SERFF Tracking Number:	*MDPC-125749179*	*State:*	*District of Columbia*
Filing Company:	*The Medical Protective Company*	*State Tracking Number:*	
Company Tracking Number:	*08-DDR-002*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0000 Med Mal Sub-TOI Combinations*
Product Name:	*Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Coverage for Healthcare Providers*		
Project Name/Number:	*DDR Rules Only/08-DDR-02*		

Filing at a Glance

Company: The Medical Protective Company

Product Name: Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Coverage for Healthcare Providers	SERFF Tr Num: MDPC-125749179	State: District of Columbia
TOI: 11.0 Medical Malpractice - Claims Made/Occurrence	SERFF Status: Closed-APPROVED	State Tr Num:
Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations	Co Tr Num: 08-DDR-002	State Status:
Filing Type: Rule		Reviewer(s): Robert Nkojo
	Author: Melissa Millican	Disposition Date: 12/01/2008
	Date Submitted: 07/27/2008	Disposition Status: APPROVED
Effective Date Requested (New): On Approval		Effective Date (New):
Effective Date Requested (Renewal): On Approval		Effective Date (Renewal):

State Filing Description:

General Information

Project Name: DDR Rules Only	Status of Filing in Domicile: Pending
Project Number: 08-DDR-02	Domicile Status Comments: Indiana is the domicile state for The Medical Protective Company. All filings were made at the same time, IN is still pending.
Reference Organization: n/a	Reference Number: n/a
Reference Title: n/a	Advisory Org. Circular: n/a
Filing Status Changed: 12/01/2008	
State Status Changed:	Deemer Date:
Created By: Melissa Millican	Submitted By: Melissa Millican
Corresponding Filing Tracking Number:	

Filing Description:

RE: RULE FILING

The Medical Protective Company hereby submits for your review and consideration the enclosed rule filing applicable to our Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Health Care Providers Programs. We request

an effective date for this submission upon approval.

The attached explanatory memorandum identifies the modifications. There is no rate impact associated with the enclosed rule filing.

Company and Contact

Filing Contact Information

Melissa Millican, Paralegal
5814 Reed Road
Fort Wayne, IN 46835

melissa.millican@medpro.com
260-486-0838 [Phone]
260-486-0733 [FAX]

Filing Company Information

The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835
(260) 486-0838 ext. [Phone]

CoCode: 11843
Group Code:
Group Name:
FEIN Number: 35-0506406

State of Domicile: Indiana
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*MDPC-125749179*	*State:*	*District of Columbia*
Filing Company:	*The Medical Protective Company*	*State Tracking Number:*	
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Robert Nkojo	12/01/2008	12/01/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
status	Note To Reviewer	Melissa Millican	10/27/2008	10/27/2008

SERFF Tracking Number:	*MDPC-125749179*	*State:*	*District of Columbia*
Filing Company:	*The Medical Protective Company*	*State Tracking Number:*	
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TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0000 Med Mal Sub-TOI Combinations*
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Project Name/Number:	*DDR Rules Only/08-DDR-02*		

Disposition

Disposition Date: 12/01/2008
Effective Date (New):
Effective Date (Renewal):
Status: APPROVED
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MDPC-125749179*	*State:*	*District of Columbia*
Filing Company:	*The Medical Protective Company*	*State Tracking Number:*	
Company Tracking Number:	*08-DDR-002*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0000 Med Mal Sub-TOI Combinations*
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Project Name/Number:	*DDR Rules Only/08-DDR-02*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter All Filings		No
Supporting Document	Consulting Authorization		No
Supporting Document	Actuarial Certification (P&C)		No
Supporting Document	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)		No
Supporting Document	District of Columbia and Countrywide Loss Ratio Analysis (P&C)		No
Rate	Comprehensive General Manual Section III Physicians & Surgeons		No
Rate	General Manual Section IV Dentists		No
Rate	Comprehensive General Manual Section V Allieds		No
Rate	Physicians & Surgeons SCM Accelerated Extension Contract Rule		No
Rate	Dentists SCM Accelerated Extension Contract Rule		No
Rate	Allieds Standard Claims Made Accelerated Extension Contract Rule		No

SERFF Tracking Number:	*MDPC-125749179*	*State:*	*District of Columbia*
Filing Company:	*The Medical Protective Company*	*State Tracking Number:*	
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Product Name:	*Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Coverage for Healthcare Providers*		
Project Name/Number:	*DDR Rules Only/08-DDR-02*		

Note To Reviewer

Created By:
Melissa Millican on 10/27/2008 07:32 AM
Last Edited By:
Melissa Millican
Submitted On:
10/27/2008 07:32 AM
Subject:
status
Comments:
I wanted to check the status of the filing, is there any additional information needed at this time to complete your review?
Thank you,
Melissa

Rate/Rule Schedule

Schedule Item Status:	Exhibit Name:	Rule # or Page #:	Rate Action	Previous State Filing Number:	Attachments
	Comprehensive General Manual Section III Physicians & Surgeons	GM-III-CW-(1-17); 05/01/08 edt	Replacement		Comprehensive General Manual, Section III Physicians & Surgeons.pdf
	General Manual Section IV Dentists	GM-IV-CW-(1-14); 05/01/08 edt	Replacement		Comprehensive General Manual, Section IV Dentists.pdf
	Comprehensive General Manual Section V Allieds	GM-V-CW-(1-11); 05/01/08 edt	Replacement		Comprehensive General Manual, Section V Allieds.pdf
	Physicians & Surgeons SCM	AEC-CW; 01/01/08 edt	Replacement		md scm accelerated extension contract

Accelerated Extension Contract Rule			rule.pdf
Dentists SCM Accelerated Extension Contract Rule	AEC-CW; 01/01/08 edt	Replacement	dds scm accelerated extension contract rule.pdf
Allieds Standard Claims Made Accelerated Extension Contract Rule	AEC-CW; 01/01/08 edt	Replacement	allied scm accelerated extension contract rule.pdf

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, shown on the State Rate Pages, in accordance with each physician's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons

1. Each medical practitioner is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part-Time Physicians

1. Any insured who is determined not to be working on a full time basis will be considered a part-time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part-time practitioner is identified on the State Rate Pages.

2. A Part-Time Practitioner may include any classification identified in the class plan, as well as those practitioners who are moonlighting or teaching. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part-time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part-time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except risk management and membership association credits.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

      Note: Do not confuse a physician in a fellowship training program with a fellow, for example, of American College of Surgeons.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

3. Coverage is available for a physician's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program. The applicable physician class for moonlighting activities, as identified in the class plan, will be utilized to determine the rate. If no such classification is identified, the applicable premium will be computed as follows.

   a. The premium will be based upon the equivalent medical specialty rate and the average number of hours the insured practices per week.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

   c. No other credits are to apply concurrent with this rule except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

D. Locum Tenens Physician –Physicians Substituting for MPCo Insured Physicians

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agency Coverage is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty;

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

G. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to the Company to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

   a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

   c. No other credits are to apply concurrent with this rule except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

H. Physician's Leave of Absence

1. A physician who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

   - The birth of insured's newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
   - To care for a spouse, child or parent who has a serious health condition.
   - To care for insured's own health condition which prevents insured from working.
   - Time to enhance the insured's education or other reason while not practicing.

   This credit is not available to an insured's leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

I. Physicians Military Leave of Absence

A physician who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. Schedule Rating

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

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

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Claim Free Credits

1. If no loss claim has been attributed to an insured, the insured will be eligible for a premium credit provided on the State Rate Pages.

   a. A loss claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non- meritorious or frivolous claims.

b. Insureds converting coverage to The Medical Protective Company, shall qualify for credit at the policy inception date in accordance with standard guidelines the Company's guidelines.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Credits shall be available, subject to underwriting guidelines.

b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

E. Experience Rating

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

   a. Premiums paid
   b. Number of claims
   c. Incurred losses
   d. Paid losses
   e. Projected incurred but not reported losses
   f. Cause of such losses
   g. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

F. Non-Discretionary Debit Plan

For any insured who is not eligible for a credit under the company's claim/loss free credit rule, points will be assigned for each claim pursuant to Schedule A, found in the State Rate Pages, for the following:

- Pending against the insured at the beginning of the current policy period; or
- Paid on the insured's behalf during the past 5 years; or
- Closed with no payment during the past 5 years.

For providers who have been practicing for less than eight complete years from their initial medical school graduation date, the total assigned claim points (as calculated from the Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

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

Insureds with less than one year of experience shall be assumed to have one year of experience. Insureds converting coverage to The Medical Protective Company who have pending claims or claims paid on their behalf within the past five years will be assigned points in accordance with Company guidelines.

A debit shall then be applied the insured's rate based upon Schedule B, found in the State Rate Pages.

For the purpose of this rule, a "claim" shall not include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

Any Debit required under this rule shall be additive with any other debits or credits applicable under the Company's rating manual.

This non-discretionary debit plan shall only apply to providers who meet the Company's Guidelines for acceptance, and the Company retains the right to refuse to insure any insured or applicant based upon the qualitative nature of any claims made against that individual or entity. As a result, the fact that this rule provides (or does not provide) a debit for claims experience is not an indication that there is a rate available for any particular insured or applicant.

G. Large Group Rating

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims-made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

6. Refer to the State Rate Pages for availability.

H. Small Group Rating Rule

Any group practice consisting of two or more physician providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Group's Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be performed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate fee agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insureds based upon applicable underwriting criteria.

4. For Individual insureds within the group, the extension contract premium will be per the filed Extension Contract Rating Rule.

5. Refer to the applicable state rate page for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Convertible Coverage Rating Plan

1. Insureds shall be provided the option, subject to underwriting guidelines, to convert from Standard Claims-Made to Occurrence coverage. The insured shall be eligible for conversion after the following conditions have been met:

a. Payment to the Company of the applicable premium for a minimum of three annual claims-made policies.

b. Achieve three years of continuous claims-made coverage under this plan with no losses attributed to the insured. (A loss shall be a culpable loss. A claim under this plan shall not be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.)

2. At the time the aforementioned conditions are met, and the insured has purchased Occurrence coverage, the Company will issue Extended Reporting Period Coverage, covering professional services subsequent to the retroactive date and prior to the expiration of the claims-made policy, and will waive any premium that would normally be due for such coverage.

3. Should the insured be unable to meet the conditions for conversion, the insured may elect to purchase the Extended Reporting Period Coverage, subject to policy provisions. Refer to the Extended Reporting Period rule to determine the applicable premium.

4. The applicable premium under this plan is presented on the State Rate Pages.

5. No other modifications are to apply concurrent with this rule except membership association, risk management and schedule rating modifications.

B. Enhanced Claims-Made

1. Insureds shall be provided the option, subject to underwriting guidelines, to purchase Claims-Made coverage under the Enhanced rating structure.

2. The Enhanced Claims-Made base rate is developed as a percentage of the applicable Occurrence rate. The applicable percentage is identified on the State Rate Pages.

3. The Enhanced Claims-Made base rate is subject to Claim Free Credits in accordance with the schedule provided on the State Rate Pages. The application of the credits shall be consistent with the criteria identified in V(C) of this section of the manual.

C. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will

be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims-Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit cannot be used in conjunction with this rating rule.

D. Full-time Equivalency Rating

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

2,500 - Group Practice
2,100 - Residency Programs

2. For group practices, the minimum average FTE assigned to any individual physician is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per physician rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the physician rates.

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

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

- The table value is determined by rounding the actual FTE per policy using the .5 rounding rule.

5. Premium modifications for new physician, part time, moonlighting, teaching, loss free credit or other similar credit cannot be used in conjunction with this rating rule.

E. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on an out-patient visit (OPV) basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of out-patient visits equivalent to a physician year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable medical specialty rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new physician, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and an Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability or permanent retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

   a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

   b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than five years.

   c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

   d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

   e. At the time the insured permanently retires he or she is associated with the group insured by the Company for one year.

   f. Refer to the State Rate Pages for availability.

G. Deferred Premium Payment Plan.

1. The Company will, subject to applicable guidelines, offer the insured various premium payment options. The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

H. Aggregate Credit Rule.

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

   This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, Risk Management or Deductible Credits.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Dentists.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per dentist, shown on the State Rate Pages, in accordance with each dentist's classification and class plan designation.

IV. CLASSIFICATIONS

A. Dentists

1. Each dental practitioner is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part Time Dentists

1. Any insured who is determined not to be working on a full time basis will be considered a part time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner is identified on the State Rate Pages.

2. A Part Time Practitioner may include any classification identified in the class plan as well as those practitioners who are moonlighting or teaching. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except risk management and membership association credits.

C. Dentists in Training

1. Coverage is available for activities directly related to a dentist's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Dental students are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

2. Coverage is available for a dentist's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program.

   a. The premium will be based upon the equivalent dental specialty rate and the average number of hours the insured practices per week.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule except risk management and membership credits.

d. The applicable modifications applicable to the manual rates are presented on the State Rate Pages.

3. Coverage is available to dental students for activities directly related to their licensing.

a. Coverage is available to dental students, on a short-term basis, for services rendered by the student during a dental externship prior to graduation and/or during the dental board exam pursuant to the student's professional licensing.

b. The coverage for dental students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages, and are not subject to the minimum premium rule. The premium shall be applied to the insured's first annual policy if coverage is purchased within one year of the successful completion of the dental board exam.

D. Locum Tenens Dentists

1. Coverage for a dentist substituting for an insured dentist will be limited to cover only professional services rendered on behalf of the insured dentist for the specified time period. Locum Tenens will share in the insured dentist's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens dentist must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

E. New Dentist

1. A "new" dentist shall be a dentist who has recently completed one of the following programs and will begin a full time practice for the first time:

a. Residency;

b. Fellowship program in their dental specialty;

c. Fulfillment of a military obligation in remuneration for dental school tuition;

d. Dental school or specialty training program.

2. To qualify for the 1st year credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

F. New to Company Dentists

1. An insured may be eligible for a New to Company credit pursuant to the following guidelines:

i. Never insured with the Company, or
ii. Previously insured with the Company more than 3 years ago.

2. Credits shall apply to the insureds first, second and third year consecutive years of coverage. All other credits will apply to the reduced rate.

3. This credit is not subject to the Aggregate Credit Rule and subject to underwriting guidelines. Only one request for this three year credit program will be granted to an eligible insured during any period of time insured by the company.

4. Please refer to the state rate pages for availability and the appropriate credit for this program.

G. Dentist Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

a. Faculty members are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for teaching activities related to an accredited training program. Refer to the Company to determine the applicable credit.

2. Coverage is available for the private practice of a dentist teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

a. The premium will be based upon the otherwise applicable dentist rate and the average number of hours per week devoted to teaching activities.

b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule except risk management and membership credits.

d. The applicable percentages are presented on the State Rate Pages.

H. Dentist's Leave of Absence

1. A dentist who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

- The birth of insureds newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
- To care for a spouse, child or parent who has a serious health condition.
- To care for insureds own health condition which prevents insured from working.
- Time to enhance the insureds education or other reason while not practicing.

This credit is not available to an insureds leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

I. Dentist Military Leave of Absence

A Dentist who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. Schedule Rating

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

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

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved for by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit on the schedule provided on the State Rate Pages.

    a. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

    b. Insureds converting coverage to The Medical Protective Company, shall qualify for credit at the policy inception date in accordance with the Company's guidelines.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

    a. Credits shall be available, subject to underwriting guidelines.

    b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

    c. Deductibles can only be revised at policy renewal.

    d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

        i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

        ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

        iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

    a. SIR's shall be offered to qualified insureds.

    b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

E. Experience Rating

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

a. Premiums paid
b. Number of claims
c. Incurred losses
d. Paid losses
e. Projected incurred but not reported losses
f. Cause of such losses
g. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

F. Non-Discretionary Debit Plan

For any insured who is not eligible for a credit under the Company's claim/loss free credit rule, points will be assigned for each claim, pursuant to Schedule A, found in the State Rate Pages, for the following:

- Pending against the insured at the beginning of the current policy period; or
- Paid on the insured's behalf during the past 5 years; or
- Closed with no payment during the past 5 years.

For providers who have been practicing for less than five complete years from their initial dental school graduation date, the total assigned claim points (as calculated from Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 2 years	5.00
At least 2 years but less than 3 years	2.50
At least 3 years but less than 4 years	1.666
At least 4 years but less than 5 years	1.25
5 years or more	No factor applied

Insureds with less than one year of experience shall be assumed to have one year of experience. Insureds converting coverage to The Medical Protective Company who have pending claims or claims paid on their behalf within the past five years, will be assigned points in accordance with Company guidelines.

A debit shall then be applied to the insured's policy based upon Schedule B, found in the State Rate Pages.

For the purpose of this rule, a "claim" shall not include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

Any debit required under this rule shall be additive with any other debits or credits applicable under the Company's rating manual.

This non-discretionary debit plan shall only apply to providers who meet the Company's guidelines for acceptance, and the company retains the right to refuse to insure any insured or applicant based upon the qualitative nature of any claims made against that individual or entity. As a result, the fact that this rule provides (or does not provide) a debit for claims experience is not an indication that there is a rate available for any particular insured or applicant.

G. Small Group Rating Rule

Any group practice consisting of two or more dentists may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insured's based upon applicable underwriting criteria.

4. For Individual insured's within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.

5. Refer to the applicable state rate page for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Convertible Coverage Rating Plan

1. Insureds shall be provided the option, subject to underwriting guidelines, to convert from Standard Claims Made to Occurrence coverage. The insured shall be eligible for conversion after the following conditions have been met:

   a. Payment to the Company of the applicable premium for a minimum of three annual claims made policies.

b. Achieve three years of continuous claims made coverage under this plan with no claims attributed to the insured. (A claim shall be a culpable loss. A claim under this plan shall not be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.)

2. At the time the aforementioned conditions are met, and the insured has purchased Occurrence coverage, the Company will issue Extended Reporting Period Coverage, covering professional services subsequent to the retroactive date and prior to the expiration of the claims made policy, and will waive any premium that would normally be due for such extension.

3. Should the insured be unable to meet the conditions for conversion, the insured may elect to purchase the Extended Reporting Period Coverage, subject to policy provisions. Refer to the Extended Reporting Period Rule to determine the applicable premium.

4. The applicable premium under this plan is presented on the State Rate Pages.

5. No other modifications are to apply concurrent with this rule except membership association, risk management and schedule rating modifications.

B. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual dentist basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new dentist, part time, moonlighting, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

C. Full-Time Equivalency Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each dentist's number of hours of dental practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
1,800 - Residency Programs

2. For group practices, the minimum average FTE assigned to individual dentists is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per dentist rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the dental rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.

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

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

* The table value is determined by rounding the actual FTE per policy using the .5 rounding rule. Policies with an FTE of 1 will receive the premium modification regardless of shared or individual limits.

5. Premium modifications for new dentist, part time, moonlighting, teaching, claim free credit or other similar credit cannot be used in conjunction with this rating rule.

D. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available at the Company's option, on an out-patient visit (OPV) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual dentist limit basis.

2. The number of out-patient visits equivalent to a dentist year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable dental specialty rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new dentist, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

E. Requirements for Waiver of Premium for Extended Reporting Period Coverage for Standard Claims Made Program.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

3. The Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

   a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

   b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of dentistry in less than five years.

   c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

   d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

   e. At the time the insured permanently retires he or she is associated with the group insured by the Company for one year.

   f. Refer to the State Rate Pages for Availability.

F. Deferred Premium Payment Plan.

1. The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the State Rate Pages.

G. Aggregate Credit Rule.

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

   This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, Risk Management, Membership Association or Deductible Credits.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Allied Health Care Providers.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Occurrence Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

B. Claims-Made Coverage

$100,000 Each Health Care Occurrence
$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per provider, shown on the State Rate Pages, in accordance with each provider's classification and class plan designation.

IV. CLASSIFICATIONS

A. Allied Health Care Providers

1. Each provider is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the State Rate Pages.

B. Part Time Allied Health Care Providers

1. Any insured who is determined not to be working on a full time basis will be considered a part time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner is identified on the State Rate Pages.

2. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.

4. No other credits are to apply concurrent with this rule except the risk management credit.

C. Dental Hygienist Training

1. Coverage is available for activities directly related to a hygienist's training program. The coverage will not apply to any professional services rendered after the training is complete.

2. Coverage is available to students for activities directly related to their licensing.

   a. Coverage is available to students, on a short-term basis, for services rendered by the student during a dental hygiene externship prior to graduation and/or during the dental hygiene board exam pursuant to the student's professional licensing.

   b. The coverage for students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages. The premium shall be applied to the insured's first annual policy if coverage is purchased within one year of the successful completion of the dental hygiene board exam.

D. Locum Tenens Allied Health Care Providers subsitituting for MPCo Insureds

1. Coverage for an allied health care provider substituting for an insured allied health care provider will be limited to cover only professional services rendered on behalf of the insured allied health care provider for the specified time period. Locum Tenens will share in the insured allied health care provider's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens allied health care provider must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agencies is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. Allied Health Care Provider's Leave of Absence

1. An Allied Healthcare Provider who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

- The birth of insureds newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
- To care for a spouse, child or parent who has a serious health condition.
- To care for insureds own health condition which prevents insured from working.

- Time to enhance the insureds education or other reason while not practicing.

This credit is not available to an insureds leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

G. Allied Healthcare Providers Military Leave of Absence

A Provider who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

A. Schedule Rating

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

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

The modification shall be based on one or more of the specific considerations identified on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved for by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of therequired documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Credits shall be available, subject to underwriting guidelines.

   b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. Deductibles can only be revised at policy renewal.

d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.

2. Self-Insured Retentions

a. SIR's shall be offered to qualified insureds.

b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

c. SIR's can only be revised at policy renewal.

d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.

ii. The insured may select an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

D. Experience Rating

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

a. Premiums paid
b. Number of claims
c. Incurred losses
d. Paid losses
e. Projected incurred but not reported losses
f. Cause of such losses
g. Nature of practice

1. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

2. The application of this modification precludes the use of all other rules based upon loss experience criteria.

E. Large Group Rating

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency_Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

6. Refer to the State Rate Pages for availability.

F. Small Group Rating Rule

Any group practice consisting of two or more healthcare providers may be collectively rated. ("Group Practice" shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the "Groups Net Premium" by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured's agent based upon the Group's size and the amount of work to be preformed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)

2. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

3. The "Individual net premiums" will equally the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insured's based upon applicable underwriting criteria.

4. For Individual insured's within the group, the extension contract premium will be calculated per the Filed Extension Contract Rating Rule.

5. Refer to the applicable state rate page for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual practitioner basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for part time or risk management credit cannot be used in conjunction with this rating rule.

B. Full Time Equivalency Rating

Coverage for an Allied Healthcare provider group is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual insured basis. Coverage is provided on an individual limit or shared limit basis. Full time equivalency is based on each allied healthcare provider's number of hours of practice per year. The definition of one FTE is based on the following number of hours per year:

2,000	Group Practice
1,800	Training/Residency Programs

For group practices, the minimum average FTE assigned to any individual Allied Healthcare provider is .10 (200 Hours), subject to a total FTE per policy of no less than 1.0. Training/residency programs (and other similar programs) are not subject to the group practice minimums.

The premium developed by applying the applicable Allied Healthcare rate to the corresponding FTE will be adjusted to reflect loss cost considerations recognized in the standard rates.

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

FTE* Per Policy	Premium Modification
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

* The table value is determined by rounding the actual FTE per policy using the .50 rounding rule.

Premium modification Part Time Practice cannot be used in conjunction with this rating rule.

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

C. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on an out-patient visit (OPV) basis rather than on an individual practitioner basis. Coverage is provided on a shared or individual practitioner limit basis.

2. The number of out-patient visits equivalent to a practitioner year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 3 visits per hour and a maximum rate of 6 visits per hour.

3. The applicable classification rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

D. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. For an insured, classified as 4B and above, the Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.

   a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.

   b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of dentistry in less than five years.

   c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.

   d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.

   e. At the time the insured permanently retires he or she is associated with the group insured by the Company for one year.

   f. Refer to the State Rate Pages for availability.

E. Aggregate Credit Rule.

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

   This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, or Risk Management Credits.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

THE COMPANY MAY AGREE TO WAIVE THE STANDARD REQUIREMENTS FOR QUALIFYING FOR A FREE EXTENDED REPORTING PERIOD ENDORSEMENT AT RETIREMENT IF THE INSURED MEETS THE FOLLOWING CRITERIA:

1) THE INSURED IS A MEMBER OF A GROUP PRACTICE THAT IS INSURED ON A CLAIMS-MADE BASIS WITH THE COMPANY.

2) THE GROUP REQUESTED THE WAIVER FOR AN INSURED WHO ANTICIPATES PERMANENTLY RETIRING FROM THE PRACTICE OF MEDICINE IN LESS THAN FIVE YEARS.

3) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSURED HAD LIMITED PRIOR ACTS EXPOSURE.

THE TOTAL NUMBER OF INSUREDS WITHIN A GROUP PRACTICE THAT MAY QUALIFY FOR THIS WAIVER MAY NOT EXCEED A RATIO OF 1 IN 3.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DENTISTS

STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

THE COMPANY MAY AGREE TO WAIVE THE STANDARD REQUIREMENTS FOR QUALIFYING FOR A FREE EXTENDED REPORTING PERIOD ENDORSEMENT AT RETIREMENT IF THE INSURED MEETS THE FOLLOWING CRITERIA:

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THE TOTAL NUMBER OF INSUREDS WITHIN A GROUP PRACTICE THAT MAY QUALIFY FOR THIS WAIVER MAY NOT EXCEED A RATIO OF 1 IN 3.

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

ALLIED HEALTH CARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

THE COMPANY MAY AGREE TO WAIVE THE STANDARD REQUIREMENTS FOR QUALIFYING FOR A FREE EXTENDED REPORTING PERIOD ENDORSEMENT AT RETIREMENT IF THE INSURED MEETS THE FOLLOWING CRITERIA:

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3) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSURED HAD LIMITED PRIOR ACTS EXPOSURE.

THE TOTAL NUMBER OF INSUREDS WITHIN A GROUP PRACTICE THAT MAY QUALIFY FOR THIS WAIVER MAY NOT EXCEED A RATIO OF 1 IN 3.

SERFF Tracking Number:	*MDPC-125749179*	*State:*	*District of Columbia*
Filing Company:	*The Medical Protective Company*	*State Tracking Number:*	
Company Tracking Number:	*08-DDR-002*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0000 Med Mal Sub-TOI Combinations*
Product Name:	*Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Coverage for Healthcare Providers*		
Project Name/Number:	*DDR Rules Only/08-DDR-02*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Cover Letter All Filings

Comments:

Attachment:

4914_001.pdf

Item Status: **Status Date:**

Satisfied - Item: Consulting Authorization

Comments:

n/a - this filing is being made by the company

Item Status: **Status Date:**

Satisfied - Item: Actuarial Certification (P&C)

Comments:

attached

Attachment:

dc.pdf

Item Status: **Status Date:**

Satisfied - Item: District of Columbia and Countrywide Experience for the Last 5 Years (P&C)

Comments:

n/a - this enclosed filing is for rules only with no assocated rate impact.

Item Status: **Status Date:**

SERFF Tracking Number:	*MDPC-125749179*	*State:*	*District of Columbia*
Filing Company:	*The Medical Protective Company*	*State Tracking Number:*	
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Project Name/Number:	*DDR Rules Only/08-DDR-02*		

Satisfied - Item: District of Columbia and Countrywide Loss Ratio Analysis (P&C)

Comments:

n/a - this enclosed filing is for rules only with no assocated rate impact.

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.
a Berkshire Hathaway Company

July 27, 2008

Thomas Hampton, Commissioner of Insurance
Department of Insurance and Security Regulations
Insurance Products Division
810 First Street, NE, Room 701
Washington, DC 20002

RE: **THE MEDICAL PROTECTIVE COMPANY - NAIC #11843**
COMPANY FILING NO. 08-DDR-02
DISTRICT OF COLUMBIA PHYSICIANS & SURGEONS, DENTISTS & ALLIEDS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
RULE FILING

DISTRICT OF COLUMBIA COMPREHENSIVE LIABILTY COVERAGE FOR HEALTH CARE PROVIDERS
Revise Section III – General Manual, Physicians & Surgeons
Revise Section IV – General Manual, Dentists
Revise Section V – General Manual, Allieds

PROPOSED EFFECTIVE DATE: UPON APPROVAL

Dear Mr. Hampton:

The Medical Protective Company hereby submits for your review and consideration the enclosed rule filing applicable to our Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Health Care Providers Programs. We request an effective date for this submission upon approval.

In addition, please find revised manual pages for Section III Physicians & Surgeons of the Company's Comprehensive Liability Coverage for Health Care Providers program. The rates used for this program mirror those used for the Company's individual Physicians & Surgeons Program, and therefore are being included in this submission.

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

Sincerely,

Melissa Coker

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

Enclosure(s)

THE MEDICAL PROTECTIVE COMPANY

DISTRICT OF COLUMBIA

PHYSICIANS AND SURGEONS
DENTISTS
ALLIED HEALTHCARE PROVIDERS

EXPLANATORY MEMORANDUM

The Medical Protective Company (MedPro) submits for your review and consideration the attached rule filing. The Company respectfully requests an effective date commensurate with the approval of the filing.

Revise Accelerated Extension Contract Rating Rule – The Accelerated Extension Contract Rating rule is being revised to remove the age requirement for eligibility of a free tail. There are no other changes to this rating rule, and the changes do not result in a rate impact.

Revised Comprehensive Liability Coverage for Healthcare Providers Manual Pages - Pease find enclosed revised General Manual pages for Section III, IV & V for the Company's Comprehensive Liability Coverage for Health Care Providers program. The rates used for this program mirror those used for the Company's individual Physician & Surgeons, Dentists & Allied Healthcare Providers Program and therefore are being included in this submission for manual consistency purposes.