average Weekly Practice Hours <20 hours</u>
Physician	1 to 7	50%
Surgeon	8 to 15	35%
Dentist	All	50%
Paramedical	All	50%

* Insureds whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of insureds receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage for each insured professional or insured paramedical employee is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens may cover multiple insured professionals or multiple insured paramedical employees up to a total of ninety (90) days during the policy period.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty (2,080 hours of work per FTE) or the average number of patient contacts/visits in a 12 month period (4,000 visits per FTE). A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

VIII. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,
 plus OB/GYN rate for claims-made year five,
 less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

C. Reporting Endorsement Coverage

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%), plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

1. If the reporting endorsement is issued at the end of an annual policy period, the reporting endorsement premium shall be limited to a maximum of 200% of the insured's expiring annual claims-made premium, including discounts and surcharges.
2. If the policy is terminated during the first year, pro-rate the reporting endorsement premium and then limit it to 200% of the pro-rated claims-made premium for the policy period, including discounts and surcharges.
3. If the policy is terminated during the second, third or fourth claims-made policy year, blend the applicable reporting endorsement factors and then limit the reporting endorsement premium to 200% of the blended annual claims-made premiums, including discounts and surcharges.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force. In the event that the insured has changed policy limits of liability within 36 months prior to the termination date, the limits of liability applicable to any reporting endorsement issued with a waiver of premium shall be equal to the limits of liability in effect during the majority of the 36 months preceding the termination date.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 50% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor/dentist discounts: up to 50%. Deductible credits may be combined with the New Doctor/Dentist discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing \$50,000 or more annualized premium

II. NEW DOCTOR OR DENTIST DISCOUNT

This discount will apply only to solo practicing physicians and dentists who have never been in practice and proceed directly into practice from training, or physicians or dentists who fit within that category except for an interim period of employment not to exceed two years. Physicians or dentists who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

<u>Year of Coverage Since Training</u>	<u>Annual Premium Discount Per Policy</u>
Year 1	50%
Year 2	25%
Year 3	0%

III. RISK MANAGEMENT PREMIUM CREDITS

Insureds who participate in risk management activities approved by the Company may be eligible for the following premium credits, up to a maximum of 8%.

<u>Activity</u>	<u>Credit</u>
1. Documented in-person attendance at a live seminar. Must be present for the entire program to earn credit.	2% each; 4% maximum
2. Successful completion of online course. Must be completed by August 31.	1% each; 4% maximum
Combined total of credits for 1 and 2 cannot exceed 6%.	
3. Demonstration of effective mechanisms for communicating diagnostic test results, based on survey results. Must be completed by June 30. Non-obstetric specialties only.	2%
4. Support for a patient safety goal of no inductions prior to 39 weeks, unless medically indicated. Confirmation must be received by August 31. Obstetric specialties only.	2%

Activities submitted for risk management credits must have been completed within twelve months prior to application.

Any risk management credit will be revoked or withheld if evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit is found.

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.
3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.
5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	<u>Debit/Credit</u>
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk and subject to a minimum eligibility of \$1,000 before and after the application of the credit/debit for subjective rating plans.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians, on both a primary and excess rate basis, as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer (\$1M/\$3M).

Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

<u>INDEMNITY ONLY</u> <u>Deductible Per Claim</u>		<u>INDEMNITY AND ALAE</u> <u>Deductible Per Claim</u>	
\$ 5,000	2.5%	\$ 5,000	6.5%
\$10,000	4.5%	\$10,000	11.5%
\$15,000	6.0%	\$15,000	15.0%
\$20,000	8.0%	\$20,000	17.5%
\$25,000	9.0%	\$25,000	20.0%
\$50,000	15.0%	\$50,000	30.5%
\$100,000	25.0%	\$100,000	44.5%
\$200,000	37.5%	\$200,000	55.0%
\$250,000	42.0%	\$250,000	58.0%
 <u>Per Claim/Aggregate</u>		 <u>Per Claim/Aggregate</u>	
\$ 5,000/15,000	2.0%	\$ 5,000/15,000	5.5%
\$10,000/30,000	4.0%	\$10,000/30,000	10.5%
\$25,000/75,000	8.5%	\$25,000/75,000	19.0%
\$50,000/150,000	14.0%	\$50,000/150,000	29.5%
\$100,000/300,000	24.0%	\$100,000/300,000	43.0%
\$200,000/600,000	36.0%	\$200,000/600,000	53.5%
\$250,000/750,000	40.0%	\$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to \$1M/\$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible

Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2 - 19	20 - 40	41 - 60	61 - 100	
5/15	.020	.018	.015	.012	\$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

Indemnity & ALAE Deductible

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

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

VIII. LARGE GROUP CREDIT

For groups generating \$50,000 or more in annualized manual premium at \$1,000,000/\$3,000,000 policy limits, where the loss ratio for the account is less than 25%, a credit of 10% will apply. The loss ratio is to be computed based on five years of historical experience, utilizing incurred indemnity plus incurred allocated loss adjustment expense experience.

IX. GENERAL RULES

- A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.
- B. Discounts will apply in the following order:
 1. Deductible Discount (primary premium only).
 2. New Doctor/Dentist Discount or other resident or part-time, semi-retired discount; and
 3. Risk Management Discount and Scheduled Rating (apply the net credit or debit).

Example: Class 1, \$1M/\$3M, 1st year new doctor, Risk Management Seminar within 12 months. \$25,000 deductible. Assume manual rate \$7,500.

\$7,500	Manual Rate for \$1M/\$3M
<u>x .91</u>	Less 9% (Deductible Credit)
6825	
<u>x .50</u>	Less 50% (New Doctor)
3,413	Applicable Net Premium
<u>x .85</u>	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

- C. Additional practice charges will be applied to the premium after all discounts have been applied.
- D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians.

<u>Number of Insureds</u>	<u>Percent</u>
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is \$1,000.

III. PARTNERSHIP-CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician or dentist will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed \$35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician or dentist's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician or dentist first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Physician Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician or dentist will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician or dentist has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

Dentists will be treated as "Class 1" for determination of their Evaluation Period and will be eligible for a maximum Claims Free Credit of 15%, in accordance with the earning schedule above. However, the Claims Free Dentist must have no incurred losses or ALAE (payments or reserves) during the Evaluation Period. Notwithstanding any other provisions of this section, no dentist with 2 or more reported claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians and dentists at no charge.

Limits of Liability will be offered as follows:

<u># of insureds</u>	<u>“Each Covered Investigation”</u>	<u>“Each Policy Period”</u>
1 - 5	\$25,000	\$25,000 X (# of insureds)
6 - 10	\$25,000	\$125,000
11 - 20	\$25,000	\$175,000
21 +	\$25,000	\$225,000

The limit of liability for “covered audits” will be \$5,000 per covered insured with a deductible of \$1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to participants in the Program at no additional charge with coverage limits as follows:

Item 1	Network Security and Privacy Liability Coverage	\$50,000 per Claim
Item 2	Regulatory Fines and Penalties Coverage	\$50,000 per Claim
Item 3	Patient Notification and Credit Monitory Costs Coverage	\$50,000 per Claim
Item 4	Data Recovery Costs Coverage	\$5,000 per Claim
Item 5	Deductible	(none) per Claim

There is a premium charge for those insureds that elect expanded coverage with higher limits. The optional additional limit of \$1 million is shared among all insureds within a practice group and is in excess of the standard coverage provided above.

Limits are in excess of \$50,000 primary coverage.

# of Physicians	\$1M Limit
1 Physician	\$ 1,125
2 Physicians	\$ 1,500
3-5 Physicians	\$ 2,063
6-10 Physicians	\$ 2,813
11-15 Physicians	\$ 3,750
16-20 Physicians	\$ 5,100
21-25 Physicians	\$ 6,375
26-30 Physicians	\$ 7,650

SECTION 6

**PHYSICIAN EXTENDER, PARAMEDICAL AND
ALLIED HEALTH PROFESSIONAL LIABILITY RATING**

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians’ assistants, psychologists, surgeons or surgeons’ assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician’s Assistant (PA)	0.026	0.080	0.025
Surgeon’s Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041
Psychologist	0.018	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.022	0.045	0.012

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	\$1M/\$3M
Health Care Professional NOC	80301	Refer to Company (Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.128
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.080
Physiotherapist	80938	0.018
Psychologist	80912	0.054
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.125
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306
		(Factors based on 80151)
Nurse Anesthetist - Medical	80960(M)	0.350

(Factors based on 80114)

Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

<u>Prior Year</u> <u>Claims-Made</u>	<u>Factors</u>
1	1.00
2	1.25
3+	1.50

STEP-RATING FACTORS

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under \$500 are not eligible for the step-rating factors.

III. EXTENDED REPORTING PERIOD ENDORSEMENT (TAIL COVERAGE)

Extended Reporting Period (Tail) Factors
By Month

**Claims-Made
Year**

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

SECTION 7

**DENTAL PROFESSIONAL LIABILITY
SPECIALTY CODES AND DESCRIPTIONS**

DENTAL SPECIALTY CODES & CLASSIFICATIONS

DENTISTS - CLASS 1A

- 80213 Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. **This class does not apply to dentists performing extractions, root canals or other oral surgery or endodontic procedures.** This class does not apply to oral surgeons.

DENTISTS - CLASS 1

- 80211 Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- 80214 Applies to orthodontists and endodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- 80215 Applies to periodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.

DENTISTS - CLASS 2

- 80211(F) Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits the initial placement of dental implants.
- 80211(G) Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, but only if the sedation is administered by a Dental or Medical Anesthetist. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 will apply. This class does not apply to oral surgeons.

DENTISTS - CLASS 3

- 80209 Applies to dentists as defined for Classes 1 or 2 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 or 2 will apply, as appropriate. This class does not apply to oral surgeons.

ORAL SURGERY - CLASS 4

- 80210 Includes all oral surgeons and also applies to dentists as defined in Classes 1A through 3 who additionally perform dentistry on patients who are being treated with general anesthesia in the office.

DENTISTS - CLASS 5

- 80211(I) Applies to dentists as defined for Classes 1 or 2 but, in addition, permits use of cosmetic Botox on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. This class does not apply to oral surgeons.

PARADENTAL EMPLOYEE COVERAGE

Coverage on a shared limits basis is automatically provided for professional employees of the Policyholder or an insured under the policy with no additional charge (e.g., dental assistants, dental hygienists and lab technicians).

While a dental insured's insured paradecimal employees are automatically covered under the policy, a premium charge for Certified Registered Nurse Anesthetists (CRNAs) will be made as indicated in Section 6, I – Employed Certified Registered Nurse Anesthetist.

SECTION 8

STATE RATES AND EXCEPTIONS – DENTISTS

I. RATES

A. Dental Rating Classes – Illinois

The following indicates the specialty classification codes applicable to the rating classes on the following pages:

1A	80213
1	80211 80214 80215
2	80211(F) 80211(G)
3	80209
4	80210
5	80211(I)

B. Dentists Professional Liability Rates

1. Claims-Made Rates by Year

Territory 1: Cook, Madison, St. Clair and Will counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	551	963	1,306	1,450	1,581
1	654	1,169	1,598	1,770	1,925
2	782	1,426	1,963	2,169	2,354
3	1,426	2,714	3,787	4,165	4,500
4	4,001	7,864	11,084	12,148	13,084
5	5,289	10,440	14,732	16,140	17,377

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	602	1,066	1,452	1,611	1,753
1	718	1,298	1,781	1,970	2,140
2	863	1,588	2,191	2,419	2,623
3	1,588	3,037	4,244	4,665	5,038
4	4,486	8,833	12,456	13,650	14,699
5	5,935	11,731	16,562	18,142	19,529

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	701	1,263	1,731	1,916	2,082
1	841	1,544	2,129	2,351	2,550
2	1,017	1,895	2,627	2,896	3,136
3	1,895	3,652	5,116	5,619	6,064
4	5,409	10,679	15,071	16,511	17,775
5	7,166	14,193	20,049	21,957	23,631

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	746	1,354	1,860	2,057	2,234
1	898	1,658	2,291	2,528	2,740
2	1,088	2,038	2,829	3,117	3,373
3	2,038	3,937	5,520	6,061	6,538
4	5,836	11,534	16,282	17,836	19,200
5	7,735	15,332	21,663	23,723	25,531

1. Claims-Made Rates by Year (cont.)

Territory 2: Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	428	718	959	1,071	1,173
1	500	862	1,164	1,295	1,414
2	591	1,043	1,420	1,575	1,716
3	1,043	1,948	2,702	2,978	3,224
4	2,853	5,567	7,829	8,587	9,255
5	3,758	7,377	10,392	11,392	12,271

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	464	790	1,062	1,183	1,294
1	546	953	1,292	1,436	1,565
2	648	1,157	1,581	1,751	1,905
3	1,157	2,175	3,023	3,330	3,602
4	3,193	6,248	8,793	9,642	10,390
5	4,211	8,284	11,678	12,799	13,784

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	533	928	1,258	1,398	1,524
1	632	1,126	1,537	1,704	1,854
2	756	1,373	1,887	2,086	2,265
3	1,373	2,607	3,636	4,000	4,322
4	3,842	7,545	10,631	11,653	12,551
5	5,076	10,013	14,128	15,479	16,666

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	566	993	1,348	1,497	1,631
1	672	1,206	1,651	1,828	1,987
2	806	1,473	2,029	2,242	2,432
3	1,473	2,807	3,919	4,310	4,656
4	4,142	8,145	11,481	12,584	13,552
5	5,476	10,814	15,262	16,720	18,001

1. Claims-Made Rates by Year (cont.)

Territory 3: Remainder of State

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	371	603	797	893	982
1	429	719	961	1,073	1,176
2	502	865	1,167	1,299	1,418
3	865	1,591	2,196	2,424	2,628
4	2,317	4,495	6,310	6,926	7,469
5	3,043	5,947	8,367	9,176	9,889

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	400	661	879	984	1,079
1	465	792	1,065	1,186	1,297
2	547	956	1,296	1,440	1,570
3	956	1,773	2,454	2,706	2,931
4	2,590	5,041	7,084	7,772	8,379
5	3,407	6,675	9,399	10,305	11,102

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	455	772	1,037	1,156	1,264
1	535	931	1,261	1,401	1,529
2	634	1,129	1,542	1,709	1,859
3	1,129	2,120	2,945	3,244	3,510
4	3,110	6,082	8,559	9,386	10,114
5	4,101	8,063	11,365	12,456	13,416

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	481	824	1,109	1,235	1,350
1	567	995	1,352	1,501	1,636
2	674	1,209	1,656	1,833	1,993
3	1,209	2,280	3,173	3,493	3,777
4	3,351	6,564	9,241	10,133	10,917
5	4,422	8,706	12,275	13,452	14,487

1. Claims-Made Rates by Year (cont.)

Territory 4: DuPage, Kane, Lake and McHenry Counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	489	840	1,132	1,261	1,377
1	577	1,015	1,381	1,532	1,669
2	687	1,235	1,691	1,872	2,035
3	1,235	2,331	3,244	3,571	3,862
4	3,427	6,716	9,456	10,368	11,170
5	4,523	8,908	12,562	13,766	14,824

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	533	928	1,257	1,397	1,524
1	632	1,125	1,537	1,703	1,853
2	755	1,372	1,886	2,085	2,264
3	1,372	2,606	3,634	3,997	4,320
4	3,839	7,540	10,624	11,646	12,544
5	5,073	10,008	14,120	15,470	16,656

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	617	1,096	1,494	1,657	1,803
1	737	1,335	1,833	2,028	2,202
2	886	1,634	2,257	2,491	2,700
3	1,634	3,130	4,376	4,809	5,193
4	4,625	9,112	12,851	14,082	15,163
5	6,121	12,103	17,088	18,718	20,149

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	656	1,173	1,604	1,777	1,932
1	785	1,432	1,971	2,178	2,364
2	947	1,755	2,429	2,679	2,902
3	1,755	3,372	4,720	5,185	5,597
4	4,989	9,840	13,882	15,210	16,376
5	6,606	13,073	18,463	20,222	21,766

1. Claims-Made Rates by Year (cont.)

Territory 5: Jackson and Vermilion Counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	510	881	1,190	1,324	1,445
1	602	1,067	1,453	1,612	1,754
2	718	1,299	1,782	1,971	2,141
3	1,299	2,459	3,425	3,769	4,074
4	3,619	7,099	9,999	10,961	11,808
5	4,779	9,419	13,286	14,557	15,675

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	556	974	1,322	1,468	1,600
1	661	1,183	1,618	1,792	1,948
2	791	1,444	1,988	2,197	2,383
3	1,444	2,749	3,837	4,220	4,559
4	4,055	7,971	11,235	12,314	13,262
5	5,360	10,582	14,934	16,361	17,614

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	645	1,151	1,573	1,743	1,896
1	772	1,405	1,932	2,136	2,318
2	930	1,721	2,381	2,626	2,845
3	1,721	3,304	4,623	5,079	5,483
4	4,886	9,634	13,591	14,892	16,034
5	6,469	12,800	18,075	19,798	21,310

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	686	1,233	1,690	1,870	2,033
1	823	1,507	2,078	2,295	2,489
2	994	1,849	2,562	2,825	3,059
3	1,849	3,560	4,986	5,477	5,911
4	5,271	10,404	14,682	16,085	17,317
5	6,982	13,826	19,529	21,389	23,021

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

3. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

\$1M/\$3M Primary

EXCESS LIMITS	Dentists/ Oral Surgeons
\$1M	0.0480
\$2M	0.0960
\$3M	0.1450
\$4M	0.1935
\$5M	0.2225

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

II. EXCEPTIONS

A. Policy Issuance

1. If the insured elects to accept the Waiver of Consent to Settle Endorsement, Form PRA-HCP-612, a credit of 7% will be applied.
2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.
3. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through the Ascension Health Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

SECTION 9

**STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND
PODIATRISTS**

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

<u>Rating Class</u>	<u>Industry Class Codes</u>					
1	80102(A) 80178	80179 80231	80235 80236	80240 80254	80256(A) 80265	80620
2	80233 80238	80249 80252	80256(B) 80263	80267 80474	80621	
3	80102(B) 80145(A) 80222(A)	80244 80245 80255	80257 80260 80266	80268 80282 80289	80420 80431 80473	80477(A)
4	80114 80145(B)	80151 80222(B)	80241 80246	80253 80261	80269 80421(A)	
5	80145(C) 80274 80278	80280 80283 80284	80286 80287 80288	80291 80293 80294	80360 80421(B) 80424(F)	80425 80477(B)
6	80102(C) 80117(A)	80159 80167	80277 80281(A)	80421(C) 80472		
7	80115	80117(B)	80281(B)	80475(A)		
8	80117(C)	80155	80169			
9	80143	80154(A)	80156			
10	80146	80150				
11	80144	80154(B)	80171	80475(B)		
12	80153					
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,519	5,556	6,914	7,593	8,272
2	4,538	7,593	9,630	10,649	11,667
3	5,556	9,630	12,346	13,704	15,062
4	6,575	11,667	15,062	16,759	18,457
5	7,593	13,704	17,778	19,815	21,851
6	8,815	16,148	21,037	23,481	25,925
7	9,630	17,778	23,209	25,925	28,641
8	11,667	21,851	28,641	32,036	35,431
9	13,704	25,925	34,073	38,147	42,220
10	15,741	29,999	39,504	44,257	49,010
11	17,778	34,073	44,936	50,368	55,800
12	19,815	38,147	50,368	56,479	62,589
13	21,851	42,220	55,800	62,589	69,379
14	27,962	54,442	72,095	80,921	89,748
15	29,999	58,515	77,526	87,032	96,537

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	2,908	4,334	5,285	5,760	6,235
2	3,621	5,760	7,186	7,899	8,612
3	4,334	7,186	9,087	10,037	10,988
4	5,047	8,612	10,988	12,176	13,364
5	5,760	10,037	12,889	14,315	15,741
6	6,616	11,748	15,170	16,881	18,592
7	7,186	12,889	16,691	18,592	20,494
8	8,612	15,741	20,494	22,870	25,246
9	10,037	18,592	24,296	27,147	29,999
10	11,463	21,444	28,098	31,425	34,752
11	12,889	24,296	31,900	35,702	39,504
12	14,315	27,147	35,702	39,980	44,257
13	15,741	29,999	39,504	44,257	49,010
14	20,018	38,554	50,911	57,090	63,268
15	21,444	41,406	54,713	61,367	68,021

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	2,623	3,764	4,524	4,905	5,285
2	3,194	4,905	6,045	6,616	7,186
3	3,764	6,045	7,566	8,327	9,087
4	4,334	7,186	9,087	10,037	10,988
5	4,905	8,327	10,608	11,748	12,889
6	5,589	9,695	12,433	13,802	15,170
7	6,045	10,608	13,650	15,170	16,691
8	7,186	12,889	16,691	18,592	20,494
9	8,327	15,170	19,733	22,014	24,296
10	9,467	17,452	22,775	25,436	28,098
11	10,608	19,733	25,817	28,858	31,900
12	11,748	22,014	28,858	32,280	35,702
13	12,889	24,296	31,900	35,702	39,504
14	16,311	31,140	41,025	45,968	50,911
15	17,452	33,421	44,067	49,390	54,713

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,214	4,945	6,100	6,677	7,254
2	4,080	6,677	8,408	9,274	10,139
3	4,945	8,408	10,716	11,871	13,025
4	5,811	10,139	13,025	14,468	15,911
5	6,677	11,871	15,333	17,065	18,796
6	7,715	13,948	18,104	20,181	22,259
7	8,408	15,333	19,950	22,259	24,567
8	10,139	18,796	24,567	27,453	30,338
9	11,871	22,259	29,184	32,647	36,110
10	13,602	25,722	33,801	37,841	41,881
11	15,333	29,184	38,418	43,035	47,652
12	17,065	32,647	43,035	48,229	53,423
13	18,796	36,110	47,652	53,423	59,194
14	23,990	46,498	61,503	69,005	76,508
15	25,722	49,961	66,120	74,200	82,279

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,316	5,149	6,371	6,982	7,593
2	4,232	6,982	8,815	9,732	10,649
3	5,149	8,815	11,260	12,482	13,704
4	6,066	10,649	13,704	15,232	16,759
5	6,982	12,482	16,148	17,981	19,815
6	8,082	14,682	19,081	21,281	23,481
7	8,815	16,148	21,037	23,481	25,925
8	10,649	19,815	25,925	28,981	32,036
9	12,482	23,481	30,814	34,480	38,147
10	14,315	27,147	35,702	39,980	44,257
11	16,148	30,814	40,591	45,479	50,368
12	17,981	34,480	45,479	50,979	56,479
13	19,815	38,147	50,368	56,479	62,589
14	25,314	49,146	65,034	72,977	80,921
15	27,147	52,812	69,922	78,477	87,032

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	4,397	7,311	9,254	10,225	11,196
2	5,854	10,225	13,139	14,596	16,053
3	7,311	13,139	17,025	18,967	20,910
4	8,768	16,053	20,910	23,339	25,767
5	10,225	18,967	24,796	27,710	30,624
6	11,973	22,464	29,458	32,955	36,452
7	13,139	24,796	32,567	36,452	40,338
8	16,053	30,624	40,338	45,195	50,052
9	18,967	36,452	48,109	53,937	59,765
10	21,882	42,281	55,880	62,680	69,479
11	24,796	48,109	63,651	71,422	79,193
12	27,710	53,937	71,422	80,164	88,907
13	30,624	59,765	79,193	88,907	98,621
14	39,366	77,250	102,506	115,134	127,762
15	42,281	83,079	110,277	123,877	137,476

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	3,522	5,562	6,922	7,602	8,282
2	4,542	7,602	9,642	10,662	11,682
3	5,562	9,642	12,362	13,722	15,082
4	6,582	11,682	15,082	16,782	18,482
5	7,602	13,722	17,802	19,842	21,882
6	8,826	16,170	21,066	23,513	25,961
7	9,642	17,802	23,242	25,961	28,681
8	11,682	21,882	28,681	32,081	35,481
9	13,722	25,961	34,121	38,201	42,281
10	15,762	30,041	39,561	44,320	49,080
11	17,802	34,121	45,000	50,440	55,880
12	19,842	38,201	50,440	56,560	62,680
13	21,882	42,281	55,880	62,680	69,479
14	28,001	54,520	72,199	81,039	89,878
15	30,041	58,600	77,639	87,158	96,678

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	3,114	4,746	5,834	6,378	6,922
2	3,930	6,378	8,010	8,826	9,642
3	4,746	8,010	10,186	11,274	12,362
4	5,562	9,642	12,362	13,722	15,082
5	6,378	11,274	14,538	16,170	17,802
6	7,357	13,232	17,149	19,107	21,066
7	8,010	14,538	18,890	21,066	23,242
8	9,642	17,802	23,242	25,961	28,681
9	11,274	21,066	27,593	30,857	34,121
10	12,906	24,329	31,945	35,753	39,561
11	14,538	27,593	36,297	40,649	45,000
12	16,170	30,857	40,649	45,544	50,440
13	17,802	34,121	45,000	50,440	55,880
14	22,698	43,913	58,056	65,127	72,199
15	24,329	47,176	62,408	70,023	77,639

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	3,960	6,437	8,088	8,914	9,739
2	5,198	8,914	11,391	12,629	13,868
3	6,437	11,391	14,693	16,345	17,996
4	7,675	13,868	17,996	20,060	22,124
5	8,914	16,345	21,299	23,776	26,253
6	10,400	19,317	25,262	28,234	31,207
7	11,391	21,299	27,904	31,207	34,510
8	13,868	26,253	34,510	38,638	42,766
9	16,345	31,207	41,115	46,069	51,023
10	18,822	36,161	47,720	53,500	59,280
11	21,299	41,115	54,326	60,931	67,537
12	23,776	46,069	60,931	68,362	75,793
13	26,253	51,023	67,537	75,793	84,050
14	33,684	65,885	87,353	98,086	108,820
15	36,161	70,839	93,958	105,518	117,077

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	4,105	6,728	8,477	9,351	10,225
2	5,417	9,351	11,973	13,285	14,596
3	6,728	11,973	15,470	17,219	18,967
4	8,039	14,596	18,967	21,153	23,339
5	9,351	17,219	22,464	25,087	27,710
6	10,924	20,366	26,661	29,808	32,955
7	11,973	22,464	29,458	32,955	36,452
8	14,596	27,710	36,452	40,824	45,195
9	17,219	32,955	43,446	48,692	53,937
10	19,842	38,201	50,440	56,560	62,680
11	22,464	43,446	57,434	64,428	71,422
12	25,087	48,692	64,428	72,296	80,164
13	27,710	53,937	71,422	80,164	88,907
14	35,578	69,674	92,404	103,769	115,134
15	38,201	74,919	99,398	111,637	123,877

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	5,248	9,013	11,523	12,778	14,033
2	7,130	12,778	16,543	18,425	20,308
3	9,013	16,543	21,563	24,073	26,583
4	10,895	20,308	26,583	29,720	32,858
5	12,778	24,073	31,603	35,368	39,133
6	15,037	28,591	37,627	42,145	46,663
7	16,543	31,603	41,643	46,663	51,683
8	20,308	39,133	51,683	57,958	64,233
9	24,073	46,663	61,723	69,253	76,783
10	27,838	54,193	71,763	80,549	89,334
11	31,603	61,723	81,804	91,844	101,884
12	35,368	69,253	91,844	103,139	114,434
13	39,133	76,783	101,884	114,434	126,984
14	50,428	99,374	132,004	148,319	164,635
15	54,193	106,904	142,044	159,614	177,185

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	4,118	6,754	8,511	9,389	10,268
2	5,436	9,389	12,025	13,342	14,660
3	6,754	12,025	15,539	17,296	19,053
4	8,071	14,660	19,053	21,249	23,445
5	9,389	17,296	22,567	25,202	27,838
6	10,970	20,458	26,784	29,946	33,109
7	12,025	22,567	29,595	33,109	36,623
8	14,660	27,838	36,623	41,016	45,408
9	17,296	33,109	43,651	48,922	54,193
10	19,931	38,380	50,679	56,829	62,978
11	22,567	43,651	57,707	64,735	71,763
12	25,202	48,922	64,735	72,642	80,549
13	27,838	54,193	71,763	80,549	89,334
14	35,744	70,006	92,848	104,268	115,689
15	38,380	75,277	99,876	112,175	124,474

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	3,591	5,699	7,105	7,808	8,511
2	4,645	7,808	9,916	10,970	12,025
3	5,699	9,916	12,727	14,133	15,539
4	6,754	12,025	15,539	17,296	19,053
5	7,808	14,133	18,350	20,458	22,567
6	9,073	16,663	21,723	24,254	26,784
7	9,916	18,350	23,972	26,784	29,595
8	12,025	22,567	29,595	33,109	36,623
9	14,133	26,784	35,217	39,434	43,651
10	16,242	31,001	40,840	45,759	50,679
11	18,350	35,217	46,462	52,085	57,707
12	20,458	39,434	52,085	58,410	64,735
13	22,567	43,651	57,707	64,735	71,763
14	28,892	56,302	74,575	83,711	92,848
15	31,001	60,518	80,197	90,036	99,876

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	4,683	7,883	10,017	11,083	12,150
2	6,283	11,083	14,284	15,884	17,484
3	7,883	14,284	18,551	20,684	22,818
4	9,483	17,484	22,818	25,485	28,152
5	11,083	20,684	27,085	30,285	33,485
6	13,004	24,525	32,205	36,046	39,886
7	14,284	27,085	35,619	39,886	44,153
8	17,484	33,485	44,153	49,487	54,821
9	20,684	39,886	52,687	59,088	65,488
10	23,885	46,287	61,221	68,689	76,156
11	27,085	52,687	69,755	78,289	86,824
12	30,285	59,088	78,289	87,890	97,491
13	33,485	65,488	86,824	97,491	108,159
14	43,086	84,690	112,426	126,294	140,162
15	46,287	91,091	120,960	135,895	150,829

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	4,871	8,260	10,519	11,648	12,778
2	6,565	11,648	15,037	16,731	18,425
3	8,260	15,037	19,555	21,814	24,073
4	9,954	18,425	24,073	26,897	29,720
5	11,648	21,814	28,591	31,979	35,368
6	13,681	25,880	34,013	38,079	42,145
7	15,037	28,591	37,627	42,145	46,663
8	18,425	35,368	46,663	52,311	57,958
9	21,814	42,145	55,699	62,476	69,253
10	25,202	48,922	64,735	72,642	80,549
11	28,591	55,699	73,771	82,808	91,844
12	31,979	62,476	82,808	92,973	103,139
13	35,368	69,253	91,844	103,139	114,434
14	45,534	89,585	118,952	133,636	148,319
15	48,922	96,362	127,988	143,801	159,614

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

Factors for limits above \$1 Million/\$3 Million Primary:

EXCESS LIMITS	\$1M/\$3M Primary	
	Classes 1 – 8	Classes 9 – 15
\$1M	0.1977	0.2535
\$2M	0.3164	0.4040
\$3M	0.4055	0.5169
\$4M	0.4723	0.6016
\$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

1. Factors for Indefinite Reporting Endorsement

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Prior Occurrence Coverage		C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Expiration Date or	Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago		0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago		0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago		0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago		0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago		0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago		0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago		0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Prior Occurrence Coverage		C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Expiration Date or	Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago		0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago		0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago		0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago		0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago		0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago		0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago		0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Prior Occurrence Coverage		C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Expiration Date or	Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
	Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016
	1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368
	2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876
	3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552
	4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396
	5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288
	6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192
	7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120
	8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072
	9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
	10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
	More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000
			7th Year	8th Year	9th Year	10th Year	11th Year+
	Up to 1 yr. ago		2.088	2.136	2.172	2.196	2.208
	1+ to 2 yrs. ago		1.416	1.452	1.476	1.488	1.488
	2+ to 3 yrs. ago		0.912	0.936	0.948	0.948	0.948
	3+ to 4 yrs. ago		0.576	0.588	0.588	0.588	0.588
	4+ to 5 yrs. ago		0.408	0.408	0.408	0.408	0.408
	5+ to 6 yrs. ago		0.288	0.288	0.288	0.288	0.288
	6+ to 7 yrs. ago		0.192	0.192	0.192	0.192	0.192
	7+ to 8 yrs. ago		0.120	0.120	0.120	0.120	0.120
	8+ to 9 yrs. ago		0.072	0.072	0.072	0.072	0.072
	9+ to 10 yrs. ago		0.036	0.036	0.036	0.036	0.036
	10+ to 11 yrs. ago		0.012	0.012	0.012	0.012	0.012
	More than 11 yrs. ago		0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4 th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000
		7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago		0.616	0.627	0.638	0.649	0.660
1+ to 2 yrs. ago		0.462	0.473	0.484	0.495	0.495
2+ to 3 yrs. ago		0.308	0.319	0.330	0.330	0.330
3+ to 4 yrs. ago		0.154	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago		0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago		0.088	0.088	0.088	0.088	0.088
6+ to 7 yrs. ago		0.066	0.066	0.066	0.066	0.066
7+ to 8 yrs. ago		0.044	0.044	0.044	0.044	0.044
8+ to 9 yrs. ago		0.033	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago		0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago		0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago		0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850

II. STATE EXCEPTIONIONS

A. Policy Issuance

B. Rules

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.
2. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through the Ascension Health Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

SECTION 10

STATE RATES AND EXCEPTIONS – GROUPS

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.
2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard rating factors.

Claims-made Rate Per 100 Patient Visits \$1,000,000 / \$3,000,000						
Class	Code	Territory 1	Territory 2	Territory 3	Territory 4	Territory 5
Emergency Room	80429	\$1,167	\$828	\$670	\$997	\$1,054
Urgent Care	80424(V)	\$978	\$696	\$564	\$837	\$884

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

- a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 7, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

- b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
- c. Determine the remaining optional separate limit premium, if applicable.
- d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONIONS

A. Policy Issuance

B. Rules

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.
2. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through the Ascension Health Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

B. Rules

SERFF Tracking #:

PCWA-128495383

State Tracking #:

PCWA-128495383

Company Tracking #:

IL-AHRPG-0712-RR

State:

Illinois

Filing Company:

ProAssurance Casualty Company

TOI/Sub-TOI:

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

Product Name:

Ascension Health Risk Purchasing Group, Inc.

Project Name/Number:

Initial Filing of Rates, Rules and Forms/

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Form RF3 - (Summary Sheet)		
Bypass Reason:	N/A - initial filing of program - no rate change involved		
		Item Status:	Status Date:
Satisfied - Item:	Certification		
Comments:			
Attachment(s):			
certification for AHRPG.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Manual		
Bypass Reason:	Manual attached to Rate/Rule Schedule		

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, Kathryn A. Neville, a duly authorized officer of ProAssurance Casualty 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 also certify that all changes made were disclosed, no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

I, Howard H. Friedman, a duly authorized actuary of ProAssurance Casualty 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.



Kathryn A. Neville, Secretary
Signature and Title of Authorized Insurance Company Officer

6/20/2012

Date



Howard H. Friedman, ACAS, MAAA, Senior Vice President
Signature, Title and Designation of Authorized Actuary

6/20/2012

Date

Insurance Company FEIN 39-1567580 Filing Number IL-AHRPG-0712-RR
Insurer's Address 100 Brookwood Place
City Birmingham State Alabama Zip Code 35209

Contact Person's:

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Product Name: Ascension Health Risk Purchasing Group, Inc.
Project Name/Number: Initial Filing of Rates, Rules and Forms/

Superseded Schedule Items

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

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/20/2012		Rate	Underwriting Manual	09/10/2012	Ascension Illinois Manual eff 7-1-2012.pdf (Superseded)
06/20/2012		Supporting Document	Explanatory Memorandum	11/30/2012	Explanatory Memorandum.pdf (Superseded)

ILLINOIS MANUAL
for
Ascension Health Risk Purchasing Group, Inc.

Healthcare Professionals
Underwriting Rules and Rates



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SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance through the Ascension Health Risk Purchasing Group, Inc., underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

- A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500. If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date. For any transaction producing under \$25 in premium, the Company may waive the premium.
- B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Policies developing annualized, \$1,000,000/\$3,000,000 limits mature claims-made manual premium of \$50,000 or more for (a) rating.
- C. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving \$.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

- A. By the Company: The earned premium shall be determined on a "pro rata" basis.
- B. By the Insured: The earned premium shall be determined on a "short rate" basis.
- C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, subject to proper notice.

III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One
 - a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
 - b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
 - c. No interest or installment charges;
 - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
 - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.

2. Quarterly Installment Option Two – (35/25/25/15)
 - a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
 - b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
 - c. No interest or installment charges;
 - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
 - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.

3. Annual Payment Plan – The premium must be paid in full prior to the inception date of the policy. A discount for this payment option is available (see Item VIII, Annual Premium Payment Discount, of Section 4, Professional Liability Discounts).

4. Semi-Annual Payment Plan – 60% of the premium must be paid prior to the policy inception date and one installment of 40% is due six months after inception.

5. Nine Payment Plan – 20% down and eight consecutive monthly installments of 10% each. This plan requires that the policyholder participate in the Electronic Payment Plan in which premiums are automatically deducted from the policyholder's bank account.

No finance charges or fees apply to these payment plans. The option to pay premium on other than the Annual Payment Plan may be withdrawn by the Company if the insured has failed to make premium payments when due.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

SPECIALTY CODES AND DESCRIPTIONS

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

<u>Specialty</u>	Industry Class Code		
	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-
<i>Endocrinology</i>	80238	-	-

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

Industry Class Code

<u>Specialty</u>	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420 - -	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
<i>Infectious Disease</i>	80246	-	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

*refer to Classification and/or Rating Modifications & Procedures Section for further definition

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

<u>Specialty</u>	<u>Industry Class Code</u>		
	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A) - -	- - -	80475(B)-basic procedures 80475(C)-intermediate procedures 80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Surgical Consultation – Office Only	80477(A)	80477(B)	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

**For rating purposes, include Neonatology in this risk class.

***See Internal Medicine – Minor Surgery.

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS

AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

- A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.
- B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.
- C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.
- D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

- A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:
 - a. First year resident - 25% of the appropriate specialty classification rate
 - b. Second year resident - 50% of the appropriate specialty classification rate
 - c. Third year resident - 75% of the appropriate specialty classification rate
 - d. Fellows and interns - 85% of the appropriate specialty classification rate
- B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).
- C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

<u>Classification</u>	<u>Rating Criteria:</u>
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. PART-TIME AND SEMI-RETIRED INSUREDS

The Part-Time Discount is available to insureds.

- A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
- B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
- C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
- D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor or Dentist Discount are not eligible for the Part-Time Discount. This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. Paramedicals covered on an individual basis, not sharing limits, are eligible for the same part-time program, discounts and rules that apply to physicians.

The available discounts are:

<u>TYPE</u>	<u>Class</u>	<u>Average Weekly Practice Hours <20 hours</u>
Physician	1 to 7	50%
Surgeon	8 to 15	35%
Dentist	All	50%
Paramedical	All	50%

* Insureds whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of insureds receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage for each insured professional or insured paramedical employee is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens may cover multiple insured professionals or multiple insured paramedical employees up to a total of ninety (90) days during the policy period.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty (2,080 hours of work per FTE) or the average number of patient contacts/visits in a 12 month period (4,000 visits per FTE). A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

VIII. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,
 plus OB/GYN rate for claims-made year five,
 less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

C. Reporting Endorsement Coverage

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%), plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

1. If the reporting endorsement is issued at the end of an annual policy period, the reporting endorsement premium shall be limited to a maximum of 200% of the insured's expiring annual claims-made premium, including discounts and surcharges.
2. If the policy is terminated during the first year, pro-rate the reporting endorsement premium and then limit it to 200% of the pro-rated claims-made premium for the policy period, including discounts and surcharges.
3. If the policy is terminated during the second, third or fourth claims-made policy year, blend the applicable reporting endorsement factors and then limit the reporting endorsement premium to 200% of the blended annual claims-made premiums, including discounts and surcharges.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force. In the event that the insured has changed policy limits of liability within 36 months prior to the termination date, the limits of liability applicable to any reporting endorsement issued with a waiver of premium shall be equal to the limits of liability in effect during the majority of the 36 months preceding the termination date.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 50% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor/dentist discounts: up to 50%. Deductible credits may be combined with the New Doctor/Dentist discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing \$50,000 or more annualized premium

II. NEW DOCTOR OR DENTIST DISCOUNT

This discount will apply only to solo practicing physicians and dentists who have never been in practice and proceed directly into practice from training, or physicians or dentists who fit within that category except for an interim period of employment not to exceed two years. Physicians or dentists who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

<u>Year of Coverage Since Training</u>	<u>Annual Premium Discount Per Policy</u>
Year 1	50%
Year 2	25%
Year 3	0%

III. RISK MANAGEMENT PREMIUM CREDITS

Insureds who participate in risk management activities approved by the Company may be eligible for the following premium credits, up to a maximum of 8%.

<u>Activity</u>	<u>Credit</u>
1. Documented in-person attendance at a live seminar. Must be present for the entire program to earn credit.	2% each; 4% maximum
2. Successful completion of online course. Must be completed by August 31.	1% each; 4% maximum
Combined total of credits for 1 and 2 cannot exceed 6%.	
3. Demonstration of effective mechanisms for communicating diagnostic test results, based on survey results. Must be completed by June 30. Non-obstetric specialties only.	2%
4. Support for a patient safety goal of no inductions prior to 39 weeks, unless medically indicated. Confirmation must be received by August 31. Obstetric specialties only.	2%

Activities submitted for risk management credits must have been completed within twelve months prior to application.

Any risk management credit will be revoked or withheld if evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit is found.

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.
3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.
5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	<u>Debit/Credit</u>
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk and subject to a minimum eligibility of \$1,000 before and after the application of the credit/debit for subjective rating plans.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians, on both a primary and excess rate basis, as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer (\$1M/\$3M).

Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

<u>INDEMNITY ONLY</u> <u>Deductible Per Claim</u>		<u>INDEMNITY AND ALAE</u> <u>Deductible Per Claim</u>	
\$ 5,000	2.5%	\$ 5,000	6.5%
\$10,000	4.5%	\$10,000	11.5%
\$15,000	6.0%	\$15,000	15.0%
\$20,000	8.0%	\$20,000	17.5%
\$25,000	9.0%	\$25,000	20.0%
\$50,000	15.0%	\$50,000	30.5%
\$100,000	25.0%	\$100,000	44.5%
\$200,000	37.5%	\$200,000	55.0%
\$250,000	42.0%	\$250,000	58.0%
 <u>Per Claim/Aggregate</u>		 <u>Per Claim/Aggregate</u>	
\$ 5,000/15,000	2.0%	\$ 5,000/15,000	5.5%
\$10,000/30,000	4.0%	\$10,000/30,000	10.5%
\$25,000/75,000	8.5%	\$25,000/75,000	19.0%
\$50,000/150,000	14.0%	\$50,000/150,000	29.5%
\$100,000/300,000	24.0%	\$100,000/300,000	43.0%
\$200,000/600,000	36.0%	\$200,000/600,000	53.5%
\$250,000/750,000	40.0%	\$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to \$1M/\$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2 - 19	20 - 40	41 - 60	61 - 100	
5/15	.020	.018	.015	.012	\$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

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

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

VIII. LARGE GROUP CREDIT

For groups generating \$50,000 or more in annualized manual premium at \$1,000,000/\$3,000,000 policy limits, where the loss ratio for the account is less than 25%, a credit of 10% will apply. The loss ratio is to be computed based on five years of historical experience, utilizing incurred indemnity plus incurred allocated loss adjustment expense experience.

IX. GENERAL RULES

- A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.
- B. Discounts will apply in the following order:
 - 1. Deductible Discount (primary premium only).
 - 2. New Doctor/Dentist Discount or other resident or part-time, semi-retired discount; and
 - 3. Risk Management Discount and Scheduled Rating (apply the net credit or debit).

Example: Class 1, \$1M/\$3M, 1st year new doctor, Risk Management Seminar within 12 months. \$25,000 deductible. Assume manual rate \$7,500.

\$7,500	Manual Rate for \$1M/\$3M
<u>x .91</u>	Less 9% (Deductible Credit)
6825	
<u>x .50</u>	Less 50% (New Doctor)
3,413	Applicable Net Premium
<u>x .85</u>	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

- C. Additional practice charges will be applied to the premium after all discounts have been applied.
- D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians.

<u>Number of Insureds</u>	<u>Percent</u>
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is \$1,000.

III. PARTNERSHIP-CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician or dentist will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed \$35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician or dentist's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician or dentist first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Physician Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician or dentist will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician or dentist has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

Dentists will be treated as "Class 1" for determination of their Evaluation Period and will be eligible for a maximum Claims Free Credit of 15%, in accordance with the earning schedule above. However, the Claims Free Dentist must have no incurred losses or ALAE (payments or reserves) during the Evaluation Period. Notwithstanding any other provisions of this section, no dentist with 2 or more reported claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians and dentists at no charge.

Limits of Liability will be offered as follows:

<u># of insureds</u>	<u>“Each Covered Investigation”</u>	<u>“Each Policy Period”</u>
1 - 5	\$25,000	\$25,000 X (# of insureds)
6 - 10	\$25,000	\$125,000
11 - 20	\$25,000	\$175,000
21 +	\$25,000	\$225,000

The limit of liability for “covered audits” will be \$5,000 per covered insured with a deductible of \$1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to participants in the Program at no additional charge with coverage limits as follows:

Item 1	Network Security and Privacy Liability Coverage	\$50,000 per Claim
Item 2	Regulatory Fines and Penalties Coverage	\$50,000 per Claim
Item 3	Patient Notification and Credit Monitory Costs Coverage	\$50,000 per Claim
Item 4	Data Recovery Costs Coverage	\$5,000 per Claim
Item 5	Deductible	(none) per Claim

There is a premium charge for those insureds that elect expanded coverage with higher limits. The optional additional limit of \$1 million is shared among all insureds within a practice group and is in excess of the standard coverage provided above.

Limits are in excess of \$50,000 primary coverage.

# of Physicians	\$1M Limit
1 Physician	\$ 1,125
2 Physicians	\$ 1,500
3-5 Physicians	\$ 2,063
6-10 Physicians	\$ 2,813
11-15 Physicians	\$ 3,750
16-20 Physicians	\$ 5,100
21-25 Physicians	\$ 6,375
26-30 Physicians	\$ 7,650

SECTION 6

**PHYSICIAN EXTENDER, PARAMEDICAL AND
ALLIED HEALTH PROFESSIONAL LIABILITY RATING**

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians’ assistants, psychologists, surgeons or surgeons’ assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician’s Assistant (PA)	0.026	0.080	0.025
Surgeon’s Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041
Psychologist	0.018	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.022	0.045	0.012

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	\$1M/\$3M
Health Care Professional NOC	80301	Refer to Company (Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.128
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.080
Physiotherapist	80938	0.018
Psychologist	80912	0.054
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.125
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306
		(Factors based on 80151)
Nurse Anesthetist - Medical	80960(M)	0.350

(Factors based on 80114)

Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

<u>Prior Year Claims-Made</u>	<u>Factors</u>
1	1.00
2	1.25
3+	1.50

STEP-RATING FACTORS

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under \$500 are not eligible for the step-rating factors.

III. EXTENDED REPORTING PERIOD ENDORSEMENT (TAIL COVERAGE)

Extended Reporting Period (Tail) Factors
By Month

**Claims-Made
Year**

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

SECTION 7

**DENTAL PROFESSIONAL LIABILITY
SPECIALTY CODES AND DESCRIPTIONS**

DENTAL SPECIALTY CODES & CLASSIFICATIONS

DENTISTS - CLASS 1A

- 80213 Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. **This class does not apply to dentists performing extractions, root canals or other oral surgery or endodontic procedures.** This class does not apply to oral surgeons.

DENTISTS - CLASS 1

- 80211 Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- 80214 Applies to orthodontists and endodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- 80215 Applies to periodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.

DENTISTS - CLASS 2

- 80211(F) Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits the initial placement of dental implants.
- 80211(G) Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, but only if the sedation is administered by a Dental or Medical Anesthetist. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 will apply. This class does not apply to oral surgeons.

DENTISTS - CLASS 3

- 80209 Applies to dentists as defined for Classes 1 or 2 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 or 2 will apply, as appropriate. This class does not apply to oral surgeons.

ORAL SURGERY - CLASS 4

- 80210 Includes all oral surgeons and also applies to dentists as defined in Classes 1A through 3 who additionally perform dentistry on patients who are being treated with general anesthesia in the office.

DENTISTS - CLASS 5

- 80211(I) Applies to dentists as defined for Classes 1 or 2 but, in addition, permits use of cosmetic Botox on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. This class does not apply to oral surgeons.

PARADENTAL EMPLOYEE COVERAGE

Coverage on a shared limits basis is automatically provided for professional employees of the Policyholder or an insured under the policy with no additional charge (e.g., dental assistants, dental hygienists and lab technicians).

While a dental insured's insured paradecimal employees are automatically covered under the policy, a premium charge for Certified Registered Nurse Anesthetists (CRNAs) will be made as indicated in Section 6, I – Employed Certified Registered Nurse Anesthetist.

SECTION 8

STATE RATES AND EXCEPTIONS – DENTISTS

I. RATES

A. Dental Rating Classes – Illinois

The following indicates the specialty classification codes applicable to the rating classes on the following pages:

1A	80213
1	80211 80214 80215
2	80211(F) 80211(G)
3	80209
4	80210
5	80211(I)

B. Dentists Professional Liability Rates

1. Claims-Made Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	551	963	1,306	1,450	1,581
1	654	1,169	1,598	1,770	1,925
2	782	1,426	1,963	2,169	2,354
3	1,426	2,714	3,787	4,165	4,500
4	4,001	7,864	11,084	12,148	13,084
5	5,289	10,440	14,732	16,140	17,377

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	602	1,066	1,452	1,611	1,753
1	718	1,298	1,781	1,970	2,140
2	863	1,588	2,191	2,419	2,623
3	1,588	3,037	4,244	4,665	5,038
4	4,486	8,833	12,456	13,650	14,699
5	5,935	11,731	16,562	18,142	19,529

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	701	1,263	1,731	1,916	2,082
1	841	1,544	2,129	2,351	2,550
2	1,017	1,895	2,627	2,896	3,136
3	1,895	3,652	5,116	5,619	6,064
4	5,409	10,679	15,071	16,511	17,775
5	7,166	14,193	20,049	21,957	23,631

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	746	1,354	1,860	2,057	2,234
1	898	1,658	2,291	2,528	2,740
2	1,088	2,038	2,829	3,117	3,373
3	2,038	3,937	5,520	6,061	6,538
4	5,836	11,534	16,282	17,836	19,200
5	7,735	15,332	21,663	23,723	25,531

1. Claims-Made Rates by Year (cont.)

Territory 2: Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	428	718	959	1,071	1,173
1	500	862	1,164	1,295	1,414
2	591	1,043	1,420	1,575	1,716
3	1,043	1,948	2,702	2,978	3,224
4	2,853	5,567	7,829	8,587	9,255
5	3,758	7,377	10,392	11,392	12,271

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	464	790	1,062	1,183	1,294
1	546	953	1,292	1,436	1,565
2	648	1,157	1,581	1,751	1,905
3	1,157	2,175	3,023	3,330	3,602
4	3,193	6,248	8,793	9,642	10,390
5	4,211	8,284	11,678	12,799	13,784

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	533	928	1,258	1,398	1,524
1	632	1,126	1,537	1,704	1,854
2	756	1,373	1,887	2,086	2,265
3	1,373	2,607	3,636	4,000	4,322
4	3,842	7,545	10,631	11,653	12,551
5	5,076	10,013	14,128	15,479	16,666

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	566	993	1,348	1,497	1,631
1	672	1,206	1,651	1,828	1,987
2	806	1,473	2,029	2,242	2,432
3	1,473	2,807	3,919	4,310	4,656
4	4,142	8,145	11,481	12,584	13,552
5	5,476	10,814	15,262	16,720	18,001

1. Claims-Made Rates by Year (cont.)

Territory 3: Remainder of State

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	371	603	797	893	982
1	429	719	961	1,073	1,176
2	502	865	1,167	1,299	1,418
3	865	1,591	2,196	2,424	2,628
4	2,317	4,495	6,310	6,926	7,469
5	3,043	5,947	8,367	9,176	9,889

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	400	661	879	984	1,079
1	465	792	1,065	1,186	1,297
2	547	956	1,296	1,440	1,570
3	956	1,773	2,454	2,706	2,931
4	2,590	5,041	7,084	7,772	8,379
5	3,407	6,675	9,399	10,305	11,102

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	455	772	1,037	1,156	1,264
1	535	931	1,261	1,401	1,529
2	634	1,129	1,542	1,709	1,859
3	1,129	2,120	2,945	3,244	3,510
4	3,110	6,082	8,559	9,386	10,114
5	4,101	8,063	11,365	12,456	13,416

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	481	824	1,109	1,235	1,350
1	567	995	1,352	1,501	1,636
2	674	1,209	1,656	1,833	1,993
3	1,209	2,280	3,173	3,493	3,777
4	3,351	6,564	9,241	10,133	10,917
5	4,422	8,706	12,275	13,452	14,487

1. Claims-Made Rates by Year (cont.)

Territory 4: DuPage, Kane, Lake and McHenry Counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	489	840	1,132	1,261	1,377
1	577	1,015	1,381	1,532	1,669
2	687	1,235	1,691	1,872	2,035
3	1,235	2,331	3,244	3,571	3,862
4	3,427	6,716	9,456	10,368	11,170
5	4,523	8,908	12,562	13,766	14,824

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	533	928	1,257	1,397	1,524
1	632	1,125	1,537	1,703	1,853
2	755	1,372	1,886	2,085	2,264
3	1,372	2,606	3,634	3,997	4,320
4	3,839	7,540	10,624	11,646	12,544
5	5,073	10,008	14,120	15,470	16,656

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	617	1,096	1,494	1,657	1,803
1	737	1,335	1,833	2,028	2,202
2	886	1,634	2,257	2,491	2,700
3	1,634	3,130	4,376	4,809	5,193
4	4,625	9,112	12,851	14,082	15,163
5	6,121	12,103	17,088	18,718	20,149

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	656	1,173	1,604	1,777	1,932
1	785	1,432	1,971	2,178	2,364
2	947	1,755	2,429	2,679	2,902
3	1,755	3,372	4,720	5,185	5,597
4	4,989	9,840	13,882	15,210	16,376
5	6,606	13,073	18,463	20,222	21,766

1. Claims-Made Rates by Year (cont.)

Territory 5: Jackson and Vermilion Counties

Class Code	\$100,000 / \$300,000				
	1	2	3	4	5+
1A	510	881	1,190	1,324	1,445
1	602	1,067	1,453	1,612	1,754
2	718	1,299	1,782	1,971	2,141
3	1,299	2,459	3,425	3,769	4,074
4	3,619	7,099	9,999	10,961	11,808
5	4,779	9,419	13,286	14,557	15,675

Class Code	\$200,000 / \$600,000				
	1	2	3	4	5+
1A	556	974	1,322	1,468	1,600
1	661	1,183	1,618	1,792	1,948
2	791	1,444	1,988	2,197	2,383
3	1,444	2,749	3,837	4,220	4,559
4	4,055	7,971	11,235	12,314	13,262
5	5,360	10,582	14,934	16,361	17,614

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	645	1,151	1,573	1,743	1,896
1	772	1,405	1,932	2,136	2,318
2	930	1,721	2,381	2,626	2,845
3	1,721	3,304	4,623	5,079	5,483
4	4,886	9,634	13,591	14,892	16,034
5	6,469	12,800	18,075	19,798	21,310

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	686	1,233	1,690	1,870	2,033
1	823	1,507	2,078	2,295	2,489
2	994	1,849	2,562	2,825	3,059
3	1,849	3,560	4,986	5,477	5,911
4	5,271	10,404	14,682	16,085	17,317
5	6,982	13,826	19,529	21,389	23,021

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

3. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

\$1M/\$3M Primary

EXCESS LIMITS	Dentists/ Oral Surgeons
\$1M	0.0480
\$2M	0.0960
\$3M	0.1450
\$4M	0.1935
\$5M	0.2225

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

II. EXCEPTIONS

A. Policy Issuance

1. If the insured elects to accept the Waiver of Consent to Settle Endorsement, Form PRA-HCP-612, a credit of 7% will be applied.
2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.
3. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through the Ascension Health Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

SECTION 9

**STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND
PODIATRISTS**

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

<u>Rating Class</u>	<u>Industry Class Codes</u>					
1	80102(A) 80178	80179 80231	80235 80236	80240 80254	80256(A) 80265	80620
2	80233 80238	80249 80252	80256(B) 80263	80267 80474	80621	
3	80102(B) 80145(A) 80222(A)	80244 80245 80255	80257 80260 80266	80268 80282 80289	80420 80431 80473	80477(A)
4	80114 80145(B)	80151 80222(B)	80241 80246	80253 80261	80269 80421(A)	
5	80145(C) 80274 80278	80280 80283 80284	80286 80287 80288	80291 80293 80294	80360 80421(B) 80424(F)	80425 80477(B)
6	80102(C) 80117(A)	80159 80167	80277 80281(A)	80421(C) 80472		
7	80115	80117(B)	80281(B)	80475(A)		
8	80117(C)	80155	80169			
9	80143	80154(A)	80156			
10	80146	80150				
11	80144	80154(B)	80171	80475(B)		
12	80153					
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,519	5,556	6,914	7,593	8,272
2	4,538	7,593	9,630	10,649	11,667
3	5,556	9,630	12,346	13,704	15,062
4	6,575	11,667	15,062	16,759	18,457
5	7,593	13,704	17,778	19,815	21,851
6	8,815	16,148	21,037	23,481	25,925
7	9,630	17,778	23,209	25,925	28,641
8	11,667	21,851	28,641	32,036	35,431
9	13,704	25,925	34,073	38,147	42,220
10	15,741	29,999	39,504	44,257	49,010
11	17,778	34,073	44,936	50,368	55,800
12	19,815	38,147	50,368	56,479	62,589
13	21,851	42,220	55,800	62,589	69,379
14	27,962	54,442	72,095	80,921	89,748
15	29,999	58,515	77,526	87,032	96,537

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	2,908	4,334	5,285	5,760	6,235
2	3,621	5,760	7,186	7,899	8,612
3	4,334	7,186	9,087	10,037	10,988
4	5,047	8,612	10,988	12,176	13,364
5	5,760	10,037	12,889	14,315	15,741
6	6,616	11,748	15,170	16,881	18,592
7	7,186	12,889	16,691	18,592	20,494
8	8,612	15,741	20,494	22,870	25,246
9	10,037	18,592	24,296	27,147	29,999
10	11,463	21,444	28,098	31,425	34,752
11	12,889	24,296	31,900	35,702	39,504
12	14,315	27,147	35,702	39,980	44,257
13	15,741	29,999	39,504	44,257	49,010
14	20,018	38,554	50,911	57,090	63,268
15	21,444	41,406	54,713	61,367	68,021

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	2,623	3,764	4,524	4,905	5,285
2	3,194	4,905	6,045	6,616	7,186
3	3,764	6,045	7,566	8,327	9,087
4	4,334	7,186	9,087	10,037	10,988
5	4,905	8,327	10,608	11,748	12,889
6	5,589	9,695	12,433	13,802	15,170
7	6,045	10,608	13,650	15,170	16,691
8	7,186	12,889	16,691	18,592	20,494
9	8,327	15,170	19,733	22,014	24,296
10	9,467	17,452	22,775	25,436	28,098
11	10,608	19,733	25,817	28,858	31,900
12	11,748	22,014	28,858	32,280	35,702
13	12,889	24,296	31,900	35,702	39,504
14	16,311	31,140	41,025	45,968	50,911
15	17,452	33,421	44,067	49,390	54,713

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,214	4,945	6,100	6,677	7,254
2	4,080	6,677	8,408	9,274	10,139
3	4,945	8,408	10,716	11,871	13,025
4	5,811	10,139	13,025	14,468	15,911
5	6,677	11,871	15,333	17,065	18,796
6	7,715	13,948	18,104	20,181	22,259
7	8,408	15,333	19,950	22,259	24,567
8	10,139	18,796	24,567	27,453	30,338
9	11,871	22,259	29,184	32,647	36,110
10	13,602	25,722	33,801	37,841	41,881
11	15,333	29,184	38,418	43,035	47,652
12	17,065	32,647	43,035	48,229	53,423
13	18,796	36,110	47,652	53,423	59,194
14	23,990	46,498	61,503	69,005	76,508
15	25,722	49,961	66,120	74,200	82,279

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,316	5,149	6,371	6,982	7,593
2	4,232	6,982	8,815	9,732	10,649
3	5,149	8,815	11,260	12,482	13,704
4	6,066	10,649	13,704	15,232	16,759
5	6,982	12,482	16,148	17,981	19,815
6	8,082	14,682	19,081	21,281	23,481
7	8,815	16,148	21,037	23,481	25,925
8	10,649	19,815	25,925	28,981	32,036
9	12,482	23,481	30,814	34,480	38,147
10	14,315	27,147	35,702	39,980	44,257
11	16,148	30,814	40,591	45,479	50,368
12	17,981	34,480	45,479	50,979	56,479
13	19,815	38,147	50,368	56,479	62,589
14	25,314	49,146	65,034	72,977	80,921
15	27,147	52,812	69,922	78,477	87,032

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	4,397	7,311	9,254	10,225	11,196
2	5,854	10,225	13,139	14,596	16,053
3	7,311	13,139	17,025	18,967	20,910
4	8,768	16,053	20,910	23,339	25,767
5	10,225	18,967	24,796	27,710	30,624
6	11,973	22,464	29,458	32,955	36,452
7	13,139	24,796	32,567	36,452	40,338
8	16,053	30,624	40,338	45,195	50,052
9	18,967	36,452	48,109	53,937	59,765
10	21,882	42,281	55,880	62,680	69,479
11	24,796	48,109	63,651	71,422	79,193
12	27,710	53,937	71,422	80,164	88,907
13	30,624	59,765	79,193	88,907	98,621
14	39,366	77,250	102,506	115,134	127,762
15	42,281	83,079	110,277	123,877	137,476

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	3,522	5,562	6,922	7,602	8,282
2	4,542	7,602	9,642	10,662	11,682
3	5,562	9,642	12,362	13,722	15,082
4	6,582	11,682	15,082	16,782	18,482
5	7,602	13,722	17,802	19,842	21,882
6	8,826	16,170	21,066	23,513	25,961
7	9,642	17,802	23,242	25,961	28,681
8	11,682	21,882	28,681	32,081	35,481
9	13,722	25,961	34,121	38,201	42,281
10	15,762	30,041	39,561	44,320	49,080
11	17,802	34,121	45,000	50,440	55,880
12	19,842	38,201	50,440	56,560	62,680
13	21,882	42,281	55,880	62,680	69,479
14	28,001	54,520	72,199	81,039	89,878
15	30,041	58,600	77,639	87,158	96,678

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	3,114	4,746	5,834	6,378	6,922
2	3,930	6,378	8,010	8,826	9,642
3	4,746	8,010	10,186	11,274	12,362
4	5,562	9,642	12,362	13,722	15,082
5	6,378	11,274	14,538	16,170	17,802
6	7,357	13,232	17,149	19,107	21,066
7	8,010	14,538	18,890	21,066	23,242
8	9,642	17,802	23,242	25,961	28,681
9	11,274	21,066	27,593	30,857	34,121
10	12,906	24,329	31,945	35,753	39,561
11	14,538	27,593	36,297	40,649	45,000
12	16,170	30,857	40,649	45,544	50,440
13	17,802	34,121	45,000	50,440	55,880
14	22,698	43,913	58,056	65,127	72,199
15	24,329	47,176	62,408	70,023	77,639

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	3,960	6,437	8,088	8,914	9,739
2	5,198	8,914	11,391	12,629	13,868
3	6,437	11,391	14,693	16,345	17,996
4	7,675	13,868	17,996	20,060	22,124
5	8,914	16,345	21,299	23,776	26,253
6	10,400	19,317	25,262	28,234	31,207
7	11,391	21,299	27,904	31,207	34,510
8	13,868	26,253	34,510	38,638	42,766
9	16,345	31,207	41,115	46,069	51,023
10	18,822	36,161	47,720	53,500	59,280
11	21,299	41,115	54,326	60,931	67,537
12	23,776	46,069	60,931	68,362	75,793
13	26,253	51,023	67,537	75,793	84,050
14	33,684	65,885	87,353	98,086	108,820
15	36,161	70,839	93,958	105,518	117,077

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	4,105	6,728	8,477	9,351	10,225
2	5,417	9,351	11,973	13,285	14,596
3	6,728	11,973	15,470	17,219	18,967
4	8,039	14,596	18,967	21,153	23,339
5	9,351	17,219	22,464	25,087	27,710
6	10,924	20,366	26,661	29,808	32,955
7	11,973	22,464	29,458	32,955	36,452
8	14,596	27,710	36,452	40,824	45,195
9	17,219	32,955	43,446	48,692	53,937
10	19,842	38,201	50,440	56,560	62,680
11	22,464	43,446	57,434	64,428	71,422
12	25,087	48,692	64,428	72,296	80,164
13	27,710	53,937	71,422	80,164	88,907
14	35,578	69,674	92,404	103,769	115,134
15	38,201	74,919	99,398	111,637	123,877

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	5,248	9,013	11,523	12,778	14,033
2	7,130	12,778	16,543	18,425	20,308
3	9,013	16,543	21,563	24,073	26,583
4	10,895	20,308	26,583	29,720	32,858
5	12,778	24,073	31,603	35,368	39,133
6	15,037	28,591	37,627	42,145	46,663
7	16,543	31,603	41,643	46,663	51,683
8	20,308	39,133	51,683	57,958	64,233
9	24,073	46,663	61,723	69,253	76,783
10	27,838	54,193	71,763	80,549	89,334
11	31,603	61,723	81,804	91,844	101,884
12	35,368	69,253	91,844	103,139	114,434
13	39,133	76,783	101,884	114,434	126,984
14	50,428	99,374	132,004	148,319	164,635
15	54,193	106,904	142,044	159,614	177,185

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	4,118	6,754	8,511	9,389	10,268
2	5,436	9,389	12,025	13,342	14,660
3	6,754	12,025	15,539	17,296	19,053
4	8,071	14,660	19,053	21,249	23,445
5	9,389	17,296	22,567	25,202	27,838
6	10,970	20,458	26,784	29,946	33,109
7	12,025	22,567	29,595	33,109	36,623
8	14,660	27,838	36,623	41,016	45,408
9	17,296	33,109	43,651	48,922	54,193
10	19,931	38,380	50,679	56,829	62,978
11	22,567	43,651	57,707	64,735	71,763
12	25,202	48,922	64,735	72,642	80,549
13	27,838	54,193	71,763	80,549	89,334
14	35,744	70,006	92,848	104,268	115,689
15	38,380	75,277	99,876	112,175	124,474

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	3,591	5,699	7,105	7,808	8,511
2	4,645	7,808	9,916	10,970	12,025
3	5,699	9,916	12,727	14,133	15,539
4	6,754	12,025	15,539	17,296	19,053
5	7,808	14,133	18,350	20,458	22,567
6	9,073	16,663	21,723	24,254	26,784
7	9,916	18,350	23,972	26,784	29,595
8	12,025	22,567	29,595	33,109	36,623
9	14,133	26,784	35,217	39,434	43,651
10	16,242	31,001	40,840	45,759	50,679
11	18,350	35,217	46,462	52,085	57,707
12	20,458	39,434	52,085	58,410	64,735
13	22,567	43,651	57,707	64,735	71,763
14	28,892	56,302	74,575	83,711	92,848
15	31,001	60,518	80,197	90,036	99,876

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	4,683	7,883	10,017	11,083	12,150
2	6,283	11,083	14,284	15,884	17,484
3	7,883	14,284	18,551	20,684	22,818
4	9,483	17,484	22,818	25,485	28,152
5	11,083	20,684	27,085	30,285	33,485
6	13,004	24,525	32,205	36,046	39,886
7	14,284	27,085	35,619	39,886	44,153
8	17,484	33,485	44,153	49,487	54,821
9	20,684	39,886	52,687	59,088	65,488
10	23,885	46,287	61,221	68,689	76,156
11	27,085	52,687	69,755	78,289	86,824
12	30,285	59,088	78,289	87,890	97,491
13	33,485	65,488	86,824	97,491	108,159
14	43,086	84,690	112,426	126,294	140,162
15	46,287	91,091	120,960	135,895	150,829

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	4,871	8,260	10,519	11,648	12,778
2	6,565	11,648	15,037	16,731	18,425
3	8,260	15,037	19,555	21,814	24,073
4	9,954	18,425	24,073	26,897	29,720
5	11,648	21,814	28,591	31,979	35,368
6	13,681	25,880	34,013	38,079	42,145
7	15,037	28,591	37,627	42,145	46,663
8	18,425	35,368	46,663	52,311	57,958
9	21,814	42,145	55,699	62,476	69,253
10	25,202	48,922	64,735	72,642	80,549
11	28,591	55,699	73,771	82,808	91,844
12	31,979	62,476	82,808	92,973	103,139
13	35,368	69,253	91,844	103,139	114,434
14	45,534	89,585	118,952	133,636	148,319
15	48,922	96,362	127,988	143,801	159,614

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

Factors for limits above \$1 Million/\$3 Million Primary:

EXCESS LIMITS	\$1M/\$3M Primary	
	Classes 1 – 8	Classes 9 – 15
\$1M	0.1977	0.2535
\$2M	0.3164	0.4040
\$3M	0.4055	0.5169
\$4M	0.4723	0.6016
\$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

1. Factors for Indefinite Reporting Endorsement

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Prior Occurrence Coverage		C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Expiration Date or	Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago		0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago		0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago		0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago		0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago		0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago		0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago		0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Prior Occurrence Coverage		C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Expiration Date or	Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago		0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago		0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago		0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago		0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago		0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago		0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago		0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Prior Occurrence Coverage		C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year	
Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016	
1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368	
2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876	
3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552	
4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396	
5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288	
6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192	
7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120	
8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072	
9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036	
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012	
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000	
		7th Year	8th Year	9th Year	10th Year	11th Year+	
Up to 1 yr. ago		2.088	2.136	2.172	2.196	2.208	
1+ to 2 yrs. ago		1.416	1.452	1.476	1.488	1.488	
2+ to 3 yrs. ago		0.912	0.936	0.948	0.948	0.948	
3+ to 4 yrs. ago		0.576	0.588	0.588	0.588	0.588	
4+ to 5 yrs. ago		0.408	0.408	0.408	0.408	0.408	
5+ to 6 yrs. ago		0.288	0.288	0.288	0.288	0.288	
6+ to 7 yrs. ago		0.192	0.192	0.192	0.192	0.192	
7+ to 8 yrs. ago		0.120	0.120	0.120	0.120	0.120	
8+ to 9 yrs. ago		0.072	0.072	0.072	0.072	0.072	
9+ to 10 yrs. ago		0.036	0.036	0.036	0.036	0.036	
10+ to 11 yrs. ago		0.012	0.012	0.012	0.012	0.012	
More than 11 yrs. ago		0.000	0.000	0.000	0.000	0.000	

Minimum factor to apply: .07.

2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4 th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000
		7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago		0.616	0.627	0.638	0.649	0.660
1+ to 2 yrs. ago		0.462	0.473	0.484	0.495	0.495
2+ to 3 yrs. ago		0.308	0.319	0.330	0.330	0.330
3+ to 4 yrs. ago		0.154	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago		0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago		0.088	0.088	0.088	0.088	0.088
6+ to 7 yrs. ago		0.066	0.066	0.066	0.066	0.066
7+ to 8 yrs. ago		0.044	0.044	0.044	0.044	0.044
8+ to 9 yrs. ago		0.033	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago		0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago		0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago		0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850

II. STATE EXCEPTIONIONS

A. Policy Issuance

B. Rules

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.
2. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through the Ascension Health Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

SECTION 10

STATE RATES AND EXCEPTIONS – GROUPS

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.
2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard rating factors.

Claims-made Rate Per 100 Patient Visits \$1,000,000 / \$3,000,000						
Class	Code	Territory 1	Territory 2	Territory 3	Territory 4	Territory 5
Emergency Room	80429	\$1,167	\$828	\$670	\$997	\$1,054
Urgent Care	80424(V)	\$978	\$696	\$564	\$837	\$884

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

- a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 7, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

- b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
- c. Determine the remaining optional separate limit premium, if applicable.
- d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.
2. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through the Ascension Health Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

B. Rules

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Explanatory Memorandum

The Healthcare Professional Liability Underwriting Rates and Rules Manual contains the rates and rules for insured members of the Ascension Health Risk Purchasing Group, underwritten by ProAssurance Casualty Company. While many of the rules contained in this filing mirror the rules currently on file with your department for ProAssurance Casualty Company, some were modified to be specific to the Ascension Program. In addition to the forms and applications contained in this filing, it is the company's intention to use the policy forms, endorsements and other applications currently filed and approved by the Illinois Department of Insurance for ProAssurance Casualty Company.

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