

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Filing at a Glance

Company: Medicus Insurance Company
Product Name: Medical Professional Liability Insurance SERFF Tr Num: MEIC-125871779 State: Arkansas
TOI: 11.1 Medical Malpractice - Claims Made Only SERFF Status: Closed State Tr Num: #? \$?
Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations Co Tr Num: AR-111408-IF RATE State Status: Fees not received
Filing Type: Rate/Rule Co Status: Reviewer(s): Betty Montesi, Edith Roberts
Author: Paula Battistelli Disposition Date: 11/17/2008
Date Submitted: 11/13/2008 Disposition Status: Filed
Effective Date Requested (New): On Approval Effective Date (New):
Effective Date Requested (Renewal): On Approval Effective Date (Renewal):
State Filing Description:

General Information

Project Name: Initial Filing Status of Filing in Domicile: Not Filed
Project Number: AR-111508-Initial Filing Domicile Status Comments:
Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:
Filing Status Changed: 11/17/2008
State Status Changed: 11/14/2008 Deemer Date:
Corresponding Filing Tracking Number: AR-111408-IF Rate
Filing Description:
This is the initial rate/rule filing for the Medicus medical professional liability program in Arkansas.

Company and Contact

Filing Contact Information

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Paula Battistelli, Regulatory Compliance pbattistelli@medicusins.com
Coordinator
8500 Shoal Creek Blvd, Ste 3, Bldg 200 (512) 879-5128 [Phone]
Austin, TX 78757 (877) 686-0558[FAX]

Filing Company Information

Medicus Insurance Company CoCode: 12754 State of Domicile: Texas
8500 Shoal Creek Blvd, Bldg 3, Ste 200 Group Code: 11 Company Type:
Austin, TX 78757 Group Name: Property and State ID Number:
Casualty
(866) 815-2023 ext. [Phone] FEIN Number: 20-5623491

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Filing Fees

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

SERFF Tracking Number: MEIC-125871779 State: Arkansas
 Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
 Company Tracking Number: AR-111408-IF RATE
 TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
 Product Name: Medical Professional Liability Insurance
 Project Name/Number: Initial Filing/AR-111508-Initial Filing

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Edith Roberts	11/17/2008	11/17/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Edith Roberts	11/14/2008	11/14/2008	Paula Battistelli	11/14/2008	11/14/2008

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Disposition

Disposition Date: 11/17/2008

Effective Date (New):

Effective Date (Renewal):

Status: Filed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MEIC-125871779 State: Arkansas
 Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
 Company Tracking Number: AR-111408-IF RATE
 TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
 Product Name: Medical Professional Liability Insurance
 Project Name/Number: Initial Filing/AR-111508-Initial Filing

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Filed	Yes
Supporting Document	NAIC Loss Cost Filing Document for OTHER than Workers' Comp	Filed	Yes
Supporting Document	NAIC loss cost data entry document	Filed	Yes
Supporting Document	Form PROMAL	Filed	Yes
Supporting Document	Form PRONOT	Filed	Yes
Supporting Document	Actuarial Memorandum	Filed	Yes
Supporting Document	PC RLC Form	Filed	Yes
Supporting Document	Medical Malpractice Survey	Filed	Yes
Rate (revised)	Rate Manual	Filed	Yes
Rate	Rate Manual	Filed	Yes

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/14/2008

Submitted Date 11/14/2008

Respond By Date

Dear Paula Battistelli,

This will acknowledge receipt of the captioned filing.

Pursuant to our telephone conversation, I understand you will be sending the appropriate filing fees for both the Form Filing (SERFF Tracking # MEIC-125877924) and for this rate filing.

Please reference Rule M. "Individual Risk Rating", which references AR Code Anno. 23-67-219. This code is not applicable to medical malpractice, but rather please reference AR Code Anno. 23-67-505(a) which states "Every malpractice insurer shall file with the Insurance Commissioner every manual of classifications, rule and rates, every rating plan and every modification of any manual classification, rule or rate that it proposes to use in this state.

Therefore, any individually rated risk must be filed with the Commissioner of Insurance, advising of the reason for departing from filed rating plans, along with the amount of the premium, policy limits, policy number and signature of the insured. Please amend the rule by including the instructions to file IRs with the Department.

When filing a med mal rate, you must complete and submit electronically, the excel spreadsheet which may be found at: <http://www.insurance.arkansas.gov/PandC/RR23Forms/MM%20Survey%20FORM%20MMPCS.xls> We must receive this before the filing is considered complete.

Additionally, we must also ask that you complete Form PC-RLC that is required under Rule & Regulation 23. This form may be accessed here:

<http://www.insurance.arkansas.gov/PandC/RR23Forms/FORM%20RF-1%20Rate%20Filing%20Abstract.doc>

Please chose "RF-1" which will direct you to Form PC RLC. Please disregard the title "NAIC Loss Cost Data Entry Document". Under #2, please inform this IS NOT a "Loss Cost" filing.

Thank you.

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Please refer to Rule M., " Individual Risk Rating",

Please feel free to contact me if you have questions.

Sincerely,

Edith Roberts

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/14/2008
Submitted Date	11/14/2008

Dear Edith Roberts,

Comments:

Response 1

Comments: The following documents are attached:

1. The Medical Malpractice Survey
2. The PC RLC form

In addition, I have revised the individual risk rating rule on the Medicus manual. Please see page 23. Thank you.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: PC RLC Form

Comment:

Satisfied -Name: Medical Malpractice Survey

Comment:

No Form Schedule items changed.

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Rate/Rule Schedule Item Changes

Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #
Rate Manual		New	
Previous Version			
Rate Manual		New	

Sincerely,
Paula Battistelli

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MEIC-125871779 State: Arkansas
 Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
 Company Tracking Number: AR-111408-IF RATE
 TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
 Product Name: Medical Professional Liability Insurance
 Project Name/Number: Initial Filing/AR-111508-Initial Filing

Rate/Rule Schedule

Review Status:	Exhibit Name:	Rule # or Page #:	Rate Action	Previous State Filing Attachments Number:
Filed	Rate Manual		New	AR Rate Manual 111408.pdf



MANUAL

SECTION I

GENERAL RULES

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

I. PURPOSE OF MANUAL

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

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

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

II. POLICY TERM

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

III. LOCATION OF PRACTICE

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

The Territory Definitions are:

AREA 1 COUNTIES

Entire State

IV. PREMIUM COMPUTATION

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

V. FACTORS OR MULTIPLIERS

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

VI. WHOLE DOLLAR RULE

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

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

VII. ADDITIONAL PREMIUM CHARGES

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

VIII. RETURN PREMIUM FOR MID-TERM CHANGES

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

IX. POLICY CANCELLATIONS

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

IX. POLICY CANCELLATIONS (continued)

1. A policy is canceled at the Company's request,
 2. The insured is leaving a group practice, or
 3. Death, Disability or Retirement of the Insured.
- B. If cancellation is for any other reason than stated in A above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

X. POLICY MINIMUM PREMIUM

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

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

XI. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. The premium payment plan requires a minimum of 25% of the total premium to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

XII. COVERAGE

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

XIII. LIMITS OF LIABILITY

The Basic Limits of Liability are \$1,000,000 per claim/ \$3,000,000 annual aggregate.

XIV. PRIOR ACTS COVERAGE

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

XV. EXTENDED REPORTING ENDORSEMENT

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

XV. EXTENDED REPORTING ENDORSEMENT (continued)

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Endorsement.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:
 - 1. The extended reporting endorsement factor is 200%.
 - 2. For First Year Claims Made step, it is applied pro-rata.
 - 3. For Second Year and all years of maturity, it is applied to the expiring premium.
- D. Premium is fully earned and must be paid, in accordance with state statutes, promptly when due.
- E. Requirements for Waiver of Premium for Extended Reporting Endorsement:
 - 1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and the Extended Reporting Endorsement will be granted for no additional charge, subject to policy provisions.
 - 2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine 3.
 - 3. Or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company,

An Extended Reporting Endorsement will be granted for no additional charge subject to policy provisions.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. DEFINITION

- A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:
- Professional Corporations, Partnerships and Associations
- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:
1. Are organized as a legal entity;
 2. Maintain common facilities (including multiple locations) and support personnel; and
 3. Maintain medical/dental records of patients of the group as a historical record of patient care.
- C. An exception to this rule is the Affinity Credit on Page 19.

II. PREMIUM COMPUTATION

- A. If shared limits for the entity is desired, such coverage shall be provided at no additional premium charge, and no endorsement is necessary.
- B. If separate limits are desired, an endorsement to convert the entity coverage from shared limits to separate limits shall be necessary.
- C. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met.
- D. The premium for professional corporations, partnerships and associations, limited liability companies, or other entities may be written with a separate limit of liability and shall be computed in the following manner:

The premium will be a percentage (selected from the table below) of the sum of each physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage, the company must insure all

II. PREMIUM COMPUTATION (continued)

member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the Company.

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

III. PREMIUM MODIFICATIONS

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

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

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

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in the Physician/Surgeon and Health Care Provider Section of Pages 10 to 14.

- END OF SECTION II-

SECTION III

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

I. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a specialty code according to his/her specialty. When more than one specialty is applicable, the highest rate classification shall apply.
2. The specialty codes will be contained on Specialty Class Plan on Pages 10-14.

B. Locum Tenens Physician

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

C. Blending Rates

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

I. CLASSIFICATIONS (continued)

D. Slot Rating

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

E. Per-Patient Visit Rating

1. Standard Claims Made coverage for group practices is available, at the Company's option, on a per-patient visit basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.
2. The number of per-patient visits equivalent to a physician year is 2500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.
3. The applicable medical specialty rate is divided by the equivalent per-patient visits resulting in the per-patient visit rate to be applied to the visits projected for the policy period. The product of the per patient rate and the projected visits results in the indicated manual premium.
4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.
5. Premium modifications for new physician, part time, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

II. PREMIUM COMPUTATION DETAILS

A. Specialty Class Plan

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

PHYSICIANS & SURGEONS

Specialty	ISO Code	Class
Abdominal Surgery	80166	9
Administrative Medicine	80240(a)	1
Aerospace Medicine	80133	1
Allergy/Immunology	80254	1
Anesthesiology- All Other	80183	5
Anesthesiology- Critical Care Medicine	80181	5
Anesthesiology- Pain Management	80182	5
Broncho-Esophagology	80101	4
Cardiac Surgery	80141	14
Cardiothoracic Surgery	80150(a)	14
Cardiovascular Disease - Minor Surgery	80281	5
Cardiovascular Disease - No Surgery	80255	3
Cardiovascular Surgery	80150	14
Colon and Rectal Surgery	80115	7
Dentistry	80210	1
Dermatology - All Other - Minor Surgery	80297(a)	3
Dermatology - All Other - No Surgery	80297	1
Dermatology - Clinical and Dermatological		
Immunology - No Surgery	80295	1
Dermatology - Dermatology	80296	1
Diabetes - Minor Surgery	80271	5
Diabetes - No Surgery	80237	2
Emergency Medicine - including Major Surgery	80157	11
Emergency Medicine - No Major Surgery	80102	8
Endocrinology- Minor Surgery	80272	4
Endocrinology- No Surgery	80238	2
Endocrinology Surgery	80103	9
Family/General Practice w/Major Surgery & OB	80117(a)	9
Family Physicians or General Practitioners - Minor Surgery	80421	7
Family Physicians or General Practitioners - No Surgery	80420	3
Forensic Medicine	80240	1
Gastroenterology - Minor Surgery	80274	5
Gastroenterology - No Surgery	80241	3
Gastroenterology - Surgery	80104	10
General Practice of Family Practice Surgery	80117	8
General Surgery	80143	11
Geriatrics - Minor Surgery	80276	5

Specialty (Continued)	ISO Code	Class
Geriatrics - No Surgery	80243	3
Geriatrics - Surgery	80105	9
Gynecology - Minor Surgery	80277	5
Gynecology - No Surgery	80244	3
Gynecology - Surgery	80167	9
Hand Surgery	80169	9
Head and Neck Surgery	80170	10
Head and Neck Surgery - No Plastic	80170(a)	9
Hematology - Minor Surgery	80278	5
Hematology - No Surgery	80245	3
Hospitalists - Including ER	80222(b)	8
Hospitalists - Invasive	80222(a)	5
Hospitalists - Non-Invasive	80222	3
Hypnosis	80232	3
Infectious Diseases - Minor Surgery	80279	5
Infectious Diseases - No Surgery	80246	3
Intensive Care Medicine	80283	4
Internal Medicine - Minor Surgery	80284	5
Internal Medicine - No Surgery	80257	3
Laryngology - Minor Surgery	80285	5
Laryngology - No Surgery	80258	3
Laryngology - Surgery	80106	7
Legal Medicine	80240	1
Neonatal/Perinatal Medicine	80804	5
Neonatology - Major Surgery	80804(a)	11
Neoplastic Diseases - Minor Surgery	80286	5
Neoplastic Diseases - No Surgery	80259	3
Neoplastic - Surgery	80107	10
Nephrology - including Child - Minor Surgery	80288	5
Nephrology - Minor Surgery	80287	5
Nephrology - No Surgery	80260	2
Nephrology - Surgery	80108	8
Neurology - including Child - Minor Surgery - All Other	80299(a)	5
Neurology - including Child - No Surgery - All Other	80299	5
Neurology - including Child - No Surgery – Pain Management	80298	5
Neurology - including Child - Surgery	80152	15
Nuclear Medicine	80262	3
Nutrition	80248	1
Obstetrics & Gynecology Surgery	80153	16
Obstetrics Surgery	80168	16
Occupational Medicine	80134	1
Oncology - Minor Surgery	80301	5
Oncology - No Surgery	80302	3
Oncology - Surgery	80164	11
Ophthalmology - Minor Surgery	80289	3
Ophthalmology - No Surgery	80263	2
Ophthalmology - Surgery	80114	5

Specialty (Continued)	ISO Code	Class
Orthopedics Minor Surgery	80204	5
Orthopedics - No Surgery	80205(a)	3
Orthopedic Surgery Not Including Spine	80154	12
Orthopedic Surgery Including Spine	80154(s)	13
Otology - Minor Surgery	80290	5
Otology - No Surgery	80264	3
Otology - Surgery	80158	7
Otorhinolaryngology - Minor Surgery	80291	5
Otorhinolaryngology - No Surgery	80265	3
Otorhinolaryngology - Surgery	80159	10
Otorhinolaryngology - Surgery - Incl Plastic	80155	10
Otorhinolaryngology - Surgery - No Plastic	80159(a)	7
Pain Management - Basic Procedures	80182(b)	5
Pain Management - Intermediate Procedures	80182(c)	14
Pain Management - Advanced Procedures	80182(d)	15
Pain Management - No Surgery	80182(a)	5
Pathology - All Other	80307	1
Pathology - Blood Banking/Transfusion Medicine - Minor Surgery	80303	2
Pathology - Blood Banking/Transfusion Medicine - No Surgery	80304	1
Pathology - Cytopathology - Minor Surgery	80305	3
Pathology - Cytopathology - No Surgery	80306	1
Pediatrics - Minor Surgery	80293	6
Pediatrics - No Surgery	80267	4
Pediatrics - Surgery	80180	9
Perinatology	80153(a)	16
Pharmacology - Clinical	80234	1
Physiatry	80209(a)	3
Physical Medicine and Rehabilitation - All Other	80209	3
Physical Medicine and Rehabilitation - Pain Management	80208	5
Physician (NOC) - Minor Surgery	80294	5
Physician (NOC) - No Surgery	80268	4
Physician - No Major Surgery - including Acupuncture	80437	3
Physician - No Major Surgery - including Colonoscopy	80443	5
Physician - No Major Surgery - including Discograms	80428	5
Physician - No Major Surgery - including Lasers - used in therapy	80425	5
Plastic Surgery	80156	10
Podiatry	80943	7
Preventive Medicine - No Surgery		
Undersea/Hyperbaric Medicine	80139	1
Psychiatry - Addiction Psychiatry	80224	3
Psychiatry - All Other	80229	3
Psychiatry - Child and Adolescent Psychiatry	80226	3
Psychiatry - Forensic Psychiatry	80227	3

Specialty (Continued)	ISO Code	Class
Psychiatry - Geriatric Psychiatry	80228	3
Psychoanalysis	80250	3
Psychosomatic Medicine	80251	3
Public Health Medicine - No Surgery	80135	2
Pulmonary Diseases - No Surgery	80269	4
Radiation Oncology	80359(a)	6
Radiology - Diagnostic - Minor Surgery	80280	6
Radiology - Diagnostic - No Surgery	80253	4
Radiology - Interventional	80360	6
Radiology - Therapeutic - Minor Surgery	80358	6
Radiology - Therapeutic - No Surgery	80359	4
Rheumatology - No Surgery	80252	2
Rhinology - Minor Surgery	80270	5
Rhinology - No Surgery	80247	3
Rhinology - Surgery	80160	7
Sports Medicine - No Surgery	80205	3
Thoracic Surgery	80144	14
Traumatic Surgery	80171	14
Urgent Care	80102(a)	4
Urological - Surgery	80145	6
Urology - Minor Surgery	80120	5
Urology - No Surgery	80121	3
Vascular Surgery	80146	14
Acupuncturists	80966	Y
X-Ray Technicians	80713	Y
Dental Hygienists	80712	Y
Certified Registered Nurse Anesthetist - Shared	80960	C-1
Psychologists	80975	1
Art, Music and Dance Therapists	80967	Y
Audiologists	80968	Y
Certified Registered Nurse Anesthetist - Separate Limit	80960	C-2
Inhalation/Respiratory Therapists	80969	Y
Massage Therapists	80970	Y
Medical Technologists	80971	Y
Nurse LPN or RN	80963	Y
Nurse Midwife	80962	N
Nutritionists/Dieticians	80972	Y
Occupational Therapists	80973	Y
Opticians	80937	Y
Optometrist	80994	Y
Orthotists/Prosthetists	80974	Y
Pharmacists	59112	Y
Physicians or Surgeons Assistants	80116	Z
Nurse Practitioner	80964	Z
Physiotherapists	80938	X

B. Manual Rates

2. Standard Claims Made Program Step Factors and Mature Rates

Step Factors:

First Year:	32%
Second Year:	59%
Third Year:	80%
Fourth Year:	92%
Fifth Year (Mature):	100%

PHYSICIANS AND SURGEONS

RATE TABLE

Mature Rates (Claims-made)

Terr 1 – Entire State

1M/3M	Rate	Class
		1
	\$4,994	
		2
	\$6,659	
		3
	\$8,323	
		4
	\$9,322	
		5
	\$12,069	
		6
	\$14,149	
		7
	\$15,814	
		8
	\$18,727	
		9
	\$22,889	
		10
	\$24,970	
		11
	\$29,131	
		12
	\$31,212	
		13
	\$33,293	
		14
	\$41,616	
		15
	\$56,182	
		16
	\$60,343	

NON PHYSICIAN HEALTHCARE PROVIDERS

RATE TABLE (1M/3M LIMITS) (Claims-made)

RATE CLASS	Separate limits	Shared limits
N	50% of Class 16	N/A
X	10% of Class 1	0% of Class 1
Y	15% of Class 1	0% of Class 1
Z	25% of Class 1	10% of Class 1
C-1	N/A	20% of Class 6
C-2	25% of Class 6	N/A

III. PREMIUM MODIFICATIONS

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

C. Part Time Physicians

A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction of 30 % on the otherwise applicable rate for that specialty.

A Part Time Practitioner may include any practitioner in classes 1 through 8 and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

D. Physicians in Training

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

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

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
 - a. Residency;
 - b. Fellowship program in their medical specialty;
 - c. Fulfillment of a military obligation in remuneration for medical school tuition;
 - d. Medical school or specialty training program.
2. A reduced rate of 30% will apply for the first two years of practice.

F. Physician Teaching Specialists

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

E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.
3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free.

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

F. Claim Free Credit (continued)

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

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than the amount noted below depending on the specialty rate class. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds who have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in Arkansas, and/or following completion of residency or fellowship.

Rate Class	ALAE and/or Indemnity Payments
1-8	\$10,000
9-11	\$15,000
12-14	\$20,000
15-16	\$30,000

G. Affinity Credit

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

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

G. Affinity Credit (continued)

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

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

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

H. Elite Credit

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

1. Board certification in area of specialization
2. No history of impairment or substance abuse
3. No incident (unless closed without any payment), including notice of a claim, claim tendered, incurred, or paid indemnity or allocated loss adjustment expense incurred or paid, and Medical Board actions reported to current or previous insurer, validated by a company generated loss run

and/or a sworn signed statement by the physician/group and the insured's agent covering the past four years qualifies a physician for consideration

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

I. Schedule Rating

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

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

Schedule Rating: Modifications, subject to Underwriting:

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

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

Maximum Modification	+ / - 25 %
----------------------	------------

J. Experience Rating

This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.

On an optional basis, large risks with sufficiently credible loss experience may be loss-rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least \$100,000 in estimated annual premium.

The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.

Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at \$250,000 per loss.

The experience period does not include the 12-month period immediately prior to the effective date of the experience modification.

The experience rating modification is calculated using the following formula:

$$\text{Credibility} \times \frac{\text{Adjusted Actual Loss Ratio} - \text{Adjusted Expected Loss Ratio}}{\text{Adjusted Expected Loss Ratio}} = \text{Experience Mod.}$$

Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.

K. Risk Management Credit

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

L. Deductible Credits

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

1. Individual Deductibles

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

INDEMNITY ONLY DEDUCTIBLE PER CLAIM		INDEMNITY AND ALAE DEDUCTIBLE PER CLAIM	
	<u>1M/3M</u>		<u>1M/3M</u>
\$5,000	2.50%	\$5,000	4.0%
\$10,000	4.50%	\$10,000	7.50%
\$15,000	6.00%	\$15,000	9.6%
\$20,000	8.00%	\$20,000	11.4%
\$25,000	9.00%	\$25,000	13.0%
\$50,000	15.00%	\$50,000	19.0%
\$100,000	25.00%	\$100,000	28.0%
\$200,000	37.50%	\$200,000	42.5%
\$250,000	42.00%	\$250,000	50.0%

2. Group Deductibles

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

Indemnity Deductible Per Claim / Aggregate (\$000)

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	2.0%	1.8%	1.5%	1.2%	\$12,750
10/30	3.8%	3.5%	3.0%	2.4%	\$25,500
25/75	8.4%	7.9%	7.0%	5.8%	\$63,750
50/150	14.5%	13.9 %	12.7 %	10.9%	\$127,500
100/300	23.4%	22.8 %	21.6 %	19.6%	\$255,000
200/600	34.8%	34.6 %	33.8 %	32.1%	\$510,000
250/750	38.5%	38.5 %	38.1 %	36.8%	\$637,500

The following Group Deductibles are available for Indemnity & ALAE. (\$000)

Indemnity & ALAE Deductible Per Claim/Aggregate Deductible	Number of Insureds				Max Credit
	2-19	20-40	41-60	61-100	
5/15	2.9%	2.6%	2.1%	1.7%	\$12,750
10/30	6.8%	6.3%	5.4%	4.3%	\$25,500
25/75	11.9%	11.2%	9.9%	8.2%	\$63,750
50/150	18.6%	17.9%	16.3%	14.0%	\$127,500
100/300	25.8%	25.2%	23.9%	21.6%	\$255,000
200/600	39.6%	39.4%	38.5%	36.6%	\$510,000
250 /750	46.7%	46.7%	46.2%	44.6%	\$637,500

M. Individual Risk Rating

A risk may be individually rated per the Arkansas Department of Insurance Code 23-67-505(a). Any individually rated risk must be filed with the Arkansas Department of Insurance. It should include the reason for departure from the filed rating plan, the amount of premium, policy limits, policy number, and signature of the insured.

- END OF MANUAL-

SERFF Tracking Number: MEIC-125871779 State: Arkansas
 Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
 Company Tracking Number: AR-111408-IF RATE
 TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
 Product Name: Medical Professional Liability Insurance
 Project Name/Number: Initial Filing/AR-111508-Initial Filing

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-Property & Casualty **Review Status:** Filed 11/17/2008

Comments:

Attachment:

AR Final Transmittal 111408.pdf

Bypassed -Name: NAIC Loss Cost Filing Document for OTHER than Workers' Comp **Review Status:** Filed 11/17/2008

Bypass Reason: We are not adopting an advisory organization's loss costs.

Comments:

Bypassed -Name: NAIC loss cost data entry document **Review Status:** Filed 11/17/2008

Bypass Reason: We are not adopting an advisory organization's loss costs.

Comments:

Bypassed -Name: Form PROMAL **Review Status:** Filed 11/17/2008

Bypass Reason: This is an initial rate filing for a new program.

Comments:

Bypassed -Name: Form PRONOT **Review Status:** Filed 11/17/2008

Bypass Reason: This is an initial rate filing for a new program.

Comments:

Satisfied -Name: Actuarial Memorandum **Review Status:** Filed 11/17/2008

Comments:

Attachment:

SERFF Tracking Number: *MEIC-125871779* *State:* *Arkansas*
Filing Company: *Medicus Insurance Company* *State Tracking Number:* *#? \$?*
Company Tracking Number: *AR-111408-IF RATE*
TOI: *11.1 Medical Malpractice - Claims Made Only* *Sub-TOI:* *11.1000 Med Mal Sub-TOI Combinations*
Product Name: *Medical Professional Liability Insurance*
Project Name/Number: *Initial Filing/AR-111508-Initial Filing*

Actuarial Memo.pdf

SERFF Tracking Number: MEIC-125871779 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-111408-IF RATE
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Filing/AR-111508-Initial Filing

Satisfied -Name: PC RLC Form **Review Status:** Filed 11/17/2008
Comments:
Attachment:
NAIC LOSS COST DATA ENTRY DOCUMENT.pdf

Satisfied -Name: Medical Malpractice Survey **Review Status:** Filed 11/17/2008
Comments:
Attachment:
MM Survey FORM MMPCS.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only

2. Insurance Department Use only	
a. Date the filing is received:	
b. Analyst:	
c. Disposition:	
d. Date of disposition of the filing:	
e. Effective date of filing:	
New Business	
Renewal Business	
f. State Filing #:	
g. SERFF Filing #:	
h. Subject Codes	

3. Group Name	Group NAIC #
Medicus Insurance Holdings, Inc.	

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Medicus Insurance Company	Texas	12754	20-5623491	2886

5. Company Tracking Number	AR-111408-IF Rate
-----------------------------------	-------------------

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Paula Battistelli Medicus Insurance Company 8500 Shoal Creek Blvd Bldg 3, Suite 200 Austin, TX 78757	Regulatory Compliance Coordinator	512-879-5128	877-686-0558	pbattistelli@medicusin s.com
7.	Signature of authorized filer		<i>Paula Battistelli</i>		
8.	Please print name of authorized filer		Paula Battistelli		

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	11.000 – Medical Malpractice Insurance
10. Sub-Type of Insurance (Sub-TOI)	11.000 – Physicians & Surgeons Medical Liability
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	Deductible Credits for Physicians & Surgeons
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input checked="" type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: On Approval Renewal: On Approval
15. Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Reference Organization (if applicable)	

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	AR-111408-IF Rate
2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	AR-110508-IF Form

Rate Increase
 Rate Decrease
 Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	File & Use
-----------	--	------------

4a. Rate Change by Company (As Proposed)							
Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
Medicus Insurance Company	New Program	New Program	New Program	New Program	New Program	New Program	New Program

4b. Rate Change by Company (As Accepted) For State Use Only							
Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)			
		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
7.	Effective Date of last rate revision	
8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	

9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01	Rate Manual	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA



November 13, 2008

Mr. Jeff Weigl, CPCU, ARM
Chief Underwriting Officer
Medicus Insurance Company
8500 Shoal Creek Blvd.
Austin, TX 78757

EVALUATION OF PROPOSED MEDICUS BASE PREMIUM RATE - ARKANSAS

Dear Jeff:

The Tillinghast insurance consulting business of Towers Perrin (Towers Perrin) has been asked by Medicus Insurance Company (Medicus) to evaluate their proposed physicians professional liability rate level for the state of Arkansas.

This letter was prepared to summarize our findings. It should be noted that our indications are subject to a number of reliances and limitations inherent to the estimation of loss and LAE, as described in subsequent sections of this letter.

Judgments about the analysis and findings presented herein should be made only after considering the document and attached exhibits in their entirety.

FINDINGS

Based on our review of Arkansas competitor filings and expense provisions provided by Medicus, we conclude that Medicus's proposed base rate of \$8,323 is not excessive, inadequate or unfairly discriminatory.

METHODOLOGY

State Volunteer Mutual Insurance Company (State Volunteer) is the dominant writer of physician medical professional liability coverage in the state of Arkansas, with almost 50% market share in 2007. We have reviewed their filing, which was effective May 15, 2008.

In the filed actuarial support for the rate change effective in 2008, State Volunteer presents a base class, base limit pure premium indication of \$4,750.

In the accompanying exhibits, we have applied Medicus's budgeted expenses to the pure premium indications from State Volunteer's actuarial support to calculate the proposed base class premium of \$8,323.

Medicus' budgeted expenses include:

- An average commission and reinsurance expense ratio of 17.9% of direct premium written (from Medicus's 2007 IEE)
- Claims handling expenses of 6.5% of Loss and Allocated Loss Adjustment Expenses (ALAE)
- Premium Taxes of 2.5% of direct written premium
- General and Other Acquisition expenses of 13.4% of direct written premium (from Medicus's 2007 IEE)
- 5% of direct written premium underwriting profit and contingency provision
- 4% of loss and LAE load for the Death Disability and Retirement tail provision

RELIANCES AND LIMITATIONS

Inherent Uncertainty

It must be understood that projections of loss and ALAE are subject to large potential errors of estimation, due to the fact that the ultimate disposition of claims to be incurred, is subject to the outcome of events that have not yet occurred. Examples of these events include jury decisions, court interpretations, legislative changes, changes in the medical condition of claimants, public attitudes, and social/economic conditions such as inflation. Any estimate of future costs is subject to the inherent limitation on one's ability to predict the aggregate course of future events. It should therefore be expected that the actual emergence of losses and ALAE will vary, perhaps materially, from any estimate. Thus, no assurance can be given that Medicus's actual loss and loss expense costs will not ultimately exceed the estimates anticipated in the indicated rates presented herein. Furthermore, there is no guarantee that the rate level indications will prove to be adequate or not excessive. In our judgment, we have employed techniques and assumptions that are appropriate, and the indications presented herein are reasonable, given the information currently available.

Extraordinary Future Emergence

We have not anticipated any extraordinary changes to the legal, social or economic environment that might affect the cost, frequency or future reporting of claims. In addition, our estimates make no provision for potential future claims arising from loss causes not represented in the historical data (e.g., new types of mass torts or latent injuries, terrorist acts, etc.), except insofar as claims of these types are included but not identified in data underlying competitor rates. Similarly, our calculations make no provision for any extraordinary changes in claim cost, frequency, or payment pattern resulting from new types of claims, tort reforms, or other types of legislative changes.

Risk Retention Considerations

Nothing in this report should be construed as recommending that Medicus should or should not consider writing or retaining risk in this coverage. Many factors other than the rate indications should be considered in that decision.

Because this rate has been selected from competitor filings, it does not consider and we have not examined the actual loss experience of the prospective insureds. We also have not considered the efficacy of Medicus's underwriting selection relative to the industry.

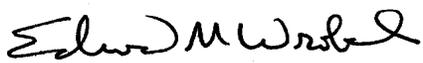
Expense Considerations

We are relying on the expense assumptions provided by Medicus, based both on their expenses as shown on their Insurance Expense Exhibit and based on their internal budgets. Actual expenses may vary from these projections.

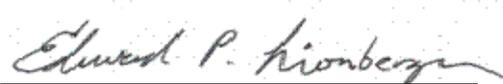
Please call with any questions or comments.

Sincerely,

TOWERS PERRIN

By: 

Edward Wrobel, FCAS, MAAA
Managing Principal
Direct Dial: (860) 843-7022

By: 

Edward Lionberger, FCAS, MAAA
Consultant
Direct Dial: (860) 843-7126

Medicus Insurance Company
Calculation of Implied Base Premiums With Medicus Expense Ratio

Exhibit 1

(1)	Industry Base Class Pure Premium: \$1,000,000 limit	\$4,750
(2)	Off - Balance for Claims Made Step	0.981
(3)	Discount Factor	0.862
(4)	Premium Payment Plan Factor	1.031
(5)	ULAE Loading	1.065
(6)	DD&R Loading	1.04
(7)	Discounted Base Class Pure Premium: \$1,000,000 limit, including ULAE and DD&R	\$4,587
(8)	Permissible Manual Loss and LAE Ratio	55.1%
(9)	Indicated Base Class Premium	\$8,323
(10)	Selected Base Class Premium	\$8,323

Notes:
(1) - (5) From State Volunteer Filing effective May, 15, 2008, Exhibit 2, Sheet 3
(5) (1) x (2) x (3) x (4) x (5) x (6)
(8) Exhibit 2, Line (5)
(9) (7) / (8)

Medicus Insurance Company
Derivation of Permissible Loss and LAE Ratio

Exhibit 2

(1)	Target Discounted Combined Ratio	95.0%
(2)	Budgeted Expenses (% of Premium):	
	a) General and Administrative Expense	13.4%
	b) Commission and Reinsurance Expense	17.9%
	c) Taxes, Licenses, and Fees	<u>2.5%</u>
	Total	33.8%
(3)	Permissible Charged Loss and LAE Ratio	61.2%
(4)	Assumed Average Premium Discount	-10.0%
(5)	Permissible Manual Loss and LAE Ratio	55.1%

Notes:
(1) Includes Profit and Contingency Load of 5%
(2) (a) and (b) from Medicus 2007 IEE
(3) (1) - (2)T
(4) Assumed - Based on proposed discount structure
(5) (3) x [1 + (4)]

NAIC LOSS COST DATA ENTRY DOCUMENT

1.	This filing transmittal is part of Company Tracking #	AR-111408-IF Rate
----	---	--------------------------

2.	If filing is an adoption of an advisory organization loss cost filing, give name of Advisory Organization and Reference/ Item Filing Number	This is not a loss cost filing
----	---	---------------------------------------

Company Name		Company NAIC Number	
3.	A.	Medicus Insurance Company	B. 12754

Product Coding Matrix Line of Business (i.e., Type of Insurance)		Product Coding Matrix Line of Insurance (i.e., Sub-type of Insurance)	
4.	A.	11.1 Medical Malpractice-Claims Made Only	B. 11.1000 Med Mal Sub-TOI Combinations

5.			FOR LOSS COSTS ONLY				
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
COVERAGE (See Instructions)	Indicated % Rate Level Change	Requested % Rate Level Change	Expected Loss Ratio	Loss Cost Modification Factor	Selected Loss Cost Multiplier	Expense Constant (If Applicable)	Co. Current Loss Cost Multiplier
Medical Professional Liability	New Program	New Program					
TOTAL OVERALL EFFECT	New Program	New Program					

6.		5 Year History		Rate Change History			
Year	Policy Count	% of Change	Effective Date	State Earned Premium (000)	Incurred Losses (000)	State Loss Ratio	Countrywide Loss Ratio
New Program	New Program	New Program	11/14/08	New Program	New Program	New Program	New Program

7.	
Expense Constants	Selected Provisions
A. Total Production Expense	-----
B. General Expense	13.4%
C. Taxes, License & Fees	2.5%
D. Underwriting Profit & Contingencies	5%
E. Other (explain): Commission and Reinsurance	17.9%
F. TOTAL	33.8%

8. NA Apply Lost Cost Factors to Future filings? (Y or N)
9. NA Estimated Maximum Rate Increase for any Insured (%). Territory (if applicable): NA
10. NA Estimated Maximum Rate Decrease for any Insured (%) Territory (if applicable): NA

**Malpractice Premium Comparison Survey Form
FORM MMPCS - last modified August, 2005**

USE THE APPROPRIATE FORM BELOW - IF NOT APPLICABLE, LEAVE BLANK

NAIC Number:	12754
Company Name:	Medicus Insurance Company
Contact Person:	Paula Battistelli
Telephone No.:	512-879-5128
Email Address:	pbattistelli@medicusins.com
Effective Date:	On Approval

Submit to: *Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904*

Telephone: 501-371-2800
 Email as an attachment to: insurance.pnc@arkansas.gov
 You may also attach to a SERFF filing or submit on a cdr disk

Physicians

Base Rate	Hospital	Clinic	Private
At	\$ NA	\$ NA	\$ NA
Discounts and Surcharges			
Emergency Room	NA %	NA %	NA %
Surgery	NA %	NA %	NA %
Delivery	NA %	NA %	NA %
Claims Free	NA %	NA %	NA %
Over 5 years Experience	NA %	NA %	NA %
Other:	NA %	NA %	NA %

Dental

Base Rate	Dentist	Orthodontist	Oral Surgeons
At	\$ NA	\$ NA	\$ NA
Discounts and Surcharges			
Claims Free	NA %	NA %	NA %
5 years Experience	NA %	NA %	NA %
Surgery	NA %	NA %	NA %
Other:	NA %	NA %	NA %



MANUAL

SECTION I

GENERAL RULES

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

I. PURPOSE OF MANUAL

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

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

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

II. POLICY TERM

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

III. LOCATION OF PRACTICE

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

The Territory Definitions are:

AREA 1 COUNTIES

Entire State

IV. PREMIUM COMPUTATION

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

V. FACTORS OR MULTIPLIERS

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

VI. WHOLE DOLLAR RULE

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

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

VII. ADDITIONAL PREMIUM CHARGES

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

VIII. RETURN PREMIUM FOR MID-TERM CHANGES

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

IX. POLICY CANCELLATIONS

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

IX. POLICY CANCELLATIONS (continued)

1. A policy is canceled at the Company's request,
 2. The insured is leaving a group practice, or
 3. Death, Disability or Retirement of the Insured.
- B. If cancellation is for any other reason than stated in A above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

X. POLICY MINIMUM PREMIUM

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

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

XI. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. The premium payment plan requires a minimum of 25% of the total premium to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

XII. COVERAGE

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

XIII. LIMITS OF LIABILITY

The Basic Limits of Liability are \$1,000,000 per claim/ \$3,000,000 annual aggregate.

XIV. PRIOR ACTS COVERAGE

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

XV. EXTENDED REPORTING ENDORSEMENT

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

XV. EXTENDED REPORTING ENDORSEMENT (continued)

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Endorsement.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:
 - 1. The extended reporting endorsement factor is 200%.
 - 2. For First Year Claims Made step, it is applied pro-rata.
 - 3. For Second Year and all years of maturity, it is applied to the expiring premium.
- D. Premium is fully earned and must be paid, in accordance with state statutes, promptly when due.
- E. Requirements for Waiver of Premium for Extended Reporting Endorsement:
 - 1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and the Extended Reporting Endorsement will be granted for no additional charge, subject to policy provisions.
 - 2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine 3.
 - 3. Or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company,

An Extended Reporting Endorsement will be granted for no additional charge subject to policy provisions.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. DEFINITION

- A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:
- Professional Corporations, Partnerships and Associations
- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:
1. Are organized as a legal entity;
 2. Maintain common facilities (including multiple locations) and support personnel; and
 3. Maintain medical/dental records of patients of the group as a historical record of patient care.
- C. An exception to this rule is the Affinity Credit on Page 19.

II. PREMIUM COMPUTATION

- A. If shared limits for the entity is desired, such coverage shall be provided at no additional premium charge, and no endorsement is necessary.
- B. If separate limits are desired, an endorsement to convert the entity coverage from shared limits to separate limits shall be necessary.
- C. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met.
- D. The premium for professional corporations, partnerships and associations, limited liability companies, or other entities may be written with a separate limit of liability and shall be computed in the following manner:

The premium will be a percentage (selected from the table below) of the sum of each physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage, the company must insure all

II. PREMIUM COMPUTATION (continued)

member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the Company.

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

III. PREMIUM MODIFICATIONS

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

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

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

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in the Physician/Surgeon and Health Care Provider Section of Pages 10 to 14.

- END OF SECTION II-

SECTION III

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

I. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a specialty code according to his/her specialty. When more than one specialty is applicable, the highest rate classification shall apply.
2. The specialty codes will be contained on Specialty Class Plan on Pages 10-14.

B. Locum Tenens Physician

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

C. Blending Rates

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

I. CLASSIFICATIONS (continued)

D. Slot Rating

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

E. Per-Patient Visit Rating

1. Standard Claims Made coverage for group practices is available, at the Company's option, on a per-patient visit basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.
2. The number of per-patient visits equivalent to a physician year is 2500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.
3. The applicable medical specialty rate is divided by the equivalent per-patient visits resulting in the per-patient visit rate to be applied to the visits projected for the policy period. The product of the per patient rate and the projected visits results in the indicated manual premium.
4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.
5. Premium modifications for new physician, part time, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

II. PREMIUM COMPUTATION DETAILS

A. Specialty Class Plan

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

PHYSICIANS & SURGEONS

Specialty	ISO Code	Class
Abdominal Surgery	80166	9
Administrative Medicine	80240(a)	1
Aerospace Medicine	80133	1
Allergy/Immunology	80254	1
Anesthesiology- All Other	80183	5
Anesthesiology- Critical Care Medicine	80181	5
Anesthesiology- Pain Management	80182	5
Broncho-Esophagology	80101	4
Cardiac Surgery	80141	14
Cardiothoracic Surgery	80150(a)	14
Cardiovascular Disease - Minor Surgery	80281	5
Cardiovascular Disease - No Surgery	80255	3
Cardiovascular Surgery	80150	14
Colon and Rectal Surgery	80115	7
Dentistry	80210	1
Dermatology - All Other - Minor Surgery	80297(a)	3
Dermatology - All Other - No Surgery	80297	1
Dermatology - Clinical and Dermatological		
Immunology - No Surgery	80295	1
Dermatology - Dermopathology	80296	1
Diabetes - Minor Surgery	80271	5
Diabetes - No Surgery	80237	2
Emergency Medicine - including Major Surgery	80157	11
Emergency Medicine - No Major Surgery	80102	8
Endocrinology- Minor Surgery	80272	4
Endocrinology- No Surgery	80238	2
Endocrinology Surgery	80103	9
Family/General Practice w/Major Surgery & OB	80117(a)	9
Family Physicians or General Practitioners - Minor Surgery	80421	7
Family Physicians or General Practitioners - No Surgery	80420	3
Forensic Medicine	80240	1
Gastroenterology - Minor Surgery	80274	5
Gastroenterology - No Surgery	80241	3
Gastroenterology - Surgery	80104	10
General Practice of Family Practice Surgery	80117	8
General Surgery	80143	11
Geriatrics - Minor Surgery	80276	5

Specialty (Continued)	ISO Code	Class
Geriatrics - No Surgery	80243	3
Geriatrics - Surgery	80105	9
Gynecology - Minor Surgery	80277	5
Gynecology - No Surgery	80244	3
Gynecology - Surgery	80167	9
Hand Surgery	80169	9
Head and Neck Surgery	80170	10
Head and Neck Surgery - No Plastic	80170(a)	9
Hematology - Minor Surgery	80278	5
Hematology - No Surgery	80245	3
Hospitalists - Including ER	80222(b)	8
Hospitalists - Invasive	80222(a)	5
Hospitalists - Non-Invasive	80222	3
Hypnosis	80232	3
Infectious Diseases - Minor Surgery	80279	5
Infectious Diseases - No Surgery	80246	3
Intensive Care Medicine	80283	4
Internal Medicine - Minor Surgery	80284	5
Internal Medicine - No Surgery	80257	3
Laryngology - Minor Surgery	80285	5
Laryngology - No Surgery	80258	3
Laryngology - Surgery	80106	7
Legal Medicine	80240	1
Neonatal/Perinatal Medicine	80804	5
Neonatology - Major Surgery	80804(a)	11
Neoplastic Diseases - Minor Surgery	80286	5
Neoplastic Diseases - No Surgery	80259	3
Neoplastic - Surgery	80107	10
Nephrology - including Child - Minor Surgery	80288	5
Nephrology - Minor Surgery	80287	5
Nephrology - No Surgery	80260	2
Nephrology - Surgery	80108	8
Neurology - including Child - Minor Surgery - All Other	80299(a)	5
Neurology - including Child - No Surgery - All Other	80299	5
Neurology - including Child - No Surgery – Pain Management	80298	5
Neurology - including Child - Surgery	80152	15
Nuclear Medicine	80262	3
Nutrition	80248	1
Obstetrics & Gynecology Surgery	80153	16
Obstetrics Surgery	80168	16
Occupational Medicine	80134	1
Oncology - Minor Surgery	80301	5
Oncology - No Surgery	80302	3
Oncology - Surgery	80164	11
Ophthalmology - Minor Surgery	80289	3
Ophthalmology - No Surgery	80263	2
Ophthalmology - Surgery	80114	5

Specialty (Continued)	ISO Code	Class
Orthopedics Minor Surgery	80204	5
Orthopedics - No Surgery	80205(a)	3
Orthopedic Surgery Not Including Spine	80154	12
Orthopedic Surgery Including Spine	80154(s)	13
Otology - Minor Surgery	80290	5
Otology - No Surgery	80264	3
Otology - Surgery	80158	7
Otorhinolaryngology - Minor Surgery	80291	5
Otorhinolaryngology - No Surgery	80265	3
Otorhinolaryngology - Surgery	80159	10
Otorhinolaryngology - Surgery - Incl Plastic	80155	10
Otorhinolaryngology - Surgery - No Plastic	80159(a)	7
Pain Management - Basic Procedures	80182(b)	5
Pain Management - Intermediate Procedures	80182(c)	14
Pain Management - Advanced Procedures	80182(d)	15
Pain Management - No Surgery	80182(a)	5
Pathology - All Other	80307	1
Pathology - Blood Banking/Transfusion Medicine - Minor Surgery	80303	2
Pathology - Blood Banking/Transfusion Medicine - No Surgery	80304	1
Pathology - Cytopathology - Minor Surgery	80305	3
Pathology - Cytopathology - No Surgery	80306	1
Pediatrics - Minor Surgery	80293	6
Pediatrics - No Surgery	80267	4
Pediatrics - Surgery	80180	9
Perinatology	80153(a)	16
Pharmacology - Clinical	80234	1
Physiatry	80209(a)	3
Physical Medicine and Rehabilitation - All Other	80209	3
Physical Medicine and Rehabilitation - Pain Management	80208	5
Physician (NOC) - Minor Surgery	80294	5
Physician (NOC) - No Surgery	80268	4
Physician - No Major Surgery - including Acupuncture	80437	3
Physician - No Major Surgery - including Colonoscopy	80443	5
Physician - No Major Surgery - including Discograms	80428	5
Physician - No Major Surgery - including Lasers - used in therapy	80425	5
Plastic Surgery	80156	10
Podiatry	80943	7
Preventive Medicine - No Surgery		
Undersea/Hyperbaric Medicine	80139	1
Psychiatry - Addiction Psychiatry	80224	3
Psychiatry - All Other	80229	3
Psychiatry - Child and Adolescent Psychiatry	80226	3
Psychiatry - Forensic Psychiatry	80227	3

Specialty (Continued)	ISO Code	Class
Psychiatry - Geriatric Psychiatry	80228	3
Psychoanalysis	80250	3
Psychosomatic Medicine	80251	3
Public Health Medicine - No Surgery	80135	2
Pulmonary Diseases - No Surgery	80269	4
Radiation Oncology	80359(a)	6
Radiology - Diagnostic - Minor Surgery	80280	6
Radiology - Diagnostic - No Surgery	80253	4
Radiology - Interventional	80360	6
Radiology - Therapeutic - Minor Surgery	80358	6
Radiology - Therapeutic - No Surgery	80359	4
Rheumatology - No Surgery	80252	2
Rhinology - Minor Surgery	80270	5
Rhinology - No Surgery	80247	3
Rhinology - Surgery	80160	7
Sports Medicine - No Surgery	80205	3
Thoracic Surgery	80144	14
Traumatic Surgery	80171	14
Urgent Care	80102(a)	4
Urological - Surgery	80145	6
Urology - Minor Surgery	80120	5
Urology - No Surgery	80121	3
Vascular Surgery	80146	14
Acupuncturists	80966	Y
X-Ray Technicians	80713	Y
Dental Hygienists	80712	Y
Certified Registered Nurse Anesthetist - Shared	80960	C-1
Psychologists	80975	1
Art, Music and Dance Therapists	80967	Y
Audiologists	80968	Y
Certified Registered Nurse Anesthetist - Separate Limit	80960	C-2
Inhalation/Respiratory Therapists	80969	Y
Massage Therapists	80970	Y
Medical Technologists	80971	Y
Nurse LPN or RN	80963	Y
Nurse Midwife	80962	N
Nutritionists/Dieticians	80972	Y
Occupational Therapists	80973	Y
Opticians	80937	Y
Optometrist	80994	Y
Orthotists/Prosthetists	80974	Y
Pharmacists	59112	Y
Physicians or Surgeons Assistants	80116	Z
Nurse Practitioner	80964	Z
Physiotherapists	80938	X

B. Manual Rates

2. Standard Claims Made Program Step Factors and Mature Rates

Step Factors:

First Year:	32%
Second Year:	59%
Third Year:	80%
Fourth Year:	92%
Fifth Year (Mature):	100%

PHYSICIANS AND SURGEONS

RATE TABLE

Mature Rates (Claims-made)

Terr 1 – Entire State

1M/3M	Rate	Class
		1
	\$4,994	
		2
	\$6,659	
		3
	\$8,323	
		4
	\$9,322	
		5
	\$12,069	
		6
	\$14,149	
		7
	\$15,814	
		8
	\$18,727	
		9
	\$22,889	
		10
	\$24,970	
		11
	\$29,131	
		12
	\$31,212	
		13
	\$33,293	
		14
	\$41,616	
		15
	\$56,182	
		16
	\$60,343	

NON PHYSICIAN HEALTHCARE PROVIDERS

RATE TABLE (1M/3M LIMITS) (Claims-made)

RATE CLASS	Separate limits	Shared limits
N	50% of Class 16	N/A
X	10% of Class 1	0% of Class 1
Y	15% of Class 1	0% of Class 1
Z	25% of Class 1	10% of Class 1
C-1	N/A	20% of Class 6
C-2	25% of Class 6	N/A

III. PREMIUM MODIFICATIONS

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

A. Part Time Physicians

A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction of 30 % on the otherwise applicable rate for that specialty.

A Part Time Practitioner may include any practitioner in classes 1 through 8 and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

B. Physicians in Training

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

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

C. New Physician

- 1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
 - a. Residency;
 - b. Fellowship program in their medical specialty;
 - c. Fulfillment of a military obligation in remuneration for medical school tuition;
 - d. Medical school or specialty training program.
- 2. A reduced rate of 30% will apply for the first two years of practice.

D. Physician Teaching Specialists

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

E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.
3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free.

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

F. Claim Free Credit (continued)

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

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than the amount noted below depending on the specialty rate class. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds who have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in Arkansas, and/or following completion of residency or fellowship.

Rate Class	ALAE and/or Indemnity Payments
1-8	\$10,000
9-11	\$15,000
12-14	\$20,000
15-16	\$30,000

G. Affinity Credit

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

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

G. Affinity Credit (continued)

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

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

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

H. Elite Credit

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

1. Board certification in area of specialization
2. No history of impairment or substance abuse
3. No incident (unless closed without any payment), including notice of a claim, claim tendered, incurred, or paid indemnity or allocated loss adjustment expense incurred or paid, and Medical Board actions reported to current or previous insurer, validated by a company generated loss run

and/or a sworn signed statement by the physician/group and the insured's agent covering the past four years qualifies a physician for consideration

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

I. Schedule Rating

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

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

Schedule Rating: Modifications, subject to Underwriting:

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

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

Maximum Modification	+ / - 25 %
----------------------	------------

J. Experience Rating

This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.

On an optional basis, large risks with sufficiently credible loss experience may be loss-rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least \$100,000 in estimated annual premium.

The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.

Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at \$250,000 per loss.

The experience period does not include the 12-month period immediately prior to the effective date of the experience modification.

The experience rating modification is calculated using the following formula:

$$\text{Credibility} \times \frac{\text{Adjusted Actual Loss Ratio} - \text{Adjusted Expected Loss Ratio}}{\text{Adjusted Expected Loss Ratio}} = \text{Experience Mod.}$$

Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.

K. Risk Management Credit

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

L. Deductible Credits

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

1. Individual Deductibles

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

INDEMNITY ONLY DEDUCTIBLE PER CLAIM		INDEMNITY AND ALAE DEDUCTIBLE PER CLAIM	
	<u>1M/3M</u>		<u>1M/3M</u>
\$5,000	2.50%	\$5,000	4.0%
\$10,000	4.50%	\$10,000	7.50%
\$15,000	6.00%	\$15,000	9.6%
\$20,000	8.00%	\$20,000	11.4%
\$25,000	9.00%	\$25,000	13.0%
\$50,000	15.00%	\$50,000	19.0%
\$100,000	25.00%	\$100,000	28.0%
\$200,000	37.50%	\$200,000	42.5%
\$250,000	42.00%	\$250,000	50.0%

2. Group Deductibles

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

Indemnity Deductible Per Claim / Aggregate (\$000)

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	2.0%	1.8%	1.5%	1.2%	\$12,750
10/30	3.8%	3.5%	3.0%	2.4%	\$25,500
25/75	8.4%	7.9%	7.0%	5.8%	\$63,750
50/150	14.5%	13.9 %	12.7 %	10.9%	\$127,500
100/300	23.4%	22.8 %	21.6 %	19.6%	\$255,000
200/600	34.8%	34.6 %	33.8 %	32.1%	\$510,000
250/750	38.5%	38.5 %	38.1 %	36.8%	\$637,500

The following Group Deductibles are available for Indemnity & ALAE.
(\$000)

Indemnity & ALAE Deductible Per Claim/Aggregate Deductible	Number of Insureds				Max
	2-19	20-40	41-60	61- 100	Credit
5/15	2.9%	2.6%	2.1%	1.7%	\$12,750
10/30	6.8%	6.3%	5.4%	4.3%	\$25,500
25/75	11.9%	11.2%	9.9%	8.2%	\$63,750
50/150	18.6%	17.9%	16.3%	14.0%	\$127,500
100/300	25.8%	25.2%	23.9%	21.6%	\$255,000
200/600	39.6%	39.4%	38.5%	36.6%	\$510,000
250 /750	46.7%	46.7%	46.2%	44.6%	\$637,500

M. Individual Risk Rating

A risk may be individually rated per the Arkansas Department of Insurance Code 23-67-219.

- END OF MANUAL-