

October 15, 2010

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STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

RECEIVED

OCT 19 2010

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

Illinois Insurance Division
Attn: Gayle Neuman
320 West Washington Street
Springfield, IL 62767

RE: Professional Solutions Insurance Company
FEIN: 42-1520773
NAIC Number: 11127
Dental Professional Liability Rule Filing
Filing Number: PSIC Dental 2010 Revision - Rule
Proposed Effective Date: 01/01/2011 New
03/01/2011 Renewal

RATE/RULE

Dear Ms. Neuman:

Professional Solutions Insurance Company (PSIC) currently has on file with the Illinois Insurance Division a claims made and occurrence professional liability rating manual for our dental professional liability program. PSIC would like to submit for your review and approval an amended claims made and occurrence professional liability rating manual to replace the manual currently on file. Please see the attached explanatory memorandums which detail all the changes being made.

Please be advised that that Professional Solutions Insurance Company continues to utilize National Independent Statistical Service for our reporting of statistics.

If you have any questions or need any additional information regarding this filing please feel free to contact me directly. I thank you in advance for your attention to this matter.

Sincerely,



Alicia Kinkle
Compliance Analyst
PH: (800) 321-7015 Ext. 4691
FX: (515) 313-4476
Email: akirkle@ncmic.com

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MEN
RUL
gfw
Jeh

Neuman, Gayle

From: Alicia Kirkle [akirkle@ncmic.com]
Sent: Wednesday, June 22, 2011 11:27 AM
To: Neuman, Gayle
Subject: RE: Professional Solutions Ins Co - Rate/Rule Filing #PSIC Dental 2010 Rev

Gayle,

Yes, the filing was put into effect January 1, 2011 for new business; March 1, 2011 for renewals.

Thank you,

Alicia Kirkle

Compliance Analyst
NCMIC Group, Inc.
515-313-4691
akirkle@ncmic.com

From: Neuman, Gayle [<mailto:Gayle.Neuman@illinois.gov>]
Sent: Wednesday, June 22, 2011 11:22 AM
To: Alicia Kirkle
Subject: Professional Solutions Ins Co - Rate/Rule Filing #PSIC Dental 2010 Rev

Ms. Kirkle,

The Department of Insurance completed its review of the filing referenced above on June 20, 2011. Originally, Professional Solutions requested the filing be effective January 1, 2011 (renewals March 1, 2011). Was the filing put into effect on January 1, 2011 or do you wish to have a different effective date?

Your prompt response is appreciated.

Gayle Neuman

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

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

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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, Roger L. Schlueter, a duly authorized officer of Professional Solutions Insurance 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, Charles W. Mitchell, FCAS, MAAA, a duly authorized actuary of Milliman am authorized to certify on behalf of Professional Solutions Insurance 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.



Signature and Title of Authorized Insurance Company Officer Chief Financial Officer 12/29/2010
Date

Charles W. Mitchell, FCAS, MAAA, Consulting Actuary

Signature, Title and Designation of Authorized Actuary 12/29/2010
Date

Insurance Company FEIN 42-1520773 Filing Number PSICDental2010Rev

Insurer's Address 14001 University Avenue

City Clive State Iowa Zip Code 50325-8258

Contact Person's:

-Name and E-mail Alicia Kirkle, Compliance Analyst akirkle@ncmic.com

-Direct Telephone and Fax Number 800-321-7015 ext. 4691 Fax: 515-313-4476

**Professional Solutions Insurance Company
Dental Professional Liability
Summary of Rating Manual Changes**

General:

- Version number removed from upper left hand corner of all pages
- Changed edition number on bottom left from 05/2007 to Edition 10/2010

Section I. Application of This Manual-Eligibility:

- Description of who is covered is changed from “This program covers Dentists engaged in general dentistry, dental anesthesia and oral surgery or operative dentistry on patients rendered unconscious through the administering of an anesthesia or analgesia” to “This program covers Dentists engaged in the rendering of professional services specific to their disciplines.”
- Removed sub-sections, A. Dental Service Providers, and B. Ancillary Dental Personnel and replaced with, “Employees of dentists are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to the listing of the mid-level dental providers who may be covered by either a shared or separate limit of liability.”
- Removed sub-section C. Corporation Coverage and replaced with, “This program also provides coverage for both dental clinics and individual practicing dentists for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the professional entity coverage section for a description of the partnership, corporation or professional association rating factors.”

Section II. Premium Determination:

- Item 1. Replaced the term “base rate” with “manual rate” to be consistent with the terminology used across our other professional liability programs.
- Item 5. Replaced the term “credit” with “discounts” and included reference to the new practitioner discount as well as the part-time discount.
- Separated out the application of Experience Rating and Schedule Rating into two separate steps.
- In example calculation changed “Experience Rating” to “Claims Free credit”
- Removed the reference to the dental candidate coverage as this will no longer be offered.

Section III. Policy Period:

- Deleted reference to policy periods “other than for a one-year term”. We only offer one-year terms. Also added a statement that mid-term changes will be pro-rated.

Section IV. Whole Dollar Premium Rule:

- No Changes.

Section V. Practice Location

- Revised the Practice Location section by deleting reference to the 25% debit where the primary state is not the highest rated location.
- Removed “If more than one location of practice exists within the same state, the rate from the highest territory will be applied.”
- Added language to clarify that “dental providers providing services under local or conscious sedation and/or facial cosmetics, the location of the primary office practice will determine the manual rate.”
- Added language to clarify that “dental providers classified as Dental Anesthesiology or Oral & Maxillofacial-Major Surgery, the location of the primary healthcare facility practice will determine the manual rate.”
- Added language to clarify that if there is equal practice in two or more locations, the rate from the highest rated location will be applied.

Professional Solutions Insurance Company
Dental Professional Liability
Summary of Rating Manual Changes

- Added language to clarify that for the purpose of this section, primary means 51% or more of the dental provider's practice time is spent in the given territory or state.

Section VI. Policy Cancellation:

- No Changes.

Section VII. Premium Payment Options:

- Deleted item 4. Other payment options available upon request for large group accounts.
- Removed sentence stating, "The premium options will be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006, and made available upon request thereafter.
- Removed sentence stating, "If the policy is issued with a final fully discounted premium less than \$500, the policy must be billed on an annual basis."

Section VIII. Renewals:

- No Changes.

Section IX. Special Provisions:

- Item A. Revised the wording "insured may purchase this equivalent of Extended Reporting Period Coverage from the Company. The insured may select the Retroactive Date (shown on the Coverage Summary) from a date that is equal to the retroactive date shown on the previous policy." with "the insured may apply for a Retroactive Date that is equal to the retroactive date shown on the previous policy."
- Item A. Removed the sentence, "No permission shall be granted for advancing the Retroactive Date after the policy has taken effect."
- Item B. Replaced the phrase "Basic Reporting Extension" with "Automatic Reporting Extension" and replaced the phrase "Extended Reporting Endorsement" with "Extended Reporting Coverage."
- Item B. Added the sentence, "The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy."
- Item C. Changed the phrase "Extended Reporting Endorsement" to "Extended Reporting Coverage."
- Item C. Added "Premium is due in full at the time of purchase; no payment plans will be offered."
- Item C. Added section to clarify that Extended Reporting Coverage is provided automatically at no additional charge in the event that the insured dies or becomes permanently disabled or in the event that the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years.
- Item C. Added an Extended Reporting Coverage discount for insureds who retire at or after age 55 with fewer than 5 years of continuous coverage.
- Item D. Changed name of section from "Prior Acts-Occurrence Only" to "Prior Acts Coverage, also called Nose Coverage-Occurrence Only"
- Item D. Changed wording at the end of sentence, "Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date..." from "referenced in the endorsement will be covered" to "of the insured's previous claims made policy will be covered."
- Item D. Added "The limit of liability provided by this option are the only limits that shall be applicable to the time period designated above. This endorsement can be applied to individual or entity policies."
- Item D. Changed wording in calculation section from "Number of Years Since Retroactive Date" to "# of Years in Claims Made Maturity". Also changed factor name from "Prior Acts Factor" to "Nose Factor".
- Item E. Added Section, "Change in Rating Classification-Claims Made Only".
- Item F. - Increased Locum Tenens coverage from 45 days to 60 days.

Professional Solutions Insurance Company
Dental Professional Liability
Summary of Rating Manual Changes

- Moved the New Practitioner and Part-Time Practitioner credits to a separate Discount section.

Section X. Discounts:

- Added a statement to clarify that insureds who receive the Part-Time discount will not be eligible to receive any further credits.
- Changed phrase New Dentist Discount to New Practitioner.
- Changed qualifications for New Practitioner discount from, “A new dentist is defined as a student who has completed his/her training within the previous six months and whose only contact with patients has been in the course of his/her training.” to “A new practitioner is defined as a person who has completed his or her training, whose only contact with patients has been in the course of his or her training and who has not been previously insured by Professional Solutions Insurance Company.
- Added language to clarify that Dental Anesthesiologists or Oral & Maxillofacial-Major Surgeons are not eligible for the part-time credit.

Section XI. Experience Rating:

- Added a statement to include “allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding \$50,000” as a claim.
- Added wording, “A claim free credit shall apply if the insured has achieved at least 3 years without a claim.”
- Changed the number of claims free years from 3-5 years to 3 years, from 5-8 years to 4 years and from 8 or more years to 5+ years.
- Revised the Claim debit factors from a factor to a percentage. Please note the same debit amounts are still being applied.
- Deleted the Claim Debit for partnership/corporate policy.

Section XII. Schedule Rating:

- Completely revised the schedule rating criteria.

Section XIII. Endorsed Coverages – Coverage Options:

- Changed the title of the Active Military Duty Endorsement to Active Military Suspension Endorsement.
- Added the Amendatory Endorsement to the rating manual. Please note this coverage is not new; it was just not previously listed in the manual.
- Changed the title of the Additional Insured Endorsement to “Additional Interests”. Changed wording from, “The charge for this endorsement will be 15% of the base corporation/partnership premium or the individual premium if there is no corporation/partnership coverage.” and broke it down to up to 15% of the named insured’s undiscounted manual premium for an individual practice for each additional interest and up to 15% of the undiscounted manual rate of the top 5 highest rated dental providers for each additional interest for a group practice.
- For the Additional Interests Endorsement, added the language “The addition of an additional interest will be based upon the underwriter’s assessment of additional exposure imputed to an insured dentist, solo practitioner corporation, partnership or multi shareholder corporation.”
- Added specific charges as follows:
 - 5%-Locations or services being provided by the additional interest to or on behalf of the Named Insured are financially and medically controlled by the Named Insured.
 - 10%-Locations or services being provided by the additional interest to or on behalf of the Named Insured are not financially controlled by the Named Insured.
 - 15%-Locations or services being provided by the additional interest to or on behalf of the Named Insured are not financially and medically controlled by the Named Insured.

Professional Solutions Insurance Company
Dental Professional Liability
Summary of Rating Manual Changes

- Added the new Accelerated Vesting for Extended Reporting Period Endorsement which amends the years of continuous coverage requirement for the Extended Reporting Endorsement at no additional charge upon retirement.
- Added the Vicarious Liability for Affiliated Dental Provider Endorsement which provides coverage for the vicarious liability of the affiliated dental provider(s) stated in the endorsement, who at the time of the alleged incident, were not otherwise named as an insured under the policy. 25% additional premium charge for each affiliated dentist and a 3% additional premium charge for each affiliated mid-level dental provider.
- Added the Covered Dentist Locum Tenens Endorsement. We previously did not have an endorsement to reflect this coverage.
- Added the Covered Dental Provider Slot Endorsement which is a slot used to accommodate one full-time position for a given specialty in practices with a high position turnover. Provides one separate limit of liability to be shared by the covered slot dental providers within the same slot position as designated in the endorsement.
- Added the Covered Full-Time Equivalent Dental Provider Endorsement which provides one separate limit of liability to be shared by the covered FTE (Full-time Equivalency) dentists within the same FTE position as designated in the endorsement.
- Added the Restricted Practice Endorsement which excludes the designated specialty procedure or practice activity for the insured(s) specified on the endorsement.
- Added the new Vicarious Liability Risks Excluded Endorsement which excludes any vicarious liability arising from professional services provided by, or which should have been provided by, any excluded dental provider(s) designated on the endorsement.
- Added the Facial Cosmetics Endorsement.
- Deleted the Partnership, Corporation or Professional Association With Separate Limits of Liability Endorsement as a Schedule of Covered Entities will be used instead.
- Deleted the Partnership, Corporation or Professional Association With Shared Limits of Liability Endorsement as a Schedule of Covered Entities will be used instead.
- Deleted the Multiple Partnership, Corporation or Professional Association Endorsement as a Schedule of Covered Entities will be used instead.
- Deleted the Product Liability Endorsement.
- Deleted the Dental Candidate Endorsement. We currently do not have any policies with this endorsement.
- Deleted the Limited Permit/Temporary Training Endorsement. We currently do not have any policies with this endorsement.

Section XIV. Classification Plan:

- Reworded the descriptions and added ISO Specialty Codes.

Added Section XV. Professional Entity Coverage:

- Moved Corporation Coverage from Section I. Application of this Manual-Eligibility, Sub-Section C. Corporation Coverage to a new Professional Entity Coverage Section.
- Changed the premium charge for the Shared Limits option from 5% of the total undiscounted manual premium for all dentists to 3% of the discounted manual rate of the top 10 highest rated dental providers.
- Changed the premium charge for the Separate Limits option from 10% of the total undiscounted manual rate for all dentists to 10% of discounted rate of the top 10 highest rated dental providers. Please note that this will allow for a reduction in the premium as the entity charge is now based on any applicable discounts for the dental providers.

**Professional Solutions Insurance Company
Dental Professional Liability
Summary of Rating Manual Changes**

Added Section XVI. Mid-Level Healthcare Provider Coverage:

- Moved Mid-level Providers from Section I. Application of this Manual-Eligibility, Sub-Section B. Ancillary Dental Personnel to a new Mid-level Healthcare Provider Coverage Section.
- Added wording that there is no additional premium charge for up to 5 mid-level providers sharing in a separate limit. More than 5 mid-level providers requesting to share in a separate limit will be referred to Underwriting.
- Added a separate limits option for Expanded Functions Dental Assistants.

Section XVII. RATES:

- No Changes.

Neuman, Gayle

From: Alicia Kirkle [akirkle@ncmic.com]
Sent: Wednesday, January 26, 2011 3:07 PM
To: Neuman, Gayle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev

Ms. Neuman,

Under the Claims free credits section we first define "claim". That definition includes the following, "...a paid claim with incurred indemnity equal to or greater than \$10,000.00..." In that same section, the manual also states: "A claim free credit shall apply if the insured has achieved at least 3 years without a claim." We believe this clearly indicates when the insured qualifies for the credit and under which circumstances he/she qualifies.

Let me know if that helps clarify things.

Thanks,

Alicia

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, January 26, 2011 2:18 PM
To: Alicia Kirkle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev

Ms. Kirkle,

I have one issue that needs addressed again.

It appears the wording under Experience Rating should indicate "to qualify for a claim free credit, the insured cannot have experienced a paid claim with incurred indemnity equal to or greater than...".

I request receipt of your response by February 1, 2011.

Gayle Neuman

Illinois Department of Insurance
(217)524-6497

From: Alicia Kirkle [mailto:akirkle@ncmic.com]
Sent: Friday, January 21, 2011 10:27 AM
To: Neuman, Gayle
Cc: Alicia Kirkle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev

Ms. Neuman,

Thank you for your response. We have amended the rating manual based on your questions and recommendations. I have outlined the changes below.

1. Under the Extended Reporting Coverage, the third and fourth paragraphs seem to have conflicting information. An extended reporting coverage endorsement should not be issued until the premium is paid in full – therefore it cannot be cancelled for nonpayment. If the endorsement is not issued until it is paid, the insured could not be liable for losses incurred. Please explain.

We agree that the wording was conflicting. We have deleted the third and fourth paragraphs and replaced them with the sentence, "Premium is due in full at the time of purchase; no payment plans will be offered."

2. Under the Prior Acts Coverage, the wording indicates the prior acts coverage would cover any loss the insured had under the claims-made policy. I believe this should only cover claims that were not reported under the previous policy.

We have amended the wording to read, "Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date of the insured's previous claims made policy will be covered but only if no claim was made, no suit was brought and no knowledge existed of a possible claim prior to the effective date of this endorsement."

3. Under Change in Rating Classification, please explain why this only applies to claims-made coverage. Additionally please explain why an insured wouldn't be charged for a change in classification more than 4 years prior.

We have deleted this section in its entirety. It does not apply as we do charge for classification changes at the time of the change for both claims-made and occurrence coverage.

4. Under Experience Rating – Claims Free Credits, "a claim is defined as a claim closed..." - this wording does not make sense. It seems it should be referred to as a paid claim.

We have amended the wording to read, "A claim is defined as a paid claim with incurred indemnity equal to or greater than \$10,000.00 or an open claim with allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding \$50,000.00."

Thank you for bringing these issues to our attention. I have attached the updated Illinois Dental Rating Manual reflecting these changes. Please let me know if you need anything further or have any other questions.

Thank you,

Alicia Kirkle

Compliance Analyst
NCMIC Group, Inc.
515-313-4691
akirkle@ncmic.com

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Neuman, Gayle

From: Alicia Kirkle [akirkle@ncmic.com]
Sent: Friday, January 21, 2011 10:27 AM
To: Neuman, Gayle
Cc: Alicia Kirkle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev
Attachments: Illinois Dental Rating Manual 10-2010.pdf

Ms. Neuman,

Thank you for your response. We have amended the rating manual based on your questions and recommendations. I have outlined the changes below.

1. Under the Extended Reporting Coverage, the third and fourth paragraphs seem to have conflicting information. An extended reporting coverage endorsement should not be issued until the premium is paid in full – therefore it cannot be cancelled for nonpayment. If the endorsement is not issued until it is paid, the insured could not be liable for losses incurred. Please explain.

We agree that the wording was conflicting. We have deleted the third and fourth paragraphs and replaced them with the sentence, "Premium is due in full at the time of purchase; no payment plans will be offered."

2. Under the Prior Acts Coverage, the wording indicates the prior acts coverage would cover any loss the insured had under the claims-made policy. I believe this should only cover claims that were not reported under the previous policy.

We have amended the wording to read, "Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date of the insured's previous claims made policy will be covered but only if no claim was made, no suit was brought and no knowledge existed of a possible claim prior to the effective date of this endorsement."

3. Under Change in Rating Classification, please explain why this only applies to claims-made coverage. Additionally please explain why an insured wouldn't be charged for a change in classification more than 4 years prior.

We have deleted this section in its entirety. It does not apply as we do charge for classification changes at the time of the change for both claims-made and occurrence coverage.

4. Under Experience Rating – Claims Free Credits, "a claim is defined as a claim closed..." - this wording does not make sense. It seems it should be referred to as a paid claim.

We have amended the wording to read, "A claim is defined as a paid claim with incurred indemnity equal to or greater than \$10,000.00 or an open claim with allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding \$50,000.00."

Thank you for bringing these issues to our attention. I have attached the updated Illinois Dental Rating Manual reflecting these changes. Please let me know if you need anything further or have any other questions.

Thank you,

Alicia Kirkle

Compliance Analyst
NCMIC Group, Inc.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, January 18, 2011 11:33 AM
To: Alicia Kirkle
Subject: Professional Solutions - Filing #PSICDental2010Rev

Ms. Kirkle,

I have a few issues to be addressed on the rate/rule manual submitted in the above referenced filing.

1. Under the Extended Reporting Coverage, the third and fourth paragraphs seem to have conflicting information. An extended reporting coverage endorsement should not be issued until the premium is paid in full – therefore it cannot be cancelled for nonpayment. If the endorsement is not issued until it is paid, the insured could not be liable for losses incurred. Please explain.
2. Under the Prior Acts Coverage, the wording indicates the prior acts coverage would cover any loss the insured had under the claims-made policy. I believe this should only cover claims that were not reported under the previous policy.
3. Under Change in Rating Classification, please explain why this only applies to claims-made coverage. Additionally please explain why an insured wouldn't be charged for a change in classification more than 4 years prior.
4. Under Experience Rating – Claims Free Credits, “a claim is defined as a claim closed...” - this wording does not make sense. It seems it should be referred to as a paid claim.

I request receipt of your response by January 25, 2011.

Gayle Neuman

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

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B. Automatic Reporting Extension – Claims Made Only

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Automatic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage – Claims Made Only

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents, which occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

<u># of Years Completed in Claims Made Program</u>	<u>Tail Factor</u>
1	0.654
2	0.975
3	1.062
4+	1.082

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

If the Insured fails to pay the Extended Reporting Endorsement premium when due, the Insured will be liable to the Company for any losses and loss expenses incurred.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

<u># of Years of Continuous Coverage</u>	<u>Extended Reporting Coverage Credit</u>
1 full year	20%
2 full years	40%
3 full years	60%
4 full years	80%

D. Prior Acts Coverage, also called Nose Coverage – Occurrence Only

This endorsement will provide nose coverage for dentists who change from a claims made policy to an occurrence policy and do not purchase Extended Reporting Coverage from their previous carrier. Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date of the insured's previous claims made policy will be covered. The limit of liability provided by this option are the

only limits that shall be applicable to the time period designated above. This endorsement can be applied to individual or entity policies.

The factors listed below will be applied to the undiscounted mature occurrence premium at the applicable limit of liability in the state in which the insured's previous claims made policy was issued.

<u># of Years in Claims Made Maturity</u>	<u>Nose Factor</u>
1	0.628
2	0.936
3	1.020
4+	1.039

E. Change in Rating Classification – Claims Made Only

In the event of a change in exposure or dental practice classification, a premium charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no additional charge;
2. with regard to dental practice classification, both the prior and the current specialty fall within the same class;
3. the exposure or dental practice of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or dental practice of the practitioner changed while insured under occurrence coverage.

F. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed sixty (60) days per policy term. A completed application must be submitted to the Company for prior underwriting approval.

X. DISCOUNTS

A. New Practitioner

A new practitioner is defined as a person who has completed his or her training, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1 st year	50% credit
2 nd year	30% credit
3 rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits.

B. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. Practitioners classified as Dental Anesthesiology or Oral & Maxillofacial – Major Surgery are not eligible for the part-time credit. The insured must complete an application for part-time credit. If the application is approved, the credit applied is 50% of the approved base premium:

Those who receive a part-time practitioner credit will not be eligible to receive any further credits.

XI. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than \$10,000.00 or allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding \$50,000.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	10%
5+ yrs	15%

Claims debits

Claim frequency debit criteria:

Debit:

One (1) claim opened in the past five (5) years:	0%
Two (2) claims opened in the past five (5) years:	50%
Three (3) claims opened in the past five (5) years:	150%

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

- The applicant
- The agent or broker
- All previous insurers with respect to the experience period in question.

XII. SCHEDULE RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance 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 the following, subject to a maximum modification of a 25% credit to a 25% debit 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 actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

SCHEDULE RATING PROGRAM		Maximum Credit	Maximum Debit
Conscious Sedation	Procedures performed on patients who have been treated with light to moderate conscious sedation, including but not limited to nitrous oxide.	0%	10%
Facial Cosmetics	Elective cosmetic/aesthetic procedures, including but not limited to Botox injections, hyaluronic acid injections and dermal fillers.	0%	25%

Neuman, Gayle

From: Alicia Kirkle [akirkle@ncmic.com]
Sent: Monday, January 10, 2011 10:26 AM
To: Neuman, Gayle
Cc: Alicia Kirkle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev
Attachments: Filing Memo-IL-DPL.pdf

Gayle,

Attached is the Filing Memorandum for PSICDental2010Rev. The indicated rate increase is 2% and the selected change is 0%.

Please let me know if you need anything further.

Thank you for your patience.

Alicia Kirkle

Compliance Analyst
NCMIC Group, Inc.
515-313-4691
akirkle@ncmic.com

From: Alicia Kirkle
Sent: Wednesday, December 29, 2010 2:49 PM
To: 'Neuman, Gayle'
Cc: Juli Frank
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev
Importance: High

Hi Gayle,

Attached is the Illinois Certification for Medical Malpractice rates signed by our actuary and an officer. There is no increase or decrease in the base rate, this is a rule filing only. Our actuary is finishing a few exhibits and we will get them to you as soon as possible.

Thank you for your patience Gayle.

Alicia Kirkle

Compliance Analyst
NCMIC Group, Inc.
515-313-4691
akirkle@ncmic.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 14, 2010 11:14 AM
To: Alicia Kirkle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev

Alicia,

I will extend the due date to December 29, 2010. In the future, a filing should not be submitted before your actuarial staff has reviewed the submission.

Gayle Neuman
Illinois Department of Insurance
(217)524-6497

From: Alicia Kirkle [mailto:akirkle@ncmic.com]
Sent: Tuesday, December 14, 2010 11:09 AM
To: Neuman, Gayle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev

Gayle,

Thank you so much for your patience. Unfortunately our actuary has advised that they will not have it done by tomorrow. Would there be any way we could extend the due date by an additional 2 weeks to 12/29/2010?

Alicia Kirkle
Compliance Analyst
NCMIC Group, Inc.
515-313-4691
akirkle@ncmic.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, December 06, 2010 10:09 AM
To: Alicia Kirkle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev

I will extend the due date to December 15, 2010.

Gayle Neuman
Illinois Department of Insurance
(217)524-6497

From: Alicia Kirkle [mailto:akirkle@ncmic.com]
Sent: Monday, December 06, 2010 10:06 AM
To: Neuman, Gayle
Subject: RE: Professional Solutions - Filing #PSICDental2010Rev

Gayle,

Thank you for your response to our filing. Would it be possible for us to get an extension to December 15th in order to allow our actuary time to review the rates and get the document back to us?

Thank you,

Alicia Kinkle

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, December 01, 2010 2:23 PM
To: Alicia Kinkle
Subject: Professional Solutions - Filing #PSICDental2010Rev

Ms. Kinkle,

You submitted filing #PSIC Dental 2010 Revision – Rule by letter dated October 15, 2010. The filing number was changed because we have a seventeen character limit, therefore please reference the filing number listed in the subject line when referencing this filing.

215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. This information is required in every rate/rule filing for medical malpractice.

I request receipt of your response by December 8, 2010.

Gayle Neuman

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

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

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distribution or reproduction of this e-mail, including attachments, is prohibited and may be unlawful.

Side-by-Side Rating Manual Comparison

Attached please find a comparison of Professional Solutions Insurance Company's currently approved Dental Professional Liability rating manual and its revised rating manual. All information that has been deleted from the currently approved manual has a ~~red line through it~~ and all new information that has been added to the revised manual is underlined in blue.

To see where the changes are, please scroll down.

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

DENTAL PROFESSIONAL LIABILITY MANUAL

~~(Claims Made and Occurrence)~~

Version 1.00

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This program covers Dentists engaged in ~~general dentistry, dental anesthesia and oral surgery or operative dentistry on patients rendered unconscious through the administering of an anesthesia or analgesia.~~ Refer to the classification plan for a description of each risk/rating category:

A. ~~Dental Service Providers~~

~~Licensed dentists who must meet the current underwriting standards of Professional Solutions Insurance Company for their particular dental practice.~~

B. ~~Ancillary Dental Personnel~~

~~Ancillary dental employees are included as insureds for their acts while performing duties within the scope of their employment while under the supervision of the insured dentist named in the Coverage Summary. Ancillary dental employees are not separately rated and do not include licensed health care providers, except for dental hygienists.~~

C. ~~Corporation Coverage~~

~~**Separate Limits:** Partnerships, corporations, or professional associations formed for the express purpose of practicing dentistry may be provided coverage for separate limits of liability. The premium for separate limits will be 10% of the total undiscounted base premium for all dentists.~~

~~**Shared Limits:** Partnerships, corporations, or professional associations formed for the express purpose of practicing dentistry may be provided coverage for shared limits of liability. The premium charge for shared limits will be 5% of the total undiscounted base premium for all dentists.~~

~~**Sole Practitioner:** This program also provides coverage for shared limits of liability at no additional charge to a dentist's professional entity, as long as the entity does not employ any other licensed health care providers.~~

~~**Multiple Corporations:** If a dentist has multiple partnerships, corporations or professional associations, they may choose to have a separate limit of liability to share between all of the entities. The premium for a separate limit of liability to share between the entities will be 10% of the total undiscounted base premium for all dentists for the first entity and 5% of the total undiscounted base premium for each additional entity.~~

II. PREMIUM DETERMINATION

- 1: ~~Determine base rate for appropriate policy type and territory.~~
- 2: Refer to Classification Listing and apply the factor for the ~~most~~ appropriate class specialty being rated.
- 3: Apply the appropriate increase limit factor.
- 4: If the policy is claims made, apply the appropriate claims made step factor to reach the undiscounted premium.
- 5: Apply credit, if necessary, for part-time status.
- 6: ~~Apply any credits/debits for scheduled or experience rating.~~
- 7: ~~Apply rounding.~~
- 8: Example Premium Calculation:

~~Assume the full time base rate is \$1000. Credits or debits will be applied in consecutive order.~~
 ~~$\$1,000.00 \times .95 = \950.00 (Schedule rating credit of 5%)
 $\$950.00 \times .95 = \902.50 (Experience rating credit of 5%)
 $\$902.50 = \903.00 (Apply rounding)~~

- 9: There will be a \$200.00 minimum premium for all dental ~~policies other than dental candidate coverage.~~

Version 1.00

III. POLICY PERIOD

The policy period shall be for a one-year term, unless it is part of a group policy and the insured joins the group in the middle of the term. In this instance, a short-term policy will be issued and will expire on the group policy's expiration date.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: ~~\$1234.30 is rounded to \$1234.~~
~~\$1234.60 is rounded to \$1235.~~

V. PRACTICE LOCATION

~~Dentists who conduct a percentage of their practice located in another state or territory will be assessed additional premium, based upon the percentage of time spent in the other state or territory.~~

~~A. For insureds who practice in multiple states, the location of their primary practice will determine the base rate, with a premium debit of 25%, to be applied, based on their practice in the secondary state. The 25% debit will not be applied if the primary state's base rate is higher.~~

~~B. If more than one location of practice exists within the same state, the rate from the highest territory will be applied.~~

~~C. The insured must be licensed in all states where practicing.~~

VI. POLICY CANCELLATION**A. Cancellation By the Insured**

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed ~~pro~~ rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard notice will be sent sixty (60) days prior to the ~~cancellation or non-renewal date~~, except that in the event of non-payment of premium, then not less than ten (10) days prior notice of cancellation will be given or in the event of a short-term policy issued for a period of less than six months, we may not non-renew.

~~Version 1-00~~**VII. PREMIUM PAYMENT OPTIONS**

1. Annual
2. Semi-Annual 50% prepayment required
3. Quarterly 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception
4. ~~Other payment options available upon request for large group accounts.~~

~~The premium payment options will be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006, and made available upon request thereafter. There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. 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 in coverage may be due immediately as a separate transaction. If the policy is issued with a final fully discounted premium less than \$500, the policy must be billed on an annual basis.~~

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium.

IX. SPECIAL PROVISIONS**A. Retroactive Coverage – Claims Made Only**

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may purchase this equivalent of Extended Reporting Period Coverage from the Company. ~~The insured may select the Retroactive Date (shown on the Coverage Summary) from a date that is equal to the retroactive date shown on the previous policy.~~

Premium for this extension is derived by rating the policy based upon the ~~claims-made~~ step factor determined by using the previous carrier's retroactive date.

~~No permission shall be granted for advancing the Retroactive Date after the policy has taken effect.~~

~~B. Basic Reporting Extension – Claims Made Only~~

~~This option applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.~~

Under the circumstances stated above, the Company will provide a thirty (30) day ~~Basic Reporting Extension~~ which allows claims to be reported during this ~~time, which~~ result from incidents that happened during the time the coverage was in force.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of an ~~extended reporting endorsement~~, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the ~~Extended Reporting Endorsement in writing.~~

Version 1.00

~~C. Extended Reporting Endorsement, also called Tail Coverage – Claims Made Only~~

~~This endorsement will provide coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents, which occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to individual or entity policies.~~

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

<u># of Years Completed in Claims Made Program</u>	<u>Tail Factor</u>
1	0.654
2	0.975
3	1.062
4+	1.082

If the Insured fails to pay the Extended Reporting Endorsement premium when due, the Insured will be liable to the Company for any losses and loss expenses incurred.

~~Professional Solutions Insurance Company cannot cancel the extended reporting endorsement except for non-payment of the additional premium.~~

~~B. Prior Acts – Occurrence Only~~

~~This endorsement provides coverage for dentists who change from a claims made policy to an occurrence policy and do not purchase tail coverage. Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date referenced in the endorsement will be covered. The factors listed below will be applied to the undiscounted occurrence premium at the applicable limit of liability in the state in which the claims made policy was issued.~~

<u>Number of Years Since Retroactive Date</u>	<u>Prior Acts Factor</u>
1	0.628
2	0.936
3	1.020
4+	1.039

~~E. Locum Tenens~~

~~Locum Tenens substituting and serving in the place of the insured shall be provided coverage at no additional premium, for a period not to exceed forty-five (45) days per policy term. A completed application must be submitted to the company for prior underwriting approval.~~

~~F. Part-Time Discount~~

~~An insured must practice less than 20 hours per week to become eligible for this credit. The insured must complete an application for part time credit. If the application is approved, the credit applied is 50% of the approved base premium.~~

~~G. New Dentist Discount~~

~~A new dentist is defined as a student who has completed his/her training within the previous six months and whose only contact with patients has been in the course of his/her training. The following credits will apply:~~

~~Version 1.00~~

~~50% for the first year in practice
30% for the second year in practice
10% for the third year in practice~~

~~Those who receive a new dentist discount will not be eligible to receive any further credits.~~

~~**X. CLASSIFICATION PLAN**~~~~**Class D-1**~~

~~Relativity 1.00~~

~~This class includes general dentists or specialists in endodontics, forensic dentistry, oral & maxillofacial radiology, oral pathology, orthodontics, pediatric dentistry, periodontics, prosthodontics, public health dentistry, or sports dentistry.~~

~~Coverage under this classification would not apply to the general practitioner or specialist who is engaged in dentistry on patients rendered unconscious through the administration of general anesthesia unless the general anesthesia is administered in a duly licensed hospital, outpatient surgical center or the insured's office by an anesthesiologist, or certified registered nurse anesthetist supervised by such anesthesiologists, other than an insured dentist, his or her employees, or any other person or organization for whose acts or omissions the insured dentist is legally responsible.~~

~~Dental Candidates are included in Class D-1.~~

~~**Class D-4**~~

~~Relativity 4.50~~

~~Members of this class are specialists in oral and maxillofacial surgery who administer, personally or by an employed/contracted anesthesiologist, any general anesthetic intended to cause unconsciousness if administered in a dental office.~~

~~Members of this class may perform TMJ Phase II procedures. Members of this class may also use lasers in their practice.~~

~~**Class D-5**~~

~~Relativity 6.00~~

~~Members of this class are specialists in dental anesthesiology whose practice includes deep sedation and/or general anesthesia.~~

~~**XI. SCHEDULED RATING PLAN**~~

~~Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance 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 the following, subject to a maximum modification of a 50% credit to a 50% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this scheduled rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.~~

~~**Scheduled Rating Credits:** The following circumstances will be considered for application of a scheduled rating credit:~~

~~Version 1.00~~

~~1: Cumulative Years of Patient Experience 0-15% Credit~~

~~Insureds who have demonstrated a stable, longstanding practice and/or significant degree of experience in their area of medicine.~~

~~2: Risk Management Practices and Procedure 0-20% Credit~~

~~In order to qualify for this credit, the insured must demonstrate that risk management procedures and activities have been properly implemented, and that these procedures will reduce the frequency and severity of claims.~~

~~3: Dental Specialty Board Certification 0-10% Credit~~

~~Any dentist in good standing that holds a current specialty certification by the licensing board. Documentation of specialty certification must be submitted every three years.~~

~~Scheduled Rating Debits. The following circumstances, based on underwriting review of risk, will be considered for a scheduled rating debit application:~~

- | | |
|---|------------------------|
| 1: High Risk Practice | 0-50% Debit |
| 2: Adverse or unusual vicarious liability exposure | 0-50% Debit |
| 3: Prior history of revocation or suspension of license | 0-50% Debit |
| 4: Prior history of disciplinary action against licensure | 0-50% Debit |
| 5: Prior or current membership in association revoked or refused | 0-50% Debit |
| 6: Prior history of alcoholism, narcotic addiction or mental illness | 0-50% Debit |
| 7: Conviction of crime | 0-50% Debit |

~~XII. EXPERIENCE RATING~~

~~Claims free credits~~

~~The following claims free credit schedule will apply if an insured has \$10,000 or less of incurred indemnity:~~

# OF YEARS CLAIMS FREE	CREDIT
3 but less than 5	5%
5 but less than 8	10%
8 or more	15%

~~Claims debits~~

~~Claim debit factors - individual policy:~~

# OF CLAIMS IN 5 YEARS	FACTOR
1	1.000
2	1.500
3	2.500

Version 1.00

~~Claim debit factors — partnership/corporate policy:~~

# OF CLAIMS IN 5 YEARS	FACTOR
1-2	1.000
3-4	1.500

~~The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.~~

~~Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.~~

~~To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:~~

- ~~a. The applicant~~
- ~~b. The agent or broker~~
- ~~c. All previous insurers with respect to the experience period in question.~~

~~XIII: ENDORSED COVERAGES~~

~~Partnership, Corporation or Professional Association With Separate Limits of Liability Endorsement- Form PSIC-DDS-02~~

~~This endorsement provides a separate limit of liability to a partnership, corporation or professional association. Coverage is provided only to the extent of the entity's liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.~~

~~Partnership, Corporation or Professional Association With Shared Limits of Liability Endorsement- Form PSIC-DDS-03~~

~~This endorsement provides a shared limit of liability to a partnership, corporation or professional association. Coverage is provided only to the extent of the entity's liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.~~

~~Additional Insured Endorsement-Form PSIC-DDS-04~~

~~This endorsement provides coverage for an additional insured. This is an optional endorsement. The charge for this endorsement will be 15% of the base corporation/partnership premium or the individual premium if there is no corporation/partnership coverage.~~

~~Temporary Leave of Absence Endorsement-PSIC-DDS-05 and PSIC-DDS-20~~

~~This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.~~

~~This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or~~

~~Version 1-00~~

~~omissions during the leave or disability period. Form claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).~~

~~If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.~~

~~For claims made policies, while on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.~~

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations

Extended Reporting Endorsement Form PSIC-DDS-06 – Claims Made Only

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Multiple Partnership, Corporation or Professional Association Endorsement Form PSIC-DDS-14

~~This endorsement is used when an insured has multiple partnerships, corporations, or professional associations and wishes to have a separate limit of liability to cover these entities. This endorsement will provide one separate limit of liability that will be shared between the entities.~~

Product Liability Endorsement Form PSIC-DDS-15 and PSIC-DDS-21

~~This endorsement provides coverage for legal defense expenses incurred if the insured is made a party to a product liability action due to a known or suspected defect, deficiency, inadequacy or dangerous condition of a product or products of another manufacturer which you sold, handled, distributed or disposed of. The limit of liability for all defense expenses under this endorsement is \$50,000 per incident and \$100,000 aggregate limit of liability. The premium charge for this coverage will be 10% of the base premium for the insured's professional liability coverage.~~

Dental Candidate Endorsement Form PSIC-DDS-16 and PSIC-DDS-22

~~This endorsement provides coverage for any claim for injury arising out of a dental candidate's acts, errors, or omissions in the rendering of or failure to render professional services, while completing State or Regional Board Examinations for a license to practice dentistry. The limits of liability for this endorsement will be \$100,000 per claim and \$300,000 aggregate. The charge for this endorsement is \$15.00.~~

Active Military Duty Endorsement Form PSIC-DDS-17 and PSIC-DDS-23

~~This endorsement suspends coverage, including premium payments, if an insured is called to active military duty. This endorsement provides coverage for claims arising from acts, errors or omissions that occurred prior to the inception of the active military leave. There is no coverage for acts, errors or omissions during the period of active military duty. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).~~

Limited Permit / Temporary Training Endorsement PSIC-DDS-18 and PSIC-DDS-24

~~This endorsement provides coverage to a dental school graduate practicing dentistry under a limited permit, a temporary license, or an extended temporary license issued by a state licensing board for any claim for injury arising out of the insured graduate dentist's acts, errors or omissions in the rendering or failure to render professional services in a specialty, residency, intern or graduate program and only while under the supervision of a state licensed dentist and according that state's limitations. The limits of liability for this endorsement will be \$1,100,000 per claim and \$3,000,000 aggregate. The charge for this endorsement is \$218.00.~~

~~Version 1.00~~

Prior Acts Endorsement-PSIC-DDS-25

This endorsement provides coverage for dentists who change from a claims made policy to an occurrence policy and do not purchase tail coverage. Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date referenced in the endorsement will be covered.

XIV. RATES

Claims-Made Base Rate (for D-1 provider @ 100/300 limits)

~~Illinois Territory 01 = \$1,529.00
(Cook County)~~

~~Illinois Territory 02 = \$838.00
(Remainder of State)~~

Occurrence Base Rate (for D-1 provider @ 100/300 limits)

~~Illinois Territory 01 = \$1,662.00
(Cook County)~~

~~Illinois Territory 02 = \$911.00
(Remainder of State)~~

Dental Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
\$100,000/\$300,000	1.00
\$200,000/\$600,000	1.14
\$250,000/\$750,000	1.31
\$500,000/\$1,000,000	1.33
\$1,100,000/\$3,000,000	1.56
\$2,000,000/\$4,000,000	1.72

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.32
2	0.60
3	0.81
4	0.90
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

**PROFESSIONAL SOLUTIONS
INSURANCE COMPANY**

STATE OF ILLINOIS

DENTAL PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE AND OCCURRENCE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This program covers Dentists engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan for a description of each risk/rating category for dentists.

Employees of Dentists are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to the listing of the mid-level dental providers who may be covered by either a shared or separate limit of liability.

This program also provides coverage for both dental clinics and individual practicing dentists for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the professional entity coverage section for a description of the partnership, corporation or professional association rating factors.

II. PREMIUM DETERMINATION

1. Determine the manual rate for the appropriate policy type and territory.
2. Refer to Classification Listing and apply the factor for the appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. If the policy is claims made, apply the appropriate claims made step factor to reach the undiscounted premium.
5. Apply discounts, as appropriate, for part-time or new practitioner.
6. Apply any applicable credits/debits for experience rating.
7. Apply any applicable credits/debits for schedule rating.
8. Apply rounding.
9. Example Premium Calculation:

Assume the full time undiscounted premium is \$1,000. Credits or debits will be applied in consecutive order.

$\$1,000 \times .95 =$	<u>\$950.00 (Claims Free credit of 5%)</u>
$\$950.00 \times .95 =$	<u>\$902.50 (Schedule Rating credit of 5%)</u>
$\$902.50 =$	<u>\$903.00 (Apply rounding)</u>
10. There will be a \$200.00 minimum premium for all dental policies.

III. POLICY PERIOD

The policy period shall be for a one-year term. Insureds added or removed mid-term will be pro-rated.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: \$1,234.30 is rounded to \$1,234.
\$1,234.60 is rounded to \$1,235.

V. PRACTICE LOCATION

The following parameters will be applied for dental providers who practice in multiple territories or states:

- A. For dental providers providing services under local or conscious sedation and/or facial cosmetics, the location of the primary office practice will determine the manual rate.
- B. For dental providers classified as Dental Anesthesiology or Oral & Maxillofacial—Major Surgery, the location of the primary healthcare facility practice will determine the manual rate.

C. If a dental provider practices equally in two or more states or territories, the rate from the highest territory or state will be applied.

For the purposes of this section, primary means 51% or more of the dental provider's practice time is spent in the given territory or state.

The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro-rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard notice will be sent sixty (60) days prior to cancellation or non-renewal, except that in the event of non-payment of premium, then not less than ten (10) days prior notice of cancellation will be given.

VII. PREMIUM PAYMENT OPTIONS

1. Annual
2. Semi-Annual 50% prepayment required
3. Quarterly 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro-rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro-rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage – Claims Made Only

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for a Retroactive Date that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Automatic Reporting Extension – Claims Made Only

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Automatic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called “Tail Coverage”.

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage – Claims Made Only

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents, which occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

<u># of Years Completed in Claims Made Program</u>	<u>Tail Factor</u>
1	0.654
2	0.975
3	1.062
4+	1.082

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

If the Insured fails to pay the Extended Reporting Endorsement premium when due, the Insured will be liable to the Company for any losses and loss expenses incurred.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

<u># of Years of Continuous Coverage</u>	<u>Extended Reporting Coverage Credit</u>
<u>1 full year</u>	<u>20%</u>
<u>2 full years</u>	<u>40%</u>
<u>3 full years</u>	<u>60%</u>
<u>4 full years</u>	<u>80%</u>

D. Prior Acts Coverage, also called Nose Coverage – Occurrence Only

This endorsement will provide nose coverage for dentists who change from a claims made policy to an occurrence policy and do not purchase Extended Reporting Coverage from their previous carrier. Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date of the insured’s previous claims made policy will be covered. The limit of liability provided by this option are the

only limits that shall be applicable to the time period designated above. This endorsement can be applied to individual or entity policies.

The factors listed below will be applied to the undiscounted mature occurrence premium at the applicable limit of liability in the state in which the insured's previous claims made policy was issued.

<u># of Years in Claims Made Maturity</u>	<u>Noise Factor</u>
1	0.628
2	0.936
3	1.020
4+	1.039

E. Change in Rating Classification – Claims Made Only

In the event of a change in exposure or dental practice classification, a premium charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no additional charge;
2. with regard to dental practice classification, both the prior and the current specialty fall within the same class;
3. the exposure or dental practice of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or dental practice of the practitioner changed while insured under occurrence coverage.

E. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed sixty (60) days per policy term. A completed application must be submitted to the Company for prior underwriting approval.

X. DISCOUNTS

A. New Practitioner

A new practitioner is defined as a person who has completed his or her training, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

<u>1st year</u>	<u>50% credit</u>
<u>2nd year</u>	<u>30% credit</u>
<u>3rd year</u>	<u>10% credit</u>

Those who receive a new practitioner credit will not be eligible to receive any further credits.

B. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. Practitioners classified as Dental Anesthesiology or Oral & Maxillofacial – Major Surgery are not eligible for the part-time credit. The insured must complete an application for part-time credit. If the application is approved, the credit applied is 50% of the approved base premium:

Those who receive a part-time practitioner credit will not be eligible to receive any further credits.

XI. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than \$10,000.00 or allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding \$50,000.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

<u>3 yrs</u>	<u>5%</u>
<u>4 yrs</u>	<u>10%</u>
<u>5+ yrs</u>	<u>15%</u>

Claims debits

Claim frequency debit criteria: **Debit:**

<u>One (1) claim opened in the past five (5) years:</u>	<u>0%</u>
<u>Two (2) claims opened in the past five (5) years:</u>	<u>50%</u>
<u>Three (3) claims opened in the past five (5) years:</u>	<u>150%</u>

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

- a. The applicant
- b. The agent or broker
- c. All previous insurers with respect to the experience period in question.

XII. SCHEDULE RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance 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 the following, subject to a maximum modification of a 25% credit to a 25% debit 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 actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

<u>SCHEDULE RATING PROGRAM</u>		<u>Maximum Credit</u>	<u>Maximum Debit</u>
<u>Conscious Sedation</u>	<u>Procedures performed on patients who have been treated with light to moderate conscious sedation, including but not limited to nitrous oxide.</u>	<u>0%</u>	<u>10%</u>
<u>Facial Cosmetics</u>	<u>Elective cosmetic/aesthetic procedures, including but not limited to Botox injections, hyaluronic acid injections and dermal fillers.</u>	<u>0%</u>	<u>25%</u>

<u>Historical Loss Experience</u>	<u>The frequency or severity of claims for the insured is greater/less than expected experience for an insured of the same classification/size or recognition of unusual circumstances of claims in the loss experience.</u>	<u>25%</u>	<u>25%</u>
<u>Cumulative Years of Patient Experience</u>	<u>The insured demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.</u>	<u>5%</u>	<u>5%</u>
<u>Classification Anomalies</u>	<u>Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of a recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.</u>	<u>25%</u>	<u>25%</u>
<u>Claims Anomalies</u>	<u>Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or unusual circumstances of a claim(s) which understate/overstate the severity of the claims(s).</u>	<u>10%</u>	<u>10%</u>
<u>Management Control Procedures</u>	<u>Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.</u>	<u>10%</u>	<u>10%</u>
<u>Number/Type of Patient Exposures</u>	<u>Size and/or demographics of the patient population which influences the frequency and/or severity of claims.</u>	<u>10%</u>	<u>10%</u>
<u>Organizational Size / Structure</u>	<u>The organization's size and processes are such that economies of scale are achieved while servicing the insured.</u>	<u>5%</u>	<u>5%</u>
<u>Medical Standards, Quality & Claim Review</u>	<u>Presence of a committee that meets on a routine basis to (1) review dental procedures, treatments, and protocols and assist in the integration of such into the practice; (2) assure the quality of the dental care being rendered; and/or (3) provide consistent review of claims/incidents that have occurred and develop corrective action.</u>	<u>10%</u>	<u>10%</u>
<u>Other Risk Management Practices and Procedures</u>	<u>Additional activities undertaken with specific intention of reducing the frequency or severity of claims.</u>	<u>10%</u>	<u>10%</u>
<u>Training, Accreditation & Credentialing</u>	<u>The insured exhibits greater/less than normal participation and support of such activities.</u>	<u>10%</u>	<u>10%</u>
<u>Record – Keeping Practices</u>	<u>Degree to which the insured incorporates methods to maintain quality patient records, referrals, and test results.</u>	<u>5%</u>	<u>5%</u>
<u>Utilization of Monitoring Equipment, Diagnostic Tests or Procedures</u>	<u>Demonstrating the willingness to expend the time and capital to incorporate the latest advances in dental treatment and equipment into the practice, or failure to meet accepted standards of care.</u>	<u>10%</u>	<u>10%</u>
<u>Maximum cumulative schedule credit / debit</u>		<u>25%</u>	<u>25%</u>

XIII. ENDORSED COVERAGES – Coverage Options

Active Military Suspension Endorsement – PSIC-DDS-02CM and PSIC-DDS-02OCC

This endorsement suspends coverage, including premium payments, if an insured is called to active military duty. This endorsement provides coverage for claims arising from acts, errors or omissions that occurred prior to the inception of the active military leave. There is no coverage for acts, errors or omissions during the period of active military duty. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail) while on active military duty.

Additional Interests Endorsement – PSIC-DDS-04

This optional endorsement provides coverage for an additional interest. For an individual practice, the charge for this endorsement will be up to 15% of the named insured's undiscounted manual premium for

each additional interest. For a group practice, the charge for this endorsement will be up to 15% of the undiscounted manual rate of the top 5 highest rated healthcare providers for each additional interest.

The addition of an additional interest will be based upon the underwriter's assessment of additional exposure imputed to an insured physician and/or surgeon, solo practitioner corporation, partnership or multi shareholder corporation.

<u>Locations or services being provided by the additional interest to or on behalf of the Named Insured are financially and medically controlled by the Named Insured.</u>	<u>5%</u>
<u>Locations or services being provided by the additional interest to or on behalf of the Named Insured are not financially controlled by the Named Insured.</u>	<u>10%</u>
<u>Locations or services being provided by the additional interest to or on behalf of the Named Insured are not financially and medically controlled by the Named Insured.</u>	<u>15%</u>

Temporary Leave of Absence Endorsement – PSIC-DDS-05CM and PSIC-DDS-05OCC

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro-rata basis for the period of the qualifying disability.

For claims made policies, while on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave or any other reason pre-approved by Professional Solutions Insurance Company – does not apply to vacations.

Extended Reporting Endorsement – PSIC-DDS-06 (Claims Made only)

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Prior Acts Endorsement – PSIC-DDS-07 (Occurrence only)

This endorsement will provide nose coverage for dentists who change from a claims made policy to an occurrence policy and do not purchase Extended Reporting Coverage from their previous carrier. Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date of the insured's previous claims made policy will be covered.

Accelerated Vesting For Extended Reporting Period Endorsement – PSIC-DDS-08 (Claims Made only)

This endorsement amends the years of continuous coverage requirement for the Extended Reporting Endorsement at no additional charge upon retirement.

Vicarious Liability for Affiliated Dental Provider Endorsement – PSIC-DDS-09

Coverage is provided for the vicarious liability of the affiliated dental provider(s) stated in the endorsement, who at the time of the alleged incident, were not otherwise named as an insured under the policy. There is a 25% additional premium charge for each affiliated dentist and a 3% additional premium charge for each affiliated mid-level dental provider.

Covered Dentist Locum Tenens Endorsement – PSIC-DDS-10

This endorsement adds coverage for the substitute dentist listed on the endorsement while the named insured is temporarily absent from professional practice. There is no additional premium for this endorsement.

Covered Dentist Slot Endorsement – PSIC-DDS-11 (Claims made only)

A slot is used to accommodate one full-time position for a given specialty in practices with a high position turnover. This endorsement provides one separate limit of liability to be shared by the covered slot dentists within the same slot position as designated in the endorsement. All covered slot dentists within a slot position must have the same classification. The premium for the slot position is based on the full-time mature rate for the given classification.

Covered Full Time Equivalent Dentist Endorsement – PSIC-DDS-12 (Claims Made only)

A Full-time Equivalency (FTE) is used to accommodate multiple dentists sharing one or more full-time positions within the given specialty. This endorsement provides one separate limit of liability to be shared by the covered FTE dentists within the same FTE position as designated in the endorsement. All covered FTE dentists within an FTE position must have the same classification. The premium for the FTE position is based on the total hours of practice of the FTE position and the full-time mature rate for the given classification.

Restricted Practice Endorsement – PSIC-DDS-13

This endorsement excludes the designated specialty, procedure or practice activity for the insured(s) specified on the endorsement.

Vicarious Liability Risks Excluded Endorsement – PSIC-DDS-14

This endorsement excludes any vicarious liability arising from professional services provided by, or which should have been provided by, any excluded dental provider(s) designated on the endorsement.

Facial Cosmetics Endorsement – PSIC-DDS-15

This endorsement amends the definition of Professional Services to include facial cosmetic/aesthetic procedures that are adjunct to dental care, performed by the dentist designated on the endorsement.

XIV. CLASSIFICATION PLAN

<u>ISO</u>	<u>Specialty Codes</u>	<u>Class Description</u>	<u>FACTOR</u>
		Dentist incl. Local anesthesia and/or oral medication only	
	80211	1 Dentist incl. Conscious Sedation	1.00
		Dentist incl. Facial Cosmetics	
	80210	4 Dental Anesthesiology	4.50
	80210	5 Oral & Maxillofacial – Major Surgery	6.00

XV. PROFESSIONAL ENTITY COVERAGE

A. Solo Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed dentists.

B. Shared Limits of Liability:

Coverage for professional entities other than solo practitioners may be written with a shared limit of liability. The charge for shared limits of liability will be 3% of the discounted manual rate of all insured providers, with the maximum premium limited to a cap of the top 10 highest rated dental providers listed on the Declarations and Schedule of Insureds when calculating the premium.

C. Separate Limits of Liability:

Coverage for professional entities may be written with a separate limit of liability. The premium charge for separate limits in which all members, stockholders or employees are insured with Professional Solutions Insurance Company will be 10% of the discounted manual rate of all insured providers, with the maximum premium limited to a cap of the top 10 highest rated dental providers listed on the Declarations and Schedule of Insureds when calculating the premium.

XVI. MID-LEVEL HEALTHCARE PROVIDER COVERAGE

A. Shared Limits of Liability:

Coverage for licensed mid-level providers may be written so the mid-level providers share a separate limit of liability with another insured as stated on the Schedule of Mid-level Providers. There is no additional premium charge for up to 5 mid-level providers sharing in a separate limit. More than 5 mid-level providers requesting to share in a separate limit will be referred to Underwriting.

B. Separate Limits of Liability:

Coverage for licensed mid-level providers is available on an individual, separate limits basis for employees of dentists insured by PSIC.

Mid-Level Provider Classification Plan

<u>ISO Specialty Codes</u>	<u>Mid-Level Dental Provider</u>	<u>Separate Limit Factor</u>
<u>80211</u>	<u>Expanded Functions Dental Assistant</u>	<u>0.200</u>

XVII. RATES

Claims Made Base Rate (for Class 1 provider @ 100/300 limits)

Illinois Territory 01 (Cook County) \$1,529.00

Illinois Territory 02 (Remainder of State) \$838.00

Occurrence Base Rate (for Class 1 provider @ 100/300 limits)

Illinois Territory 01 (Cook County) \$1,662.00

Illinois Territory 02 (Remainder of State) \$911.00

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
\$100,000/\$300,000	1.00
\$200,000/\$600,000	1.14
\$250,000/\$750,000	1.31
\$500,000/\$1,000,000	1.33
\$1,100,000/\$3,000,000	1.56
\$2,000,000/\$4,000,000	1.72

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.32
2	0.60
3	0.81
4	0.90
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

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

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

<u>Line(s) of Business</u>	<u>Code(s)</u>	
<input checked="" type="checkbox"/> MEDICAL MALPRACTICE	11.0000	***This checklist is for rate/rule filings only. See separate form checklist.
<input checked="" type="checkbox"/> Claims Made	11.1000	
<input checked="" type="checkbox"/> Occurrence	11.2000	

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

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

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		<p>To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings.</p> <p>Please see the separate form filing checklist for requirements related to medical liability forms.</p>	
GENERAL FILING REQUIREMENTS FOR ALL RATE/ RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	<p><u>215 ILCS 5/4</u></p> <p>List of Classes/ Clauses</p>	<p>To write Medical Liability insurance in Illinois, companies must be licensed to write:</p> <p>1. Class 2, Clause (c)</p>	OK
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/ rules and for forms/ endorsements, etc.		<p>The laws and regulations for medical liability forms/ endorsements and the laws for medical liability rates/ rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately.</p> <p>For requirements regarding form filings, see separate form filing checklist.</p>	OK
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	<p><u>215 ILCS 5/155.18</u></p> <p><u>50 IL Adm. Code 929</u></p>	<p>"New Insures" are insurers who are:</p> <ul style="list-style-type: none"> • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, <p>New insurers must file the following:</p> <ol style="list-style-type: none"> a) Medical liability insurance rate manual, including all rates. b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: 	N/A

		<ul style="list-style-type: none"> • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). <p>The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency.</p> <p>Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.</p>	<p>N/A</p>
<p>Amendments to Initial Rate/Rule Filings</p>			
<p>After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.</p>	<p><u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u></p>	<p>After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added.</p> <p>Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director.</p> <p>Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents.</p> <p>The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency.</p> <p>Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.</p>	<p>OK</p>
<p>EFFECTIVE DATES OF RATE/RULE FILINGS</p>			
<p>Illinois is "file and use" for medical liability rates and rules.</p>	<p><u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u></p>	<p>A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty Compliance Section, except as otherwise provided in Section 155.18.</p>	<p>OK</p>
<p>ADOPTIONS OF ADVISORY ORGANIZATION FILINGS</p>			
<p>Insurer must file all rates and rules on its own behalf.</p>	<p><u>50 IL Adm. Code 929</u></p>	<p>Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.</p>	<p>N/A</p>
<p>COPIES, RETURN ENVELOPES, ETC.</p>			

Requirement for duplicate copies and return envelope with adequate postage.	<u>50 IL Adm. Code 929</u>	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	OK
COVER LETTER & EXPLANATORY MEMORANDUM			
<p>Two copies of a submission letter are required, and the submission letter must contain the information specified.</p> <p>"Me too" filings are not allowed.</p> <p>Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.</p>	<p><u>215 ILCS 5/155.18</u></p> <p><u>50 IL Adm. Code 929</u></p> <p><u>Company Bulletin 88-53</u></p> <p><u>Actuarial Certification Form</u></p> <p><u>NAIC Uniform Transmittal Form</u></p>	<p>All filings must be accompanied by a submission letter which includes <u>all</u> of the following information:</p> <ol style="list-style-type: none"> 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify <u>all</u> changes in superseding filings, and <u>all</u> superseded filings, including the following information: <ul style="list-style-type: none"> • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. 	OK

		<p>Companies under the same ownership or general management are required to make <u>separate, individual company filings</u>. Company Group ("Me too") filings are unacceptable.</p> <p>If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.</p>	<p>OK</p>
<p>FORM RF-3 Summary Sheet</p>			
<p>For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.</p>	<p>50 IL Adm. Code 929 <u>Form RF-3 Summary Sheet</u></p>	<p>For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use.</p> <p>Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line.</p> <p>If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business.</p> <p>The RF-3 form must indicate whether the information is "exact" or "estimated."</p>	<p>OK</p>
<p>PAYMENT PLANS</p>			
<p>Quarterly premium payment installment plan required as prescribed by the Director.</p>	<p>215 ILCS 5/155.18</p>	<p>A company writing medical liability insurance in Illinois shall offer to each of its medical liability insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements:</p> <ul style="list-style-type: none"> • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no 	<p>Section VII page 3</p>

		<p>more than the lesser of 1% of the total premium or \$25;</p> <ul style="list-style-type: none"> • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than \$500. However, if offered to either, the plan must be made available to all within that group. 	<p>Section VII page 3</p>
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	N/A
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Section X page 5
CLAIMS MADE REQUIREMENTS			
Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2) Company Bulletin 88-50	<p>When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals:</p> <ul style="list-style-type: none"> • Offer of an extended reporting period (tail coverage) of <u>at least</u> 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which <u>must</u> be priced as a factor of one of the following:*** <ul style="list-style-type: none"> ○ the last 12 months' premium. ○ the premium in effect at policy issuance. ○ the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured 	Section IX page 3

requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated.

- Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request.
- Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.***
- Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first.

***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must:

- Offer free 5-year extended reporting period (tail coverage) or
- Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate expiring limits for the duration)
- Cap the premium at 200% of the annual premium of the expiring policy; and
- Give the insured a free-60 day period after the end of the policy to request the coverage.

Section IX
page 3

GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	N/A
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	Section VI page 3
ACTUARIAL REVIEW REQUIREMENTS			

<p>Rates shall not be excessive, inadequate, or unfairly discriminatory.</p>	<p>215 ILCS 5/155.18</p>	<p>In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory.</p> <p>Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive.</p> <p>The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.</p>	<p>OK</p>
<p>PRICING</p>			
<p>Insurers shall consider certain information when developing medical liability rates.</p>	<p>215 ILCS 5/155.18</p>	<p>Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois.</p> <p>Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers.</p> <p>The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.</p>	<p>N/A Rule Change Only</p>
<p>Minimum Premium Rules</p>			
<p>Insurers may group or classify risks for establishing rates and minimum premiums.</p>	<p>215 ILCS 5/155.18</p>	<p>Risks may be grouped by classifications for the establishment of rates and minimum premiums.</p>	<p>N/A</p>
<p>"A" RATED RISKS</p>			
<p>Individual Risk Rating</p>			

Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	N/A
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	N/A
Unfair methods of competition or unfair or deceptive acts or practices defined.	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	N/A
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	N/A
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	N/A
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	N/A Rule Change Only
ACTUARIAL OR STATISTICAL INFORMATION			

Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	N/A Rule Change Only
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The explanatory memorandum shall contain, at minimum, the following information: <ul style="list-style-type: none"> • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing. 	See Explanatory Memo
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	N/A Rule Change Only
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: <ul style="list-style-type: none"> • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc. 	N/A Rule Change Only
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	N/A
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	N/A Rule Change Only
Trend Factors and Analysis			

Insurers shall include support for trend factors and analysis.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	N/A
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	N/A
Loss Adjustment Expenses			
Insurers shall include support for loss adjustment expenses.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	N/A Rule Change Only
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	N/A
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	N/A
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	N/A
Other Actuarial Information Required			
Insurers must include the information described in this section.	<u>215 ILCS 5/155.18</u> <u>50 IL Adm. Code 929</u>	Insurers shall also include the following information: <ul style="list-style-type: none"> • All actuarial support/justification for all rates being changed, including but not limited to changes in: <ul style="list-style-type: none"> ○ Base rates; ○ Territory definitions; ○ Territory factor changes; ○ Classification factor changes; ○ Classification definition changes; ○ Changes to schedule credits/debits, etc. • Exhibits containing current and proposed rates/ 	N/A Rule Change Only

factors for all rates and classification factors, etc. being changed.

- Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.

Schedule Rating

Insurers must include the described information described at right.

215 ILCS 5/155.18
50 IL Adm. Code 929

Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.

N/A

JAN 01 2011

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

**PROFESSIONAL SOLUTIONS
INSURANCE COMPANY**
STATE OF ILLINOIS
DENTAL PROFESSIONAL LIABILITY MANUAL
CLAIMS MADE AND OCCURRENCE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This program covers Dentists engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan for a description of each risk/rating category for dentists.

Employees of Dentists are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to the listing of the mid-level dental providers who may be covered by either a shared or separate limit of liability.

This program also provides coverage for both dental clinics and individual practicing dentists for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the professional entity coverage section for a description of the partnership, corporation or professional association rating factors.

II. PREMIUM DETERMINATION

1. Determine the manual rate for the appropriate policy type and territory.
2. Refer to Classification Listing and apply the factor for the appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. If the policy is claims made, apply the appropriate claims made step factor to reach the undiscounted premium.
5. Apply discounts, as appropriate, for part-time or new practitioner.
6. Apply any applicable credits/debits for experience rating.
7. Apply any applicable credits/debits for schedule rating.
8. Apply rounding.
9. Example Premium Calculation:

Assume the full time undiscounted premium is \$1,000. Credits or debits will be applied in consecutive order.

\$1,000 x .95 =	\$950.00 (Claims Free credit of 5%)
\$950.00 x .95 =	\$902.50 (Schedule Rating credit of 5%)
\$902.50 =	\$903.00 (Apply rounding)

10. There will be a \$200.00 minimum premium for all dental policies.

III. POLICY PERIOD

The policy period shall be for a one-year term. Insureds added or removed mid-term will be pro-rated.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: \$1,234.30 is rounded to \$1,234.
\$1,234.60 is rounded to \$1,235.

V. PRACTICE LOCATION

The following parameters will be applied for dental providers who practice in multiple territories or states:

- A. For dental providers providing services under local or conscious sedation and/or facial cosmetics, the location of the primary office practice will determine the manual rate.
- B. For dental providers classified as Dental Anesthesiology or Oral & Maxillofacial – Major Surgery, the location of the primary healthcare facility practice will determine the manual rate.

- C. If a dental provider practices equally in two or more states or territories, the rate from the highest territory or state will be applied.

For the purposes of this section, primary means 51% or more of the dental provider's practice time is spent in the given territory or state.

The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro-rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard notice will be sent sixty (60) days prior to cancellation or non-renewal, except that in the event of non-payment of premium, then not less than ten (10) days prior notice of cancellation will be given.

VII. PREMIUM PAYMENT OPTIONS

- 1. Annual
- 2. Semi-Annual 50% prepayment required
- 3. Quarterly 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro-rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro-rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage – Claims Made Only

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for a Retroactive Date that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

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B. Automatic Reporting Extension – Claims Made Only

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Automatic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage – Claims Made Only

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents, which occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

<u># of Years Completed in Claims Made Program</u>	<u>Tail Factor</u>
1	0.654
2	0.975
3	1.062
4+	1.082

Premium is due in full at the time of purchase; no payment plans will be offered.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

<u># of Years of Continuous Coverage</u>	<u>Extended Reporting Coverage Credit</u>
1 full year	20%
2 full years	40%
3 full years	60%
4 full years	80%

D. Prior Acts Coverage, also called Nose Coverage – Occurrence Only

This endorsement will provide nose coverage for dentists who change from a claims made policy to an occurrence policy and do not purchase Extended Reporting Coverage from their previous carrier. Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date of the insured's previous claims made policy will be covered but only if no claim was made, no suit was brought and no knowledge existed of a possible claim prior to the effective date of this endorsement. The limit of liability provided by this option are the only limits that shall be applicable to the time period designated above. This endorsement can be applied to individual or entity policies.

The factors listed below will be applied to the undiscounted mature occurrence premium at the applicable limit of liability in the state in which the insured's previous claims made policy was issued.

<u># of Years in Claims Made Maturity</u>	<u>Nose Factor</u>
1	0.628
2	0.936
3	1.020
4+	1.039

E. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed sixty (60) days per policy term. A completed application must be submitted to the Company for prior underwriting approval.

X. DISCOUNTS

A. New Practitioner

A new practitioner is defined as a person who has completed his or her training, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1 st year	50% credit
2 nd year	30% credit
3 rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits.

B. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. Practitioners classified as Dental Anesthesiology or Oral & Maxillofacial – Major Surgery are not eligible for the part-time credit. The insured must complete an application for part-time credit. If the application is approved, the credit applied is 50% of the approved base premium:

Those who receive a part-time practitioner credit will not be eligible to receive any further credits.

XI. EXPERIENCE RATING

Claims free credits

A claim is defined as a paid claim with incurred indemnity equal to or greater than \$10,000.00 or an open claim with allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding \$50,000.00

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	10%
5+ yrs	15%

Claims debits

Claim frequency debit criteria:	Debit:
One (1) claim opened in the past five (5) years:	0%
Two (2) claims opened in the past five (5) years:	50%
Three (3) claims opened in the past five (5) years:	150%

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

- a. The applicant
- b. The agent or broker
- c. All previous insurers with respect to the experience period in question.

XII. SCHEDULE RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance 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 the following, subject to a maximum modification of a 25% credit to a 25% debit 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 actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

SCHEDULE RATING PROGRAM		Maximum Credit	Maximum Debit
Conscious Sedation	Procedures performed on patients who have been treated with light to moderate conscious sedation, including but not limited to nitrous oxide.	0%	10%
Facial Cosmetics	Elective cosmetic/aesthetic procedures, including but not limited to Botox injections, hyaluronic acid injections and dermal fillers.	0%	25%
Historical Loss Experience	The frequency or severity of claims for the insured is greater/less than expected experience for an insured of the same classification/size or recognition of unusual circumstances of claims in the loss experience.	25%	25%
Cumulative Years of Patient Experience	The insured demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	5%	5%
Classification Anomalies	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of a recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.	25%	25%
Claims Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or unusual circumstances of a claim(s) which understate/overstate the severity of the claims(s).	10%	10%
Management Control	Specific operational activities undertaken by the insured	10%	10%

Procedures	to reduce the frequency and/or severity of claims.		
Number/Type of Patient Exposures	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	10%	10%
Organizational Size / Structure	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	5%	5%
Medical Standards, Quality & Claim Review	Presence of a committee that meets on a routine basis to (1) review dental procedures, treatments, and protocols and assist in the integration of such into the practice; (2) assure the quality of the dental care being rendered; and/or (3) provide consistent review of claims/incidents that have occurred and develop corrective action.	10%	10%
Other Risk Management Practices and Procedures	Additional activities undertaken with specific intention of reducing the frequency or severity of claims.	10%	10%
Training, Accreditation & Credentialing	The insured exhibits greater/less than normal participation and support of such activities.	10%	10%
Record – Keeping Practices	Degree to which the insured incorporates methods to maintain quality patient records, referrals, and test results	5%	5%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in dental treatment and equipment into the practice, or failure to meet accepted standards of care.	10%	10%
Maximum cumulative schedule credit / debit		25%	25%

XIII. ENDORSED COVERAGES – Coverage Options

Active Military Suspension Endorsement – PSIC-DDS-02CM and PSIC-DDS-02OCC

This endorsement suspends coverage, including premium payments, if an insured is called to active military duty. This endorsement provides coverage for claims arising from acts, errors or omissions that occurred prior to the inception of the active military leave. There is no coverage for acts, errors or omissions during the period of active military duty. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail) while on active military duty.

Additional Interests Endorsement – PSIC-DDS-04

This optional endorsement provides coverage for an additional interest. For an individual practice, the charge for this endorsement will be up to 15% of the named insured's undiscounted manual premium for each additional interest. For a group practice, the charge for this endorsement will be up to 15% of the undiscounted manual rate of the top 5 highest rated dental providers for each additional interest.

The addition of an additional interest will be based upon the underwriter's assessment of additional exposure imputed to an insured dentist, solo practitioner corporation, partnership or multi shareholder corporation.

Locations or services being provided by the additional interest to or on behalf of the Named Insured are financially and medically controlled by the Named Insured.	5%
Locations or services being provided by the additional interest to or on behalf of the Named Insured are not financially controlled by the Named Insured.	10%
Locations or services being provided by the additional interest to or on behalf of the Named Insured are not financially and medically controlled by the Named Insured.	15%

Temporary Leave of Absence Endorsement – PSIC-DDS-05CM and PSIC-DDS-05OCC

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate

reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro-rata basis for the period of the qualifying disability.

For claims made policies, while on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave or any other reason pre-approved by Professional Solutions Insurance Company – does not apply to vacations.

Extended Reporting Endorsement – PSIC-DDS-06 (Claims Made only)

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Prior Acts Endorsement – PSIC-DDS-07 (Occurrence only)

This endorsement will provide nose coverage for dentists who change from a claims made policy to an occurrence policy and do not purchase Extended Reporting Coverage from their previous carrier. Under this endorsement, injuries which occurred on or after the retroactive date and before the expiration date of the insured's previous claims made policy will be covered.

Accelerated Vesting For Extended Reporting Period Endorsement - PSIC-DDS-08 (Claims Made only)

This endorsement amends the years of continuous coverage requirement for the Extended Reporting Endorsement at no additional charge upon retirement.

Vicarious Liability for Affiliated Dental Provider Endorsement – PSIC-DDS-09

Coverage is provided for the vicarious liability of the affiliated dental provider(s) stated in the endorsement, who at the time of the alleged incident, were not otherwise named as an insured under the policy. There is a 25% additional premium charge for each affiliated dentist and a 3% additional premium charge for each affiliated mid-level dental provider.

Covered Dentist Locum Tenens Endorsement – PSIC-DDS-10

This endorsement adds coverage for the substitute dentist listed on the endorsement while the named insured is temporarily absent from professional practice. There is no additional premium for this endorsement.

Covered Dentist Slot Endorsement – PSIC-DDS-11 (Claims made only)

A slot is used to accommodate one full-time position for a given specialty in practices with a high position turnover. This endorsement provides one separate limit of liability to be shared by the covered slot dentists within the same slot position as designated in the endorsement. All covered slot dentists within a slot position must have the same classification. The premium for the slot position is based on the full-time, mature rate for the given classification.

Covered Full Time Equivalent Dentist Endorsement – PSIC-DDS-12 (Claims Made only)

A Full-time Equivalency (FTE) is used to accommodate multiple dentists sharing one or more full-time positions within the given specialty. This endorsement provides one separate limit of liability to be shared

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by the covered FTE dentists within the same FTE position as designated in the endorsement. All covered FTE dentists within an FTE position must have the same classification. The premium for the FTE position is based on the total hours of practice of the FTE position and the full-time, mature rate for the given classification.

Illinois Restricted Practice Endorsement – PSIC-DDS-IL-04

This endorsement excludes the designated specialty, procedure or practice activity for the insured(s) specified on the endorsement. The Named Insured’s signature is required on this endorsement.

Illinois Vicarious Liability Risks Excluded Endorsement – PSIC-DDS-IL-03

This endorsement excludes any vicarious liability arising from professional services provided by, or which should have been provided by, any excluded dental provider(s) designated on the endorsement. The Named Insured’s signature is required on this endorsement.

Facial Cosmetics Endorsement – PSIC-DDS-15

This endorsement amends the definition of Professional Services to include facial cosmetic/aesthetic procedures that are adjunct to dental care, performed by the dentist designated on the endorsement.

XIV. CLASSIFICATION PLAN

<u>Specialty Codes</u>	<u>Class</u>	<u>Description</u>	<u>FACTOR</u>
80211	1	Dentist incl. Local anesthesia and/or oral medication only	1.00
		Dentist incl. Conscious Sedation	
		Dentist incl. Facial Cosmetics	
80210	4	Dental Anesthesiology	4.50
80210	5	Oral & Maxillofacial – Major Surgery	6.00

XV. PROFESSIONAL ENTITY COVERAGE

A. Solo Practitioner Corporation:

Coverage for an insured’s professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed dentists.

B. Shared Limits of Liability:

Coverage for professional entities other than solo practitioners may be written with a shared limit of liability. The charge for shared limits of liability will be 3% of the discounted manual rate of all insured providers, with the maximum premium limited to a cap of the top 10 highest rated dental providers listed of the Declarations and Schedule of Insureds when calculating the premium.

C. Separate Limits of Liability:

Coverage for professional entities may be written with a separate limit of liability. The premium charge for separate limits in which all members, stockholders or employees are insured with Professional Solutions Insurance Company will be 10% of the discounted manual rate of all insured providers, with the maximum premium limited to a cap of the top 10 highest rated dental providers listed on the Declarations and Schedule of Insureds when calculating the premium.

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XVI. MID-LEVEL HEALTHCARE PROVIDER COVERAGE

A. Shared Limits of Liability:

Coverage for licensed, mid-level providers may be written so the mid-level providers share a separate limit of liability with another insured as stated on the Schedule of Mid-level Providers. There is no additional premium charge for up to 5 mid-level providers sharing in a separate limit. More than 5 mid-level providers requesting to share in a separate limit will be referred to Underwriting.

B. Separate Limits of Liability:

Coverage for licensed, mid-level providers is available on an individual, separate limits basis for employees of dentists insured by PSIC.

Mid-Level Provider Classification Plan

<u>Specialty Codes</u>	<u>Mid-Level Dental Provider</u>	<u>Separate Limit Factor</u>
80211	Expanded Functions Dental Assistant	0.200

XVII. RATES

Claims Made Base Rate (for Class 1 provider @ 100/300 limits)

<u>Illinois Territory 01 (Cook County)</u>	\$1,529.00
<u>Illinois Territory 02 (Remainder of State)</u>	\$838.00

Occurrence Base Rate (for Class 1 provider @ 100/300 limits)

<u>Illinois Territory 01 (Cook County)</u>	\$1,662.00
<u>Illinois Territory 02 (Remainder of State)</u>	\$911.00

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
\$100,000/\$300,000	1.00
\$200,000/\$600,000	1.14
\$250,000/\$750,000	1.31
\$500,000/\$1,000,000	1.33
\$1,100,000/\$3,000,000	1.56
\$2,000,000/\$4,000,000	1.72

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.32

2	0.60
3	0.81
4	0.90
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

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