Missouri Medical Malpractice Joint Underwriting Association

Operations and Rating Manual

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I. Plan Overview

A. Purpose of Missouri Medical Malpractice Joint Underwriting Association

The Missouri Medical Malpractice Joint Underwriting Association (hereinafter the "Association") was established to provide medical professional liability insurance that is not otherwise reasonably available in the voluntary market and began issuing policies effective June 2004.

B. Eligibility

Any health care provider shall be entitled to apply to the association for medical malpractice liability insurance. For the purposes of this Operations and Rating Manual (hereinafter the "Manual"), the term "Applicant", whether in the singular or plural, shall refer to applicants, policyholders, named insureds and additional insureds. Such application may be made on behalf of an Applicant by a broker or agent authorized by the Applicant.

However, in order to be eligible for coverage the provider shall:

- Be duly licensed or registered as a health care provider under Missouri Law and meet the definition of a Health Care Provider as stated in RSMo 383.150: "physicians, dentists, clinical psychologists, pharmacists, optometrists, podiatrists, registered nurses, physicians' assistants, chiropractors, physical therapists, nurse anesthetists, anesthetists, emergency medical technicians, hospitals, nursing homes and extended care facilities; but shall not include any nursing service or nursing facility conducted by and for those who rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination";

- Have a professional health care practice which is located in whole or in part within the state of Missouri;

- Be seeking professional liability or related coverages, through the Association, only for Missouri activities or premises;

- Have been unable to obtain such coverage through the voluntary market for the period of time for which coverage is requested at comparable cost;

- Provide proof of similar coverages for all professional activities rendered and premises situated in other states;

- Pay the premium or portion thereof required under the underwriting manual of the Association;

- Have no unpaid, uncontested premium due for prior insurance;

- Agree to participate in any loss control steps or programs required by the Association; and

- Conform to any other reasonable underwriting guidelines in the underwriting manual.

- Not participate in the certification of patients for the medical use of marijuana.

II. Operations Overview

A. Servicing Company's Authority

The Board grants operational and underwriting authority to the Servicing Company. The Operations and Rating Manual provides a consistent and structured framework for the Servicing Company to equitably manage the Association. The guidelines established are subject to change as the Association evolves. Upon Board approval, the Manual will be amended to incorporate changes. The commemoration of changes in this manual is not required for the changes to take effect.

B. Policy Forms

The Association will provide professional liability insurance under policy forms and applications as approved by the Board and the Missouri Department of Insurance. A list of approved policy forms and applications is contained on Appendix A and available for review on the Association's website at www.mmmjua.com.

C. Manual Rules

Coverage will be underwritten in accordance with the rules, specialty classifications, territorial location and basic rates as set forth in this manual.

Health care providers applying for coverage may have characteristics that indicate a different exposure than that presented by others in the same rating classifications. These differences in exposure shall be recognized through the application of credits/debits as set forth in this Manual.

If at any time rules in this manual conflict with one another, or circumstances arise that are not covered by manual rules, the servicing carrier will obtain approval from the General Counsel to the board of the Association for revisions to the manual or forms, or submittal of Consent to Rate filings to the Department of Insurance.

D. Distribution System

Eligible health care providers may apply for professional liability insurance through an agent authorized to place casualty insurance under subdivision 1 (4) of Section 375.018, RSMo., or direct to the Association. Commissions shall not be paid or premiums shall not be reduced if a policy is purchased direct from the Association.

The Association will not license or have any agent or broker representation. The Servicing Company will not recommend insurance agents to health care providers. If the

Board approves a list of agents for recommendation to Applicants who request assistance in obtaining agent representation, the Servicing Company will provide the list of agents to such Applicants. If the Servicing Company determines that an agent has made material misrepresentations with respect to any Applicant or that such agent has acted in any way to deceive or defraud the Association, it will report this information to the Board and request authority to remove such agent from the approved list of agents.

Commissions will be paid to authorized agents on a sliding scale as follows:

Annual Premium	Commission (as a % of annual premium)
First $25,000	8%
Next $75,000	5%
Over $100,000	3%

Agents are not authorized to withhold their commission from payments made to the Association. In order for the Association to proceed with payment of commission to an agent, a copy of their current license, and a W-9 form must be on file with the Servicing Company. The Servicing Company will pay commissions to the agents by the last day of the month after the effective date of each policy or the last day of the month after the month in which payment is received and posted by the accounting department, from the insured for a policy, endorsement or installment billing, whichever is later. Commissions will not be paid on installment billings until after the installment payments are received and posted by the Servicing Company.

The Servicing Company will remit premiums collected less commissions paid or payable to the Association in accordance with its contract.

In the event of cancellation of a policy, the Servicing Company will return any return premium due to the insured, less any other balances due to the Association. Any commission due back from the agent for premium returned to the insured will be deducted from the agent's commission in the next month commissions are processed. If no commission is due to the agent, the agent will be billed for the unearned commission.

For any premium financing company approved by the Servicing Company, the Servicing Company will remit return premiums to the finance company in accordance with the provisions of the approved finance agreements. If the Servicing Company returns the entire unearned premium, including agent's commissions, to the finance company, the Servicing Company will have the right to offset any amount of commission paid by the Servicing Company from any other amounts due to the agent, or bill the agent directly for such unearned commission. The Servicing Company will also then forward a separate billing to the insured for any remaining amount due for the Additional First Year Charge, per the Promissory Note signed by the insured. The Association reserves the right not to accept a finance agreement from a finance company not previously approved, and/or if a copy of the signed finance agreement is not submitted with the binding information.

Requests to change agents received, in writing from an insured, will be honored immediately, in regard to servicing of the account. The agent who submitted the application will receive commissions through the end of the policy term.

E. Additional First Year Charge

Pursuant to Missouri Statute 383.165 RSMo, each policyholder shall pay to the Association in the first policy year, in addition to premium payment due for insurance through the Association, an amount equal to said premium payment. Such charge shall be stated in the policy.

Effective December 12, 2006, for quotes for new insureds, the full amount of the Additional First Year Charge will be considered fully earned at binding, however, the Additional First Year Charge may be paid using the Association's installment plan.

F. Right of Appeal

Any Applicant for insurance coverage, any person insured by the Association or their representatives, or any affected insurer, agent or agency aggrieved with respect to any ruling, action, or decision by or on behalf of the Association, including by its staff, any committee thereof or any servicing companies hired by the Board, regarding matters within the discretion of such persons or entities under the relevant provisions of Chapter 383, RSMo., the Plan of Operation, or the manuals of the Association, or any other matters agreed to specifically by the Board after a formal vote, may submit a grievance in writing to the Board for its review. The submission of the grievance to the Board shall be made within thirty (30) days following notice of such ruling, action or decision. The Board may limit its review to the written submission or, in its sole discretion, permit the grievant to present oral argument to the Board. The Board shall provide its decision on the appeal in writing within thirty (30) days of the submission of the grievance or within thirty (30) days of the oral argument, if permitted.

Only decisions of the Board on appeals may be appealed to the Director of Insurance, provided however, that decisions regarding underwriting and rating shall not be appealable to the Director. Any appeal that is permitted to be made to the Director shall be made in writing within thirty (30) days from the decision of the Board.

In accordance with Section 383.190, RSMo, any person aggrieved by any decision of the Director on any such appeal may, within ten (10) days after notice thereof, file a petition in the Circuit Court of Cole County for a review thereof.

III. Underwriting Procedures

A. Application and Quoting Process

Each Health Care Provider is required to submit the appropriate application(s) in order to be considered for coverage with the Association. Applications can be obtained from the Servicing Company, authorized agent, or from the Association's web-site at www.MMMJUA.com.

New Applications should be returned to the Association at least 60 days prior to the requested effective date of coverage to ensure ample time to complete the underwriting review process. The Servicing Company will endeavor to provide a firm quotation at least 30 days prior to the requested effective date on complete submissions received at least 60 days prior to the requested effective date. Applications signed more than 90 days prior to the effective date of coverage (120 days for renewals), must be re-signed and dated prior to binding.

Complete submissions received less than 60 days prior to the requested effective date of coverage will receive a firm quotation upon completion of the underwriting review.

Applicants with incomplete submissions will receive a letter summarizing the items necessary to make the submission complete. Premium indications, which are subject to change, may be released if the underwriting information needed to release a premium indication has been provided. No firm premium quotation may be given before a fully completed application has been submitted.

A complete submission for physicians, surgeons, dentists and allied health care providers includes the following:

- Application with original signature and date;
- Every question completed (use N/A, when appropriate) and detailed explanations provided, when requested;
- Five-Year Claims History from current and/or previous insurance carriers;
- Supplementary Loss Form completed for each medical malpractice case;
- Expiring Declaration Page from current/expiring insurance coverage;
- Business letterhead;
- Verification of Claims-Made Reporting Coverage from expiring insurance carrier;
- Application for each allied health care provider for which coverage is requested;
- Curriculum Vitae; and
- Copy of Missouri Medical License
- Completed, Signed Authorization to Release Information

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In addition to the above, health care facilities need to provide:

- Application for each employed physician, surgeon, and dentist for which coverage is requested;
- Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies;
- Copy of medical staff by-laws; (not required prior to binding)
- A.H.A. Survey of hospitals;
- Risk Management and Quality Improvement Plan;
- Verification of professional liability coverage for all contracted services; and
- All hold harmless agreements.

In reviewing an application form, the Association and/or Servicing Company may seek such additional information as is reasonable to verify the information on the application or otherwise determine the Applicant's loss history or exposure to claims.

Applicants shall endeavor to obtain coverage through the voluntary market. Only where an Applicant or their agent certifies on an application approved by the Department that the Applicant and/or agent has been unable to obtain such coverage for the Applicant through the voluntary market for the period of time for which coverage is requested, at comparable cost, shall such coverage be available to the Applicant with the Association. If the Applicant is applying for coverage through an agent, the certification regarding the Applicant's inability to obtain coverage through the voluntary market shall be made by the Applicant's agent.

Renewal Applications will be mailed to insureds 120 days prior to their expiration date/renewal date. Renewal Applications should be returned to the Association at least 60 days prior to the expiration date/renewal date.

Firm Quotations and Premium Indications expire 7 days after the requested effective date or 30 days from the release date, whichever is less.

B. Refusal to Issue

The Association's right to refuse to issue coverage in response to an initial application for coverage is not limited to but may include one or more of the following reasons:

- Applicant does not meet the Association's eligibility requirements;

- Any concealment, misrepresentation or fraud on the part of the Applicant concerning the Applicant's medical practice, the application for insurance, or otherwise;

- Unacceptable or unsupportable loss severity or loss frequency based upon the Applicant's loss history;

- Applicant has unpaid, uncontested premium due for prior insurance;

- Unwillingness or inability to conform to reasonable underwriting standards.

C. Binding of Coverage

The Association shall rely on the information developed from the application and underwriting review process for the purposes of determining the required premium. Coverage may not be bound (made effective) until the submission is complete including any additional information requested by the Servicing Company, the necessary investigation is completed, and the required premium is paid (including cash deposit and signed promissory note, or full cash payment, of the Additional First Year Charge). The Servicing Company will issue a written binder based upon the Applicant's request in accordance with a proposal made to the Applicant, after premium and Additional First Year Charge has been received per the premium payment guidelines of the Association. The binder will remain in effect for the term shown on the binder or until a policy is issued to replace the binder, whichever is sooner. Binders may be extended where necessary.

In circumstances where state licensure is pending, coverage may be accepted by the Association pending issuance and confirmation of the license. The Association will issue a binder upon receipt of all information including a copy of the license. If all other required information and payment have been received, the Association may backdate coverage to the effective date of the state issued license.

D. Coverage

If approved, the Applicant is offered coverage based on the following:

Individual Professional Liability Coverage for eligible individual physicians, dentists, and allied health care providers, written on an Occurrence form, with limits of liability in the amount of $500,000 each medical incident/$1,500,000 annual aggregate or $1,000,000 each medical Incident/$3,000,000 annual aggregate.

Partnership, Limited Liability Company, Association or Corporation Professional Liability Coverage for physician groups and eligible facilities, written on an Occurrence form with limits of liability in the amount of $500,000 each medical incident/$1,500,000 annual aggregate or $1,000,000 each medical incident/$3,000,000 annual aggregate.

Prior Acts Policy for Claims Made Exposure with Prior Carrier
This policy will be written on a claims-made form, incidental to Occurrence professional liability coverage issued by the Association, with limits of liability of $500,000 each medical incident/$1,500,000 annual aggregate or $1,000,000 each medical incident/$3,000,000 annual aggregate.

Commercial General Liability Coverage written on an Occurrence form with limits of liability of $500,000 each incident/$1,500,000 general aggregate or $1,000,000 each incident/$3,000,000 general aggregate, available to facilities in conjunction with professional liability coverage only.

E. Premium Payment

Premium and Additional First Year Charge payments are expected in advance of binding of coverage. At the discretion of the Association, coverage may not be bound until payment is received by the Association. Payment is considered received on the date payment is sent to the Association, as evidenced by the post-mark date or date shown as received by delivery service for items sent by overnight mail service.

A premium payment plan is available for active policy premiums when the total annual policy premium is at least $10,000. Annual premiums under $10,000 are due in full at the time coverage is bound. The premium payment plan requires a deposit of 40% of the annual premium at binding with 30% due within 60 days of the effective date and the remaining 30% due within 120 days of the effective date. A non-refundable service fee equal to 2.5% of the total financed premium is due at binding, along with the deposit. The premium payment plan is not available for Prior Acts Policy premiums and mid-term endorsements. Those choosing to make full cash payment of the Additional First Year Charge, or making a 25% down or installment payment of the charge, may pay using the premium payment plan, provided they otherwise qualify for the payment plan. Failure to pay a premium installment timely when due will result in cancellation of the policy for non-payment of premium. The full amount of any unpaid balance due for the Additional First Year Charge will be fully due and collectible at the time of cancellation. The Association will retain any unearned premium due the insured due to cancellation for application to any unpaid Additional First Year Charge note balance, after any amounts remaining due to premium finance companies have been paid.

For all policies issued on an installment premium basis, installment billing notices will be sent at least 30 days in advance of the premium due date. Notices of cancellation for non-payment of premium will be sent immediately if payment is not **received on or before the due date**. The notice of cancellation for non-payment provides 10 days plus 3 days mailing, within which payment must be received in order to continue coverage without a lapse. The Association reserves the right to not accept late payments or accept late payments subject to restrictions.

After a policy has been cancelled a second time within a single policy term due to non-payment, the insured must pay the entire account balance within 13 days in order to reinstate coverage. Further, the insured forfeits the option to pay in installments the following renewal term.

If a policy is cancelled due to non-payment, the outstanding amount due for the Additional First Year Charge will be fully due and payable. After payment of any outstanding premium finance company balances, the Association will withhold refund of any unearned premium due the insured in order to apply toward these outstanding amounts.

All premium payments shall be made by check payable to: Missouri Medical Malpractice Association, and mailed to the Association lockbox: P.O. Box 85, Jefferson City, MO 65102-0085.

Agency checks are discouraged. Checks will be accepted by Association approved financing companies. A copy of the signed finance agreement is required to be included with the binding request.

F. Certificates of Insurance

The Servicing Company will issue certificates evidencing insurance coverage, to interested parties upon request of the insured. An interested party is considered to be a hospital, nursing home, HMO, PPO, or other practice or managed care program that the Association deems to have a legitimate interest in the coverage of the insured. Agents or brokers are not authorized to issue certificates. Certificates indicating individual named insureds on the policy as the certificate holder will not be issued.

G. Cancellation

The insured may cancel coverage at any time. Cancellation will be effective no earlier than the date that the Association receives written notice of the requested cancellation from the insured.

The Association's right to cancel coverage is not limited to but may include one or more of the following reasons:

- Applicant no longer meets the Association's eligibility requirements;
- Any concealment, misrepresentation or fraud on the part of the Applicant, whether before or after a loss, concerning the Applicant's medical practice, the application for insurance, or otherwise;
- Violations of terms or conditions contained in the policy;
- Applicant has unpaid, uncontested premium due for prior insurance;
- Changes in exposure which have materially increased the risk assumed by the Association;
- Death or disability of the Applicant;
- A material breakdown of the relationship between the Applicant and the Association.

Written notice of cancellation shall be provided by certified United States mail to the first Named insured, at the last mailing address known to us, stating the actual reason for cancellation, giving at least:

- 10 days prior to the effective date of the of cancellation plus 3 days mailing in the case of non-payment of premium;
- 30 days prior to the effective date of the of cancellation plus 3 days mailing in the case of fraud or material misrepresentation affecting the policy or in the presentation of a claim thereunder;

- 30 days prior to the effective date of the of cancellation plus 3 days mailing in the case of changes in conditions after the effective date of the policy which have material increased the hazards originally insured; or

- 60 days prior to the effective date of the cancellation for any other reason.

Cancellation requests from premium finance companies for cancellation due to non-payment of premium will be processed upon receipt of the notice from the finance company, and after the Association has provided the insured with the legally required 10 days notice plus 3 days mailing.

Subject to Missouri cancellation requirements, the following provisions apply:

Pro Rata Cancellation is used when a policy is cancelled at the request of the Association, due to death or disability, concealment, misrepresentation or fraud, or for non-payment of premium. Pro rata return premium will be computed and rounded to the next higher whole dollar.

Short Rate Cancellation is used when a policy is cancelled for any reason other than pro rata. Short rate cancellation will be computed at .90 of the pro-rata unearned premium factor and rounded to the nearest dollar.

Proof of mailing by certified United States mail to the first Named insured, at the last mailing address known to us, will be sufficient proof of notice.

Minimum premium will be retained, unless the policy is cancelled flat as of the inception date stated in the declaration page. If the policy is cancelled mid-term, and the full Additional First Year Charge has not been paid, any unpaid balance of the Additional First Year Charge will become fully due and payable at the time of cancellation. The Association will retain unearned premium for application to unpaid Additional First Year Charge balances, after payment of any remaining amounts due to premium finance companies. The Association will notify the insured of the note balance due, and the insured will be given 14 days from the date of the notice in order for payment to be received by the Association. If payment is not received within that time, the file will be turned over for collection.

H. Non-Renewal

The Association's right to non-renew a policy is not limited to but may include one or more of the following reasons:

- Applicant no longer meets the Association's eligibility requirements;

- Any concealment, misrepresentation or fraud on the part of the Applicant, whether before or after a loss, concerning the Applicant's medical practice, the application for insurance, or otherwise;

- Violations of terms or conditions contained in the policy;

- Unacceptable or unsupportable loss severity or loss frequency based upon the Applicant's loss history;

- Applicant has unpaid, uncontested premium due for prior insurance;
- Unwillingness or inability to conform to reasonable underwriting standards;
- Changes in exposure which have materially increased the risk assumed by the Association;
- A material breakdown of the relationship between the Applicant and the Association.

Written notice of non-renewal shall be provided by certified United States mail to the first Named insured, at the last mailing address known to us, stating the actual reason for non-renewal, at least:

- 30 days prior to the effective date of the non-renewal in case of failure to pay sums due;
- 30 days prior to the effective date of the non-renewal in case of termination or suspension of the insured's license to practice medicine in the State of Missouri;
- 30 days prior to the effective date of the non-renewal in case of material change in the nature of the insured's health care practice; or
- 60 days prior to the effective date of the non-renewal for any other reason.

Proof of mailing by certified United States mail to the first Named insured, at the last mailing address known to us, will be sufficient proof of notice.

If the policy is non-renewed by the insured, the Association will immediately bill the insured for the remaining unpaid balance of the Additional First Year Charge. Payment of this charge will be due within 14 days of the date of the invoice or demand letter. If payment is not received within that time, the file will be turned over for collection.

At least 60 days prior to renewal date, each provider will receive a Conditional Non-Renewal Notice from the Association advising that the coverage provided under the policy will end at the policy expiration date, and will not be renewed unless all required renewal information and funds are received prior to the renewal date, as evidenced by U. S. Postal Service postmark on the envelope addressed to the Association.

IV. General Rating Rules

A. Unknown Classification

If there is no classification included in the rate filing for operations applicable to a health care provider, a classification will be assigned that most closely reflects the type of work and relative exposure to loss of the provider's activities compared to activities contemplated by the filed class codes.

B. Multiple Classifications

Health care providers will be classified in accordance with the classification schedule included with the rate filing made by the Association to the Division of Insurance. If more than one classification applies, the classification with the highest base rates will apply.

C. Multiple Territories

If a health care provider's practice involves two or more rating territories, the highest rating territory applies subject to underwriting judgment.

D. Covered Medical Employees

Under the **Physicians, Surgeons & Dentists** form, coverage for medical employees (other than those listed below) will be provided on a shared limit of liability basis, at no additional charge, per the terms and conditions of the policy.

This provision does not apply to physicians, surgeons, dentists, physician assistants, surgeon assistants, certified nurse midwives, certified nurse practitioners, psychologists, emergency medical technicians, perfusionists, chiropractors, certified nurse anesthetists, cytotechnologists, optometrists, podiatrists, residents, or interns. Separate individual coverage must be evidenced to the Association for these specialties. The Association can provide coverage to those providers eligible for coverage, subject to the procedures outlined above in Section III - Underwriting Procedures. If coverage for such employees is obtained with a carrier other than the Association, a charge equal to 15% of the Association's charge for such employee will be added to the employer's premium, if insured with the Association, for the vicarious liability exposure.

Under the **Facility Professional Liability** form, coverage for medical employees (other than those listed below) will be provided on a shared limit of liability basis, at no additional charge, per the terms and conditions of the policy.

This provision does not apply to physicians, surgeons, dentists, chiropractors, podiatrists, anesthetists, certified nurse anesthetists, certified nurse midwives, certified nurse practitioners, physician/surgeon assistants, residents, or interns. These individuals must meet eligibility requirements and apply for separate coverage subject to the procedures outlined above in Section III – Underwriting Procedures.

E. Policy Terms

Policies will be written for a twelve- (12) month term.

Prior Acts policies will be issued to allow reporting of claims that occurred during the policy period indicated on the policy declarations page, for an indefinite coverage term. Prior Acts policies will only be offered for terms of coverage for which proof of previous coverage and confirmation of retro-active date can be provided.

F. Premium Computation

Premiums including endorsement changes will be computed using the rules and rates in effect at the inception of the policy. Prior Acts Policy premiums will be computed using the rules and rates in effect at the inception of the related professional liability policy. All changes requiring a change in premium are to be pro-rated for the remaining term. Whenever factors or multipliers are used to compute the premium, they will be applied consecutively and not added together, except with respect to the scheduled rating plans. Scheduled rating plan debits will be added together then applied in total to the adjusted premium.

The Association reserves the right to adjust a provider's premium effective at policy inception if information is developed during the policy term that differs from the information the provider supplied in the application.

Minimum Premium: The minimum premium per policy period is $500 per provider, regardless of the term.

Rounding Rule: Rates, factors (except experience modifications) and multipliers will be rounded to two decimal places. Experience Modifications will be rounded to three places. Round premiums to the nearest whole dollar. Round premiums involving $0.50 or over to the next highest dollar.

Additional Premium Charges: All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of $15.00 or less will be waived. Return premiums requested by the insured will be granted. Retain the policy minimum premium.

G. Deductibles

Deductible options are not customarily available, however, in lieu of non-renewal or declination of an Applicant, the Association, at its sole discretion, may mandate an indemnity deductible. For mandatory deductibles equal to or in excess of $25,000, the Association may also require a Letter of Credit on file.

H. Prior Acts Policy

If a provider wishes to move from a claims-made form to a Association occurrence form policy, and wishes to purchase a Prior Acts policy from the Association in lieu of purchasing an extended reporting or "tail" endorsement from their expiring carrier, they may do so.
Incidental to, and in conjunction with, the occurrence based professional liability policy, the Association will issue a separate claims-made policy equal to the previous claims-made coverage limit subject to Association policy rates, rules, and forms to cover reporting for the expiring claims-made policy. In order to be eligible for the Prior Acts policy, the provider must show evidence of active claims-made coverage written with the same named insured that does not terminate until the effective date of the occurrence coverage written by the Association. The retro-active date accepted by the Association will be the retro-active date from the last active claims-made policy. There must have been no change in ownership of the entity between the prior claims-made policy retro-active date and the new Association occurrence policy effective date to be eligible for Association provided prior acts coverage.

Prior Acts policy coverage will not extend to known or previously reported “medical incidents”. Coverage will be specifically excluded for any “medical incident” which has been reported to another carrier (whether accepted as a claim or not accepted as a claim) or if the provider knew or believed, or had reason to know or believe, that such “medical incident” occurred prior to the first date coverage is provided with the Association.

Premium for the Prior Acts policy must be paid in full prior to binding (premium payment plan does not apply), and coverage may not be cancelled for any reason once it becomes effective. Rates for this program are included in Section V below, and are calculated based on number of years of prior acts coverage included, as determined by the retroactive date of the policy. The physician & surgeon, dentist, and allied health premiums will be pro-rated for prior periods less than a year. Any surcharge premium adjustments applicable to the named insured in the current Association policy will also apply to the prior acts policy premium (e.g. if an experience debit was used on the current Association policy for a named insured, it will also apply to the Prior Acts policy rates). Credits applied to the premium do not apply to the Prior Acts policy rates, except for part-time credits.

This policy will only be offered in conjunction with an Occurrence based professional liability policy issued by the Association.

I. Providers with Multi-State Exposures

Should a provider practice in more than one state, coverage under the Association policy will only apply to professional medical or dental services rendered within the state of Missouri. A limitation endorsement will be attached to the policy, and the endorsement will require an acceptance signature from the insured. In addition, the Association will require proof of ongoing insurance coverage from the provider’s insurer for the exposures outside of the state of Missouri. A certificate of insurance including a definitive cancellation clause providing the Missouri Medical Malpractice Association with 30 days written notice prior to cancellation of the other carrier’s coverage is required. A provider who does not have proof of current “other states” coverage on file with the Association is no longer eligible for coverage through the Association, and may be subject to cancellation or non- renewal.

V. Physicians, Surgeons, Dentists, and Allied Health Care Providers Rates and Rating Rules

A. Physician Professional Liability Class Plan

GENERAL SPECIALTY DEFINITIONS

Column Heading Definitions

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

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

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

	Industry Class Code		
Specialties	**No Surgery**	**Minor Surgery**	**Major Surgery**
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology – including Spinal Caudal And General	- -	80151	
Bariatrics – Including but not limited to Gastric Bubble and Gastric Stapling	-	-	80476
Cardiovascular Disease	80255	80281	80150
Colon & Rectal	- -	80115	
Dermatopathology	80474	-	
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

Specialties	Industry Class Code No Surgery	Minor Surgery	Major Surgery
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-
Family Practitioner or General Practitioner - Limited Obstetrics (<20 per year)	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics (20+ per year)			80117(C)
Family Practitioner or General Practitioner – Obstetrics with no C-section Privileges			80117(D)
Family Practitioner or General Practitioner - No Obstetrics	80420	80421(A)* 80421(B)*	80117(A) 80421(C)*
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General - N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventative Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Intensive Care Medicine/Hospitalist	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic - No Spinal Surgery	-	-	80154(A)
Orthopedic - Including Spinal Surgery	-	-	80154(B)

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

Specialties	Industry Class Code No Surgery	Minor Surgery	Major Surgery
Otorhinolaryngology – No Plastic Surgery	80265	80291	80159
Otorhinolaryngology-Including Plastic	-	-	80155
Pain Management [80475(A) Medicine Only] [80475(B) Dorsal Root Gangliotomies, Thoracic Sympathectomies, Spinal Cord Stimulators, Implantation/Removal of Drug Infused Pumps, Sphenopalatine Lesioning} [80475(C) Class Not Used] [80475(D) Trigeminal Lesioning, Cordotomies]	80475(A)	-	 80475(B) 80475(C) 80475(D)
Pathology	80266	-	
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic – Including Breast Implants	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry - Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Rheumatology	80252	***	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

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

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

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

***See Internal Medicine - Minor Surgery

The following schedule identifies into which surgery classification each of the listed procedures should be classified.

Procedure	Rating Class Determination
Acupuncture	Minor
Angiography	Minor
Angioplasty	Minor
Appendectomy	Major
Arteriography	Minor
Blepharoplasty	Minor
Breast Biopsy	Minor
Bronchoscopy	Minor
Cholecystectomy	Major
Laparoscopic Cholecystectomy	Major
Colonoscopy	Minor
Cryosurgery (other than external lesions)	Minor
Chemical peels	Minor
Chemobrasion	Minor
Dermabrasion	Minor
Fat Transfer	Minor
Hair transplants	Minor
Silicone Injections	Minor
Tumescent Liposuction	Major
D&C	Minor
Encephalography	Minor
Endoscopic laser therapy	Minor
Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy	Minor
ERCP	Minor
Exchange Transfusions in newborns	Minor
Fluoroscopy	Minor
Open Fracture Reductions	Major
Closed Fracture Reductions	No Surgery
Gastroscopy	Minor
Hip nailings	Major
Hyperbaric Medicine	Minor
Hysterectomy	Major
Intensive care for newborns within a Tertiary Care Unit	Minor

Laminectomy	Minor
Laparoscopy	Major
Laser Hair Removal	Minor
Laser Skin Resurfacing	Minor
Laser surgery	Minor
Left Heart Catheterization	Minor
Liposuction	Major
Lithotripsy	Minor
Lumbar Fusion	Major
Mammography	Minor
Norplant Insertion/Extraction	Minor
Organ Transplant	Major
Permanent Pacemaker	Minor
Polypectomy	Minor
Prenatal Care	No Surgery
Radiation/X-ray Therapy	Minor
Radiopaque Dye	Minor
Scoliosis Surgery	Minor
Shock Therapy	Minor
Thyroidectomy	Major
Tonsillectomy	Major
Tubal ligation	Major
Vasectomy	Minor

B. Rating Territories

Territory 1 - St. Louis, St. Louis County, St. Charles County, Jefferson County
Territory 2 - Kansas City, Jackson County, and Clay County
Territory 3 - Remainder of State

C. Physician & Surgeon Professional Liability Rates

1. Rating Classes - Missouri

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

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

Occurrence Rates

		Territory	Territory		Territory	Territory
		1 & 2	3		1 & 2	3
Class		$500,000/ $1,500,000	$500,000/ $1,500,000		$1,000,000/ $3,000,000	$1,000,000/ $3,000,000
1		$9,181	$8,340		$10,381	$9,421
2		13,382	12,122		15,184	13,743
3		17,584	15,904		19,986	18,065
4		21,787	19,686		24,788	22,388
5		25,989	23,467		29,591	26,710
6		31,032	28,006		35,353	31,896
7		34,393	31,032		39,196	35,353
8		42,798	38,596		48,801	43,998
9		51,201	46,159		58,405	52,642
10		59,606	53,723		68,010	61.287
11		68,010	61,287		77,615	69,931
12		76,415	68,850		87,220	78,576
13		84,818	76,415		96,824	87,220
14		N/A	N/A		N/A	N/A
15		118,435	106,670		135,244	121,798

D. Prior Acts Policy Rates – Physicians & Surgeons

Prior Acts Policy Rates by Year					
Territory 1 and 2					
Rating Class	**$500,000/$1,500,000**				
	1	**2**	**3**	**4**	**5+**
1	$9,456	$14,873	$16,754	$17,719	$18,131
2	13,783	21,680	24,423	25,828	26,431
3	18,112	28,487	32,091	33,938	34,729
4	22,441	35,295	39,762	42,049	43,029
5	26,769	42,102	47,430	50,159	51,329
6	31,963	50,271	56,632	59,891	61,287
7	35,424	55,716	62,767	66,378	67,926
8	44,082	69,332	78,105	82,599	84,525
9	52,737	82,946	93,442	98,819	101,122
10	61,394	96,561	108,781	115,040	117,722
11	70,050	110,176	124,118	131,259	134,320
12	78,707	123,792	139,457	147,480	150,919
13	87,363	137,405	154,793	163,699	167,516
14	104,676	164,636	185,469	196,139	200,713
15	121,989	191,865	216,144	228,580	233,909

Prior Acts Policy Rates by Year					
Territory 1 and 2					
Rating Class	**$1,000,000/$3,000,000**				
	1	**2**	**3**	**4**	**5+**
1	$10,693	$16,818	$18,946	$20,036	$20,503
2	15,639	24,597	27,710	29,304	29,987
3	20,585	32,378	36,475	38,573	39,473
4	25,532	40,157	45,239	47,841	48,957
5	30,478	47,937	54,003	57,109	58,442
6	36,414	57,272	64,520	68,232	69,824
7	40,372	63,498	71,533	75,648	77,413
8	50,265	79,057	89,061	94,186	96,382
9	60,157	94,616	106,590	112,722	115,351
10	70,050	110,176	124,118	131,259	134,320
11	79,944	125,737	141,648	149,798	153,291
12	89,837	141,296	159,177	168,334	172,260
13	99,729	156,856	176,705	186,871	191,229
14	119,516	187,976	211,763	223,946	229,168
15	139,302	219,095	246,820	261,021	267,106

Prior Acts Policy Rates by Year					
Territory 3					
Rating					
Class	**$500,000/$1,500,000**				
	1	**2**	**3**	**4**	**5+**
1	$8,591	$13,511	$15,220	$16,096	$16,471
2	12,485	19,638	22,122	23,395	23,941
3	16,381	25,765	29,026	30,695	31,411
4	20,277	31,892	35,928	37,994	38,881
5	24,171	38,017	42,828	45,292	46,348
6	28,847	45,370	51,112	54,053	55,312
7	31,963	50,271	56,632	59,891	61,287
8	39,754	62,525	70,438	74,490	76,227
9	47,543	74,777	84,240	89,087	91,164
10	55,334	87,031	98,044	103,686	106,103
11	63,126	99,286	111,849	118,284	121,043
12	70,916	111,537	125,652	132,881	135,980
13	78,707	123,792	139,457	147,480	150,919
14	94,288	148,298	167,064	176,676	180,795
15	109,871	172,806	194,673	205,873	210,674

Prior Acts Policy Rates by Year					
Territory 3					
Rating					
Class	**$1,000,000/$3,000,000**				
	1	**2**	**3**	**4**	**5+**
1	$9,704	$15,262	$17,193	$18,182	$18,606
2	14,155	22,263	25,081	26,524	27,142
3	18,607	29,265	32,969	34,865	35,678
4	23,059	36,268	40,857	43,208	44,216
5	27,510	43,270	48,745	51,549	52,752
6	32,853	51,672	58,210	61,560	62,994
7	36,414	57,272	64,520	68,232	69,824
8	45,318	71,277	80,297	84,916	86,897
9	54,221	85,281	96,073	101,600	103,969
10	63,126	99,286	111,849	118,284	121,043
11	72,029	113,288	127,624	134,967	138,114
12	80,934	127,293	143,401	151,652	155,188
13	89,837	141,296	159,177	168,334	172,260
14	107,644	169,304	190,728	201,702	206,405
15	125,451	197,312	222,281	235,069	240,550

E. Dentists Professional Liability Class Plan

DENTISTS - CLASS 1A

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

DENTISTS - CLASS 1

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

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

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

DENTISTS - CLASS 2

80211.1 Applies to dentists, endodontics and periodontics as defined for Class 1 but, in addition, permits the initial placement dental implants. This classification also permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, but only if the sedation is administered by a Dental or Medical Anesthesiologist. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 will apply. This class does not apply to oral surgeons.

DENTISTS - CLASS 3

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

ORAL SURGERY - CLASS 4

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

Dental Rating Classes

Class	Industry Class Codes
1A	80213
1	80211 80214 80215
2	80211.1
3	80209
4	80210

F. Dentist Professional Liability Rates

Dentists				
Occurrence Coverage				
Industry		**MMMJUA**		
Specialty		**Rating**	**$500,000/**	**$1,000,000/**
Code	**Description***	**Class**	**$1,500,000**	**$3,000,000**
80213	General Dentistry – No anesthesia, extractions	1A	$2,077	$2,534
80211	General Dentistry – No anesthesia, dental implants	1	2,404	2,943
80214	Dentistry – Orthodontics/ Endodontics – no oral surgery	1	2,404	2,943
80215	Dentistry – Periodontics	1	2,404	2,943
80211.1	General Dentistry – No anesthesia, including dental implants	2	3,058	3,760
80209	Dentists - Includes intravenous sedation	3	6,985	8,664
80210	Oral Surgery	4	26,399	32,910
* See individual class details regarding specific procedures				

G. Prior Acts Policy Rates – Dentists

Dentists				
Prior Acts Policy Rates by Year- Claims-Made				
MMMJUA				
Rating				
Class	**$500,000/$1,500,000**			
	1	**2**	**3**	**4**
1A	$1,662	$2,596	$2,908	$3,219
1	1,924	3,005	3,366	3,726
2	2,446	3,823	4,282	4,741
3	5,587	8,730	9,779	10,827
4	21,118	32,998	36,958	40,918

Dentists				
Prior Acts Policy Rates by Year- Claims-Made				
MMMJUA				
Rating				
Class	$1,000,000/$3,000,000			
	1	2	3	4
1A	$2,026	$3,167	$3,547	$3,927
1	2,354	3,678	4,119	4.561
2	3,007	4,700	5,264	5,828
3	6,930	10,830	12,128	13,429
4	26,327	41,138	46,074	51,011

H. Allied Health Classifications and Rates

			Allied Health		
			Occurrence Coverage		
Territory 1&2					
Industry				**Annual Rate**	**Annual Rates**
Specialty				**$500,000/**	**$1,000,000/**
Code		**Description**		**$1,500,000**	**$3,000,000**
80964		Certified Nurse Practitioner		$7,034	$7,994
80998		Nurse		317	360
82998		Nurse – Student		88	100
80714		Nurse, RN Perform X-Ray Therapy		317	360
80944		Optometrist (Optical)		703	799
80944		Optometrist * (Employee)		3,346	3,796
80944		Optometrist * (Independent)		10,037	11,388
59112		Pharmacist		440	500
80945		Physical Therapist (Emp)		440	500
80946		Physical Therapist (Ind)		1,583	1,799
80995		Physical Therapy Aide		317	360
80912		Psychologist		1,952	2,218
80116		Physician's Assistant		7,034	7,994
80116		Surgeon's Assistant		7,034	7,994
80022		Certified Nurse Midwives		30,773	34,975
80027		Emergency Medical Technician		176	200
80410		Chiropractor		13,188	14,989
80045		Certified Nurse Anesthetists		10,861	12,374

* If administering topical ocular pharmaceutical agents

			Allied Health		
			Occurrence Coverage		
Territory 3					
Industry				**Annual Rates**	**Annual Rates**
Specialty				**$500,000/**	**$1,000,00/**
Code		**Description**		**$1,500,000**	**$3,000,000**
80964		Certified Nurse Practitioner		$6,362	$7,226
80998		Nurse		286	325
82998		Nurse – Student		80	90
80714		Nurse, RN Perform X-Ray Therapy		286	325
80944		Optometrist (Optical)		636	723
80944		Optometrist* (Employee)		3,031	3,436
80944		Optometrist* (Independent)		9,092	10,307
59112		Pharmacist		398	452
80945		Physical Therapist (Emp)		398	452
80946		Physical Therapist (Ind)		1,431	1,626
80995		Physical Therapy Aide		286	325
80912		Psychologist		1,765	2,005
80116		Physicians' Assistant		6,362	7,226
80116		Surgeons' Assistant		6,362	7,226
80022		Certified Nurse Midwives		27,832	31,613
80027		Emergency Medical Technician		159	181
80410		Chiropractor		11,928	13,548
80045		Certified Nurse Anesthetists		9,802	11,164

* If administering topical ocular pharmaceutical agents

I. Allied Health Prior Acts Premium

The following factors should be applied to the occurrence rates applicable by classification and territory to determine the Prior Acts policy premium. Term of coverage will not be rounded downward in order to determine factor (i.e. for a retro active date13 months prior to effective date, the year 2 factor will be used):

Year Prior to Eff Date	Factor
1	1.00
2	1.25
3+	1.50

J. Professional Liability Premium Credits

Moonlighting Credit

A 50% Moonlighting Credit is available to healthcare providers whose practice is limited to 20 or less hours per week and who perform covered "moonlighting" activities. This credit is not available to residents in training. This credit may be applied to full-time providers whose Missouri practice is limited to 20 hours or less per week.

Covered "moonlighting" activities include:

- Healthcare providers in active, full-time military service requesting coverage for outside activities.
- Full-time Federal Government employees (such as V.A. Hospital employees) requesting coverage for outside activities.
- Full-time State or County Health Department employees requesting coverage for outside activities.

Practice hours are defined as:

- Hospital rounds
- Charting
- On call hours involving patient contact, whether direct or by telephone,
- Consultations, and
- Patient visits/consultations.

Part-Time/Semi-Retired Credit

A 50% Part-Time Credit is available to healthcare providers whose practice is limited to 20 or less hours per week. This credit is not available to healthcare providers who perform invasive surgical procedures.

Practice hours are defined as:

- Hospital rounds
- Charting
- On call hours involving patient contact, whether direct or by telephone,
- Consultations, and
- Patient visits/consultations.

Practice hours of healthcare providers receiving the Moonlighting Discount or Part-Time/Semi-Retired Credit are subject to random audit by the Association.

Practice Interruption Credit

Individual Health Care Providers whose practice is interrupted are eligible for a one-time Practice Interruption Credit. The purpose of this discount is to “freeze” coverage while allowing the policy to remain in force. Coverage for services rendered during the “frozen” period will cease. Eligible reasons for practice interruption include sabbatical leave, active military duty, maternity leave, disability, or volunteer charitable medical assignments.

This discount is not intended for absence due to vacation, illness, leaves of less than 90 days or that extend longer than one year.

A 30% premium credit will be applied to the period of practice interruption. The discount will be applied upon return to the practice of medicine.

Group Practice Credit

A Group Practice Credit is available when a single policy issued includes five (5) or more individual healthcare providers practicing as a partnership, professional corporation, or are independently employed by the same Healthcare System.

Number of Healthcare Providers in Group	Factor
0 - 4	1.0
5 - 8	.99
8 - 11	.98
12+	.97

Loss Free Credit

A Loss Free Credit of 10% is available to healthcare providers that are loss free for five (5) or more years. The Loss Free Credit is determined based on the loss information available at the time of the underwriting review for new or subsequent renewal coverage. The credit will be evaluated based on the preceding 5 years of loss history provided by the expiring carriers’ loss runs. The credit will apply only to the active individual premium. The credit does not apply to Prior Acts Policy premiums.

“Loss” is defined as the sum of the indemnity reserve, allocated loss adjustment expenses reserve, paid indemnity, and paid allocated loss adjustment expenses as determined by the expiring carrier. Class action and individual drug litigation (i.e. Lotronex, Fen-Phen, Propulsid, Rezulin) will be forgiven and not considered when granting this credit.

K. Professional Liability Premium Surcharges

Loss Evaluation Surcharge

The Loss Evaluation Surcharge is evaluated based on the preceding ten (10) years* of loss history provided by the expiring carriers' loss runs. The Loss Evaluation Surcharge is determined based on the loss information available at the time of the underwriting review for new or subsequent renewal coverage. The debit will apply to all premiums including Prior Acts Policy premiums.

"Loss" is defined as the sum of the indemnity reserve, allocated loss adjustment expenses reserve, paid indemnity, and paid allocated loss adjustment expenses as determined by the expiring carrier. When allocated loss expense is unknown, multiply total incurred indemnity by 1.20. Two losses of $10,000 or less each, including indemnity reserve, allocated loss adjustment expenses reserve, paid indemnity, and paid allocated loss adjustment expenses will be forgiven. In addition, class action and individual drug litigation (i.e. Lotronex, Fen-Phen, Propulsid, Rezulin) will be forgiven and not considered when granting this debit.

The surcharge schedule considers both frequency and severity of cases as outlined below:

	Number of Losses									
	1	2	3	4	5	6	7	8	9	10
Up to and including $100,000	1.00	1.15	1.30	1.45	1.85	2.05	2.20	2.35	2.50	2.65
$100,001 to $250,000	1.15	1.30	1.45	1.60	2.05	2.20	2.35	2.50	2.65	2.80
$250,001 to $500,000	1.30	1.45	1.60	1.70	2.20	2.35	2.45	2.65	2.80	2.95
$500,000 to $750,000	1.45	1.60	1.70	2.20	2.35	2.45	2.60	2.80	2.95	3.10
$750,000 to $1,000,000	1.60	1.75	1.85	2.35	2.50	2.60	2.75	2.95	3.10	3.25
$1,000,000 to $1,500,000	1.75	1.90	2.00	2.50	2.65	2.75	2.90	3.10	3.25	3.40

*Loss information to be considered includes all losses *reported* in the previous ten (10) years.

Scheduled Evaluation Surcharge Criteria

A healthcare provider who is subject to any of the following shall be assessed a premium surcharge equal to 5% of the annual premium, for each offense which occurred within the last five years. If the offense occurred more than five years ago but less than 10 years ago, a surcharge equal to 2.5% of the annual premium for each offense, will apply. The surcharges are applied with the understanding that more than one surcharge may be applied for the same occurrence. (i.e. A healthcare provider reports 1) One year ago entering into a consent agreement with the state licensing board due to 2) treatment for substance abuse with 3) Hospital privileges suspension during the treatment period.) Based on the Scheduled Evaluation Surcharge Criteria the premium calculation would be base premium + .05 + .05 + .05). The surcharge will be capped at a maximum of 25% of annual premium.

These surcharges may be assessed in addition to, and not in place of, any other action taken by the Association based on information received by the Association with respect to the provider's status or standing.

1) A healthcare provider who has practiced without medical malpractice insurance.
2) A healthcare provider whose expiring coverage is with a non-standard, non-admitted carrier for cause.
3) A healthcare provider whose practice patterns or type/nature of practice presents an increased risk including but not limited to prescribing substances that are not FDA approved, performing procedures that are considered experimental, practicing a specialty for which they have not received appropriate training.
4) A healthcare provider whose hospital privileges have been denied, restricted, suspended, or revoked, or against whom probation has been invoked by a hospital.
5) A health care provider who has had their license denied, suspended, restricted or revoked or against whom probation has been invoked by the licensing authority.
6) A healthcare provider who has been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental health.
7) A healthcare provider who has relapsed following alcohol or chemical dependency treatment.
8) A healthcare provider who has been asked to participate in or has volunteered to participate in an impaired healthcare provider program.
9) A healthcare provider against whom a claim for sexual misconduct has been made.
10) A healthcare provider who has had a patient or his representative file a complaint or grievance against them with a hospital committee, state licensing or regulatory agency or other medical review committee (other than complaints determined that no probable cause existed and file closed).
11) A healthcare provider who has been charged with or convicted of a felony and/or misdemeanor including but not limited to mail fraud, and perjury.
12) A healthcare provider who has had an injury, illness, or other event occur that may impair, lessen or diminish their physical or mental ability to practice as a physician, surgeon, dentist or allied healthcare provider.
13) A healthcare provider who has appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical or dental review committee.
14) A healthcare provider who has altered medical records.
15) A healthcare provider who fails to cooperate with Association Risk Management recommendation and/or attend a sponsored Loss Prevention Seminar.
16) Ability to participate with Medicare or Medicaid revoked, suspended, placed on probation or voluntarily surrendered.

L. Locum Tenens Coverage

Coverage for temporary substitute physicians, surgeons, and dentists may be provided for a maximum of 90 days policy term with no additional premium charge. Locum Tenens are defined as physicians, surgeons, and dentists who provide temporary coverage for an insured who is normally scheduled to work but is unable to do so due to vacation, maternity leave, hospitalization, attendance at a professional meeting/seminar, illness, or family emergency. Locum Tenens coverage is not available for allied health care providers.

In order to obtain coverage, the substitute provider must complete an application and receive underwriting approval prior to the dates for which the substitute physician is providing coverage. Applications will be kept on file for one year, then an updated application will be required prior to additional use of the Locum Tenens provider. An endorsement will be issued to the insured's policy adding the substitute provider, and scheduling dates coverage is provided, on a shared limit of liability basis. Additional dates for the same provider may be added, but the Association must be notified in advance, and the policy endorsed for each additional period of time for which coverage is requested.

M. Organization Coverage

Shared Limit

For a single physician, surgeon, dentist, or allied health care provider that has formed a corporation or limited liability corporation, the coverage for the organization will be provided at no additional charge, but the limits of liability will be shared with the provider. As indicated in Section IV, General Rating Rules, Item D, Covered Medical Employees, a solo physician who employs an Allied Health Care provider who is not qualified for shared limit coverage, must purchase a separate limit.

Separate Limit

For partnerships, limited liability companies, associations, corporations or other similar entities owned by or employing more than one physician, surgeon, dentist, or allied healthcare provider, coverage can be provided for the entity on an optional basis when coverage is provided for one or more of the owner physicians.

The rate shall be 10% of all applicable charges for insured physicians, surgeons, and dentists of the organization.

This charge applies in all instances when an organization purchases a separate limit of liability. Any entity that desires coverage and is either owned by or employs more than a single physician or provider must purchase a separate limit.

Note: If there are any physicians, surgeons, dentists, or allied health care providers who own, are employed by or independently contracted by the entity who are not insured through the Association, entity coverage for the vicarious liability arising out of the activities of those providers can be included if approved by the underwriters. The rate shall be 15% of the rate that would have applied if such providers were also insured through the Association. The underwriter will require evidence of medical malpractice insurance maintained by such providers in limits equal to or greater than the limits provided by the Association policy for the organization. Such other insurance must be primary coverage with respect to the Association policy.

If coverage for entities is provided, a single policy will be issued for all providers who own or are employed by the entity who are insured through the Association. Each provider who is separately scheduled will have separate limits of liability. The organization will have a single limit of liability for all claims under the policy regardless of the number of providers covered or number of claims made against the organization.

Prior Acts Policy Rating – Premium for Prior Acts Policies for Entities will be determined in the same manner as above, except the rate will be applied to the Prior Acts Policy Rates for the provider members of the corporation rather than the Occurrence Policy Rates. Charges for non-Association insured ancillary employees will not be included in this calculation.

VI. Health Care Facility Rates and Rating Rules

A. Rating Territories

Territory 1 St. Louis City, St. Louis County, Buchanan County and City of Joplin

Territory 2 Jefferson and St. Charles County

Territory 3 Jackson County

Territory 4 Clay and Platte Counties

Territory 5 Boone and Greene Counties

Territory 6 Cities of Cape Girardeau, Carthage, Fulton, Hannibal, Jefferson City, Marshall, Mexico,

Territory 7 Remainder of State

B. Professional Liability Rates

Hospital and Outpatient Facility Rates							
$500,000/$1,500,000 Limit							
			Territory				
			1/3		2/4/5		6/7
Beds (Per Bed*)							
Acute Care Beds			$3,878		$2,327		$1,939
Mental Hospitals NP Beds			1,551		931		776
Sanitariums FP Beds			1,163		698		582
Sanitariums NP Beds			776		465		388
Rehabilitation FP Beds			388		233		194
Non-Acute Care Beds (Per Bed*)							
Medicare Certified Skilled Nursing Facility			2,909		1,745		1,454
Long Term Care (Including ICP)			194		116		97

Outpatient Visits (Rate Per Visit)**							
Mental Hospitals NP Visits			1		1		1
Rehabilitation FP Visits			1		1		1
Surgical			4		2		2
Emergency Room			2		1		1
Medicare			4		2		2
OB Clinic visits			4		2		2
Freestanding surgical center visits			19		12		10
Freestanding or remote clinic visits			1		1		1
Home health/hospice visits			1		1		1
Homemaker visits			1		1		1
Other visits			1		1		1

Hospital and Outpatient Facility Rates					
$1,000,000/$3,000,000 Limit					
			Territory		
			1/3	2/4/5	6/7
Beds (Per Bed*)					
Acute Care Beds			$4,294	$2,577	$2,147
Mental Hospitals NP Beds			$1,718	$1,031	$859
Sanitariums FP Beds			$1,288	$773	$644
Sanitariums NP Beds			$859	$515	$429
Rehabilitation FP Beds			$429	$258	$215
Non-Acute Care Beds (Per Bed*)					
Medicare Certified Skilled Nursing Facility			$3,221	$1,932	$1,610
Long Term Care (Including ICP)			$215	$129	$107

Outpatient Visits (Rate Per Visit)**					
Mental Hospitals NP Visits			$1	1	1
Rehabilitation FP Visits			$1	1	1
Surgical			$4	2	2
Emergency Room			$2	1	1
Medicare			$4	2	2
OB Clinic visits			$4	2	2
Freestanding surgical center visits			$21	12	10
Freestanding or remote clinic visits			$1	1	1
Home health/hospice visits			$1	1	1
Homemaker visits			$1	1	1
Other visits			$1	1	1

Nursing Home Rates (Per Bed*)* **					
$500,000/$1,500,000 Limits			**Territory**		
			1/3	2/4/5	6/7
Skilled Care			$923	$554	$462
Assisted Living			392	236	196
Independent Living			231	138	115
Residential Living			46	28	23

Nursing Home Rates (Per Bed*)* **					
$1,000,000/$3,000,000 Limits			**Territory**		
			1/3	2/4/5	6/7
Skilled Care			$1,073	$644	$537
Assisted Living			456	274	228
Independent Living			268	161	134
Residential Living			54	32	27

***Note outpatient services provided by Nursing Homes (i.e. Home Health or Nursing Home associated clinics) will be charged for using the “Hospital and Outpatient Facility Rates”.

Skilled Care is defined as: Professional nursing care by licensed nurses. Skilled care services usually include some or all of the following: Medical administration, tube feedings, other procedures ordered, injections, catheterizations and other procedures as ordered by a physician, assistance with activities of daily living (e.g. walking, bathing, dressing, eating). (Skilled licenses)

Assisted Living is defined as: Residents are ambulatory, with only minor medical disorders. Residents are provided protective environments (including meals, planned activities, and personal services including assistance with activities of daily living). Residents may receive incidental health care services, such as assistance with medication. (RCF I or RCF II licenses)

Independent Living is defined as: Residents are in general good health and occupy apartment, condominium, or dwelling units that may include cooking facilities. Residents do not receive any health care services or assistance with medications, but may have access to skilled intermediate or residential nursing care within the same facility complex.

Residential Living is defined as: Residents are in good general health, and occupy own apartment, condominium or dwelling including own cooking facilities. Limited supervision, no health care services or assistance with medications. Limited supportive services available; the lowest level of monitored care.

*Occupied Beds: Licensed beds times (x) occupancy rate or number of inpatient days for the policy period divided by 365 days.

** Outpatient Visits: The actual number of persons (counting each visit) who come through the door and use your outpatient facilities or services. Office visits to hospital owned physician practices should be counted in this category as outpatient visits.

(1) Use visits rather than occasions of service. For example, a patient referred to the hospital by a physician for a laboratory test and an x-ray would be counted as one visit but two occasions of service. A visit may involve multiple occasions of service from more than one clinical department.

(2) For serial visits or registrations, whereby several visits are necessary for the same type of treatment, use visits or occasions of service rather than number of registrations. If you have no way to determine each visit or occasion of service, it is recommended that you do a sample study to determine an appropriate multiple to adjust your institution's registrations or serial visits. For example, if a chemotherapy registration commonly requires 8 visits or episodes of treatment and you have 100 chemotherapy registrations, you would report an estimated 800 outpatient visits.

(3) Registrations through the emergency room for "23 hour" observation services should be reported as emergency room or all other outpatient visits (as currently registered by your institution).

(4) Specimens delivered for evaluations do not constitute OPVs. The related revenue should be reported in the revenue section of this questionnaire.

(5) Billings or other financial transactions should not be used to count OPVs.

C. Prior Acts Policy Rates

The factors in the following table will be applied to the above Occurrence based facility or nursing home rates to determine the Claims-made premium for the Prior Acts policy. Term of coverage will not be rounded downward in order to determine factor (i.e. for a retro active date13 months prior to effective date, the year 2 factor will be used):

Years of Prior Claims Made Coverage	Prior Acts Factor
1	0.75
2	1.15
3	1.30
4	1.35
5	1.40

D. Professional Liability Premium Surcharges

Facility Professional Liability Experience Rating Plan

1. Instructions

The rules of this Plan shall govern the experience rating procedure to be followed in connection with Facility Professional Liability in Missouri.

The rules below will set forth procedures, which describe use of occurrence experience.

2. Definitions

A. Risk – The term "risk" as used in this plan shall mean the exposure of any one insured to be rated by the Missouri Medical Malpractice Joint Underwriting Association.
B. Experience – For the purpose of this plan, "experience" shall mean the facility professional liability experience.
C. Experience Period Premium at Present Rates – "Experience period premium at present rates" is the sum of the premiums computed by extending the present exposures for Facility Professional Liability at present occurrence rates for limits of $1,000,000 per medical incident or occurrence, $3,000,000 aggregate, regardless of the limits of liability used in rating during the experience period.
D. Incurred Losses – "Incurred Losses" are the sum of (1) all paid and outstanding allocated claim expenses and (2) paid and outstanding indemnity losses limited to $1,000,000/claim for Facility Professional Liability allocated to the experience period in which they occurred. If loss runs do not include Allocated Loss Expense information, a 15% factor will be applied to paid loss amounts to determine claim expense to be included in this calculation.

3. General Provisions

Eligibility Requirements: Any risk developing an annual manual premium on an occurrence basis of $25,000 or more at $1,000,000/$3,000,000 rates for the Facility Professional Liability exposures shall be subject to the rules of this experience rating plan.

4. Application of Experience Modification

The experience modification developed by this plan for the risk shall be applicable to the total premium for the risk for Facility Professional Liability insurance.

5. Experience to be Used for Rating

A. The experience to be used in this plan shall be the latest available five years' experience incurred by the risk. The experience period shall commence no more than six years prior to the effective date of the experience modification to be established and expire at least one year prior to the effective date of the experience modification to be established.
B. If five years of experience is not available, the experience available shall be used in determining the experience modifications. In no instance will an experience period of less than one year be used in the determination of an experience modification.
C. Experience incurred by companies other than the Missouri Medical Malpractice Joint Underwriting Association or self-insured experience shall be used subject to the periods described above, and given credence in accordance with its apparent reliability.

6. Rating Procedure

A. Premium Subject to Experience Rating shall be the "Experience Period Premium at Present Rates" as defined in Section 2 (C) modified by the following factors:

Number of Years Between The Effective Date of Each Policy in the Experience Period and the Effective Date of the Experience Modification Being Established	Hospital Professional Liability Factor
2	.87
3	.82
4	.76
5	.71
6	.67

B. Incurred Losses Subject to Experience Rating are the sum of:

(1) "Incurred Losses" as defined in 2(D)
(2) Occurrence Policy Experience:
IBNR and Loss Development determined as a function of expected losses. Facility Professional Liability Losses. Premium Subject to Experience Rating as determined in 6(A) above for Facility Professional Liability for each year of the experience period is multiplied by the Expected Loss Ratio to produce expected losses. The appropriate loss development factor from the following table is multiplied times the expected losses to produce the indicated IBNR and loss development:

Number of Months (N) Between the Loss evaluation Date and the effective date of the latest Policy included in the Experience period	Occurrence Facility Professional Liability Factor				
	Latest Policy Year (N)	2nd Latest Policy Year (N)+12	3rd Latest Policy Year (N)+24	4th Latest Policy Year (N)+36	5th Latest Policy Year (N)+48
18	.62	.37	.20	.09	.04
21	.55	.32	.17	.07	.03
24	.48	.28	.14	.05	.02
27	.42	.24	.12	.05	.01

C. Actual Loss Ratio. The actual loss ratio for the risk shall be determined by dividing the Incurred Losses subject to Experience Rating by the Premium Subject to Experience Rating for Facility Professional Liability.

D. Credibility. The credibility rating for the risk is displayed on Table B, based on the Premium Subject to Experience Rating for Facility Professional Liability.

E. Experience Modification. The experience modification shall be determined by application of the following formula:

$$\text{Credibility} \times \frac{\text{Actual Loss Ratio} - \text{Expected Loss Ratio}}{\text{Expected Loss Ratio}} = \text{Experience Modification}$$

If the experience modification is negative, it is a credit; if positive a debit.

F. Expected Loss Ratio. The Expected Loss Ratio at limits of $1,000,000/$3,000,000 is equal to .763.

Table B
Credibility
Factors

Premium Subject to Experience Rating		Credibility Factor	Premium Subject to Experience Rating		Credibility Factor	Premium Subject to Experience Rating		Credibility Factor
0 -	16,780	0.01	579,488 -	605,529	0.35	2,392l,945 -	2,507,527	0.69
16,781 -	28,235	0.02	605,530 -	632,391	0.36	2,507,528 -	2,629,885	0.70
28,236 -	39,927	0.03	632,392 -	660,113	0.37	2,629,886 -	2,760,837	0.71
39,928 -	51,864	0.04	660,114 -	688,736	0.38	2,760,838 -	2,901,323	0.72
51,865 -	64,054	0.05	688,737 -	718,306	0.39	2,901,324 -	3,052,422	0.73
64,055 -	76,504	0.06	718,307 -	748,870	0.40	3,052,423 -	3,215,385	0.74
76,505 -	89,224	0.07	748,871 -	780,479	0.41	3,215,386 -	3,391,667	0.75
89,225 -	102,222	0.08	780,480 -	813,188	0.42	3,391,668 -	3,582,971	0.76
102,223 -	115,507	0.09	813,189 -	847,055	0.43	3,582,972 -	3,791,304	0.77
115,508 -	129,089	0.10	847,056 -	882,143	0.44	3,791,305 -	4,019,048	0.78
129,090 -	142,978	0.11	882,144 -	918,519	0.45	4,019,049 -	4,269,048	0.79
142,979 -	157,184	0.12	918,520 -	956,254	0.46	4,269,049 -	4,544,737	0.80
157,185 -	171,719	0.13	956,255 -	995,428	0.47	4,544,738 -	4,850,292	0.81
171,720 -	186,594	0.14	995,429 -	1,036,124	0.48	4,850,293 -	5,190,850	0.82
186,595 -	201,821	0.15	1,036,125 -	1,078,431	0.49	5,190,851 -	5,572,794	0.83
201,822 -	217,413	0.16	1,078,432 -	1,122,449	0.50	5,572,795 -	6,004,167	0.84
217,414 -	233,382	0.17	1,122,450 -	1,168,282	0.51	6,004,168 -	6,495,238	0.85
233,383 -	249,744	0.18	1,168,283 -	1,216,046	0.52	6,495,239 -	7,059,341	0.86
249,745 -	266,512	0.19	1,216,047 -	1,265,865	0.53	7,059,342 -	7,714,103	0.87
266,513 -	283,703	0.20	1,264,866 -	1,317,874	0.54	7,714,104 -	8,483,333	0.88
283,704 -	301,331	0.21	1,317,875 -	1,372,222	0.55	8,483,334 -	9,400,000	0.89
301,332 -	319,414	0.22	1,372,223 -	1,429,070	0.56	9,400,001 -	10,511,111	0.90
319,415 -	337,970	0.23	1,429,071 -	1,488,594	0.57	10,511,112 -	11,886,111	0.91
337,971 -	357,018	0.24	1,488,595 -	1,550,987	0.58	11,886,112 -	13,632,143	0.92
357,019 -	376,577	0.25	1,550,988 -	1,616,463	0.59	13,632,144 -	15,923,810	0.93
376,578 -	396,668	0.26	1,616,464 -	1,685,256	0.60	15,923,811 -	19,066,667	0.94
396,669 -	417,314	0.27	1,685,257 -	1,757,625	0.61	19,066,668 -	23,650,000	0.95
417,315 -	438,537	0.28	1,757,626 -	1,833,855	0.62	23,650,001 -	30,983,333	0.96
438,538 -	460,362	0.29	1,833,856 -	1,914,264	0.63	30,983l,334 -	44,733,333	0.97
460,363 -	482,816	0.30	1,914,265 -	1,999,206	0.64	44,733,334 -	61,400,000	0.98
482,817 -	505,925	0.31	1,999,207 -	2,089,076	0.65	61,400,001 -	80,000,000	0.99
505,926 -	529,719	0.32	2,089,077 -	2,184,314	0.66	80,000,001 -	Infinity	1.00
529,720 -	554,229	0.33	2,184,315 -	2,285,417	0.67			
554,230 -	579,487	0.34	2,285,418 -	2,392,944	0.68			

Schedule Rating Plan

A healthcare facility subject to any of the following, shall be assessed a premium surcharge equal to 5% of the annual premium for each offense that occurred within the last five years. The surcharges apply with the understanding that more than one surcharge may be applied for the same occurrence. Surcharges will be added together, and will be subject to a maximum applicable surcharge of 25% of annual premium.

These surcharges may be assessed in addition to, and not in place of, any other action taken by the Association based on information received by the Association with respect to the provider's status or standing.

1) A healthcare facility or nursing home that has operated without medical malpractice insurance.
2) A healthcare facility or nursing home that fails to maintain Commercial General Liability with limits of liability of at least $500,000 each occurrence/$1,500,000 general aggregate or $1,000,000 each occurrence/$3,000,000 general aggregate.
3) A healthcare facility or nursing home whose expiring coverage is with a non-standard, non-admitted carrier for cause.
4) A healthcare facility or nursing home that fails to obtain Extended Reporting Coverage from previous claims-made carriers or to purchase a Prior Acts Policy from the Association, covering all previous claims-made policy terms.
5) A healthcare facility whose type/nature of operation presents an increased risk including but not limited to administering substances that are not FDA approved or engaging in procedures that are considered experimental.
6) A healthcare facility or nursing home whose licenses, certification or ability to participate with Medicare or Medicaid has been revoked, suspended, placed on probation or voluntarily surrendered.
7) A healthcare facility or nursing home that fails to meet current life safety code requirements as published in Fire Code/Uniform Fire Code.
8) A healthcare facility or nursing home that fails to maintain a written patient transfer plan for all contingencies which includes an audit process and is monitored through committee.
9) A healthcare facility that is not accredited by JCAHO, AHCA, or equivalent accreditation or whose accreditation has outstanding contingencies. (For nursing homes, the state inspection is sufficient to meet this requirement).
10) A healthcare facility or nursing home that fails to perform background checks on all staff who have patient or resident contact (employees, leased workers, students, and volunteers) including criminal history (5 years), felonies, misdemeanors, sexual offenses, abuse, theft, assault, credit history, verification of all education, verification of references, US citizenship status/Visa, substance test, federal database, local database
11) A healthcare facility or nursing home whose employed or contracted physicians fail to maintain individual professional liability coverage with limits of liability equal to the limits selected by the facility.
12) A healthcare facility or nursing home that fails to maintain a written continuing education plan which includes risk management topics for nursing, physicians, administration, governing board and department heads.
13) A healthcare facility or nursing home that fails to cooperate with Association Risk Management recommendation and/or attend a sponsored Loss Prevention Seminar.

(14) Nursing Homes - for each Class I or I/II deficiency (whether corrected or not) as indicated on the most recent State Inspection.
(15) Nursing Homes – for each case of repeated class II/III or III deficiencies (whether corrected or not) as indicated on the most recent three State Inspections.
(16) Nursing Homes without a policy to check on residents every day.
(17) Nursing Homes which do not conduct a nursing assessment for every new resident including evaluation of Skin/Decubiti, Mobility Limitations, Urinary Incontinence, History of Prior Injuries, Required Assistance, Orientation/Cognition, Current Medications, Fall Risk, Wandering Tendencies, Nutritional Needs, and Risk of Provoking or Initiating Abusive Behavior.
(18) Nursing Homes that do not have a policy clearly identifying the types of Dementia residents for whom staff is capable of providing care.
(19) Nursing Homes that accept Dementia/Alzheimer's patients that do not include a secured unit(s) for residents prone to wandering.
(20) Nursing Homes that do not perform fall assessments.
(21) Nursing Homes that do not have and enforce a policy regarding smoking in and around the facility.
(22) Nursing Homes that do not perform and document regular rounds of the physical plant and grounds, to ensure they are in a safe and well maintained condition.
(23) Nursing Homes that do not provide education on wound prevention and treatment to their staff.
(24) Nursing Homes that do not have documented policies and procedures on assisting residents with self-medication and administering medication in place.
(25) Nursing Homes that do not have written protocols in place for notification of resident's health care provider in cases of Acute Change of Condition.
(26) Nursing Homes that do not have a written Emergency Evacuation Plan for the facility.

E. Commercial General Liability Rating Rules

Commercial General Liability premium shall be calculated by applying a 10% factor to the professional liability premium as determined above. Terrorism coverage is included within the 10% charge. Should a provider wish to reject Terrorism coverage, the premium will be reduced by an amount equal to 1% of the General Liability Premium. Coverage shall be provided based on limits of $500,000 per occurrence, $1,500,000 annual general aggregate, $1,500,000 annual products/completed aggregate; or $1,000,000 per occurrence, and $3,000,000 annual general aggregate, $3,000,000 annual products/completed operations aggregate, and $100,000 limit for premises damage liability. No Medical Payments coverage is available under this program.

Charges will be made for additional exposures located on the same premises as the insured facility as indicated in the following table:

Description	Rating Basis	Rate at	Rate at
		$500,000/$1,500,000	$1,000,000/$3,000,000
Swimming Pools	Each	$647	$730
Saunas/Hot Tubs	Each	$647	$730
Exercise/Weight Rooms	Each	$647	$730
Gymnasiums	Each	$647	$730
Rental Dwellings	Each	$86	$97
Meeting Rooms	Per 1,000 square feet	$104.65	$112.19
Cafeterias serving food to other than residents for a charge	Per $1,000 receipts	$4.69	$5.08

The Association will not provide General Liability coverage at locations other than the insured facility location(s).

Should the provider's previous coverage have been written on a claims-made form, and the provider wishes to purchase a Prior Acts Policy from the Association, the following factors may be applied to the provider's Association General Liability premium to determine the claims- made Prior Acts Policy premium:

Year 1 of Retro-Active Coverage	.30
Year 2 or more	.40

The Prior Acts Policy may only be offered incidental to Occurrence coverage written for the provider by the Association.

APPENDIX A

Policy Forms and Applications
(as of July 19, 2019)

Approved Policy Forms

Occurrence Physicians, Surgeons, and Dentists Professional Liability Declarations Page #MMM100P0116
Occurrence Physicians, Surgeons, and Dentists Professional Liability Supplemental Declarations Page #MMM101P0506
Occurrence Physicians, Surgeons, and Dentists Professional Liability Coverage Form #MMM120PSD0704
Physicians, Surgeons or Dentists – Missouri Limitation Endorsement #MMM125PSD0604
Individual Named Insured's Personal Professional Corporation #MMM-MP-120-0
Exclusion – Military Service or Federal Government Employee #MMM130PSD1004
Locum Tenens Endorsement #MMM135PSD0805
Leave of Absence or Disability Endorsement #MMM140PSD0506
Occurrence Facility Declarations Page #MMM300F0116
Occurrence Facility Supplemental Declarations Page #MMM301F0506
Occurrence Facility Professional Liability Coverage Form #MMM320F0704
Occurrence Allied Health Declarations Page #MMM200A0116
Occurrence Allied Health Supplemental Declarations Page #MMM201A0506
Occurrence Allied Health Professional Liability Coverage Form #MMM220A0704
Occurrence Commercial General Liability Coverage Form #MMM400G0105
Commercial General Liability Terrorism Disclosure Form #MMM401G0604
Commercial General Liability Terrorism Notice Form #MMM405G1204
Commercial General Liability – Additional Insured Endorsement #MMM403GL0804
Commercial General Liability – Additional Insured – Lender Endorsement #MMM406GL0707
Commercial General Liability – Missouri Limitation Endorsement #MMM420GL0604
Commercial General Liability – Designated Premises Exclusion #MMM404GL1104
Exclusion of Certified Acts of Terrorism and Other Acts of Terrorism #MMM402GL0904
Prior Acts Policy Declarations Page #MMM500PA0116
Prior Acts Physician, Surgeon or Dentist Professional Liability Coverage Form #MMM501PSD0105
Prior Acts Allied Health Professional Liability Coverage Form #MMM502A0105
Prior Acts Facility Declaration Page #MMM505FPA0116

Prior Acts Facility Professional Liability Coverage Form #MMM503F0105
Prior Acts Commercial General Liability Coverage Form #MMM504G0105
General Endorsement #MMM600G0904

Prior Acts Forms are issued incidental to an Occurrence Physicians, Surgeons and Dentists, Facility, or Allied-Health Professional Liability Coverage Form.

Approved Applications
Physicians and Surgeons Professional Liability Application #MMM110PS0116
Physicians and Surgeons Professional Liability Renewal Application #MMM110PSRe0116
Dentist Professional Liability Application #MMM130D0116
Dentist Professional Liability Renewal Application #MMM130DRe0116
Facility Professional Liability Application #MMM310F0116
Allied-Health Professional Liability Application #MMM215A0116
Allied-Health Professional Liability Renewal Application #MMM215ARe0116
Locum Tenens Application #MMM125L0116

Certificates of Insurance
Facility Certificate of Insurance #MMMJUAFACCT
Physicians and Surgeons Professional Liability Certificate of Insurance #MMMJUAPHYSCT