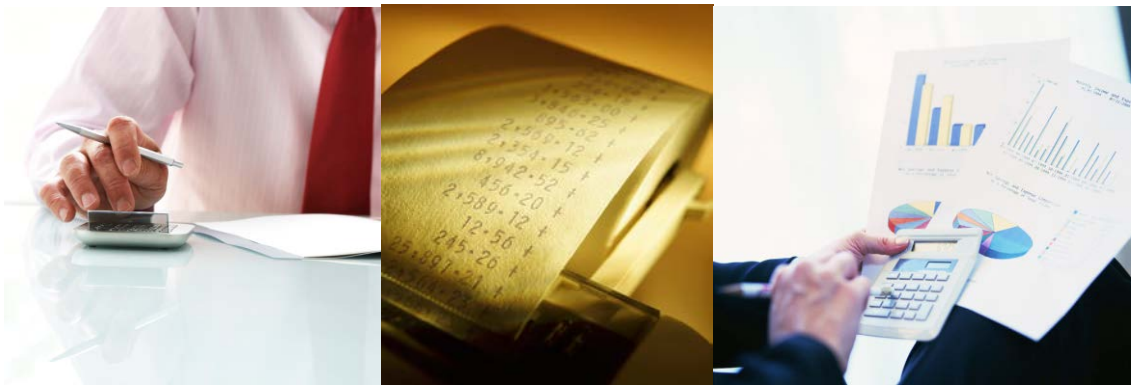
Commonwealth of Pennsylvania

pennsylvania
INSURANCE DEPARTMENT

Medical Care Availability and Reduction of Error Fund

2012
Assessment Manual



Tom Corbett, Governor / Michael F. Consedine, Insurance Commissioner

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Commonwealth of Pennsylvania
Insurance Department

Medical Care Availability and Reduction of Error Fund ("Mcare")

2012 ASSESSMENT MANUAL

Introduction

This manual should be used to calculate the Mcare assessment for 2012 as required by Act 13 of 2002 ("Act 13"). It is essential that this manual is read in its entirety. While the manual is intended to clarify and periodically modify procedures associated with calculating the assessment, the manual is not a substitute for complying with Act 13 (40 P.S. § 1303.101 et seq.) and the regulations (31 Pa. Code § 242.1 et seq.). Although the information in this manual is intended to complement Act 13 and its attending rules and regulations, if a conflict exists, Act 13 and its regulations are controlling.

The Mcare assessment is a percentage of the Pennsylvania Professional Liability Joint Underwriting Association ("JUA") rates as approved by the Pennsylvania Insurance Department. For Mcare assessment calculation purposes, the JUA rates to be used are the base rates that are effective January 1, 2012. It has been determined that the 2012 assessment rate is 23%.

TIP: Consulting the JUA Rate Manual at www.pajua.com may provide details not specifically addressed in this manual.

2012 MCARE LIMITS

Act 13 provides that the total required amounts of medical professional liability coverage, including primary and Mcare coverage, for health care providers, excluding hospitals, are $1,000,000 per occurrence and $3,000,000 per annual policy year aggregate. For hospitals, the required total coverage amounts are $1,000,000 per occurrence and $4,000,000 per annual aggregate. As in recent years, Mcare Fund participating health care providers will be required in 2012 to obtain primary coverage in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate. Hospitals must obtain primary coverage in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate. Mcare provides participating health care providers coverage of $500,000 per occurrence and $1,500,000 per annual aggregate in excess of the primary coverage.

CONTACTING MCARE

This manual addresses assessment calculation issues that most commonly arise. The principles contained in this manual can also be applied to many novel situations. After reading this manual, anyone with questions regarding calculation of the Mcare assessment should submit their questions in writing to Mcare.

Mailing Address:
Mcare
Division of Policy Administration
P.O. Box 12030
Harrisburg, PA 17108-2030

For Special Deliveries:
Mcare
Division of Policy Administration
30 N. Third Street, 8th Floor
Harrisburg, PA 17101

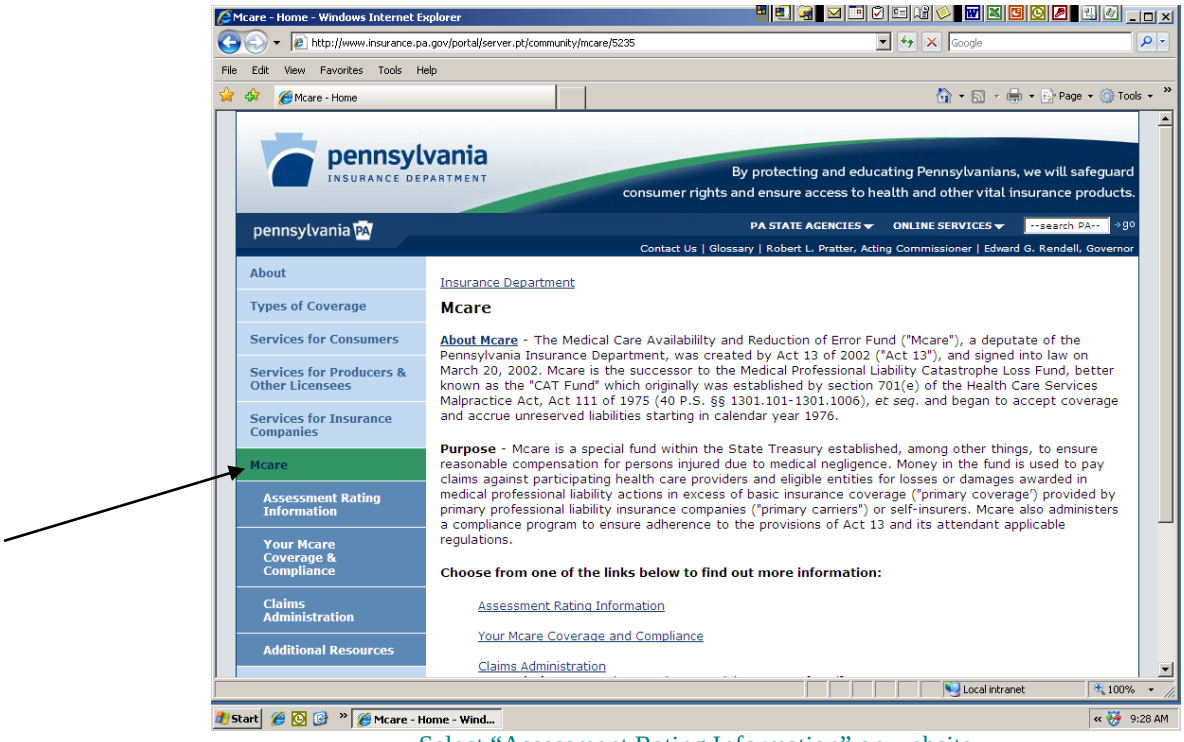
e-216 submission e-mail: ra-in-remittance@pa.gov
Phone: (717) 783-3770 **Fax:** (717) 705-7342

SECTION I - REMITTANCE ADVICE FORM AND e-216

A. FORM 216 GENERAL INFORMATION: Form 216 serves as both a coverage reporting form as well as an accounting form. Prior written permission must be obtained from Mcare before alternate electronic submission or hardcopy only submissions will be accepted.

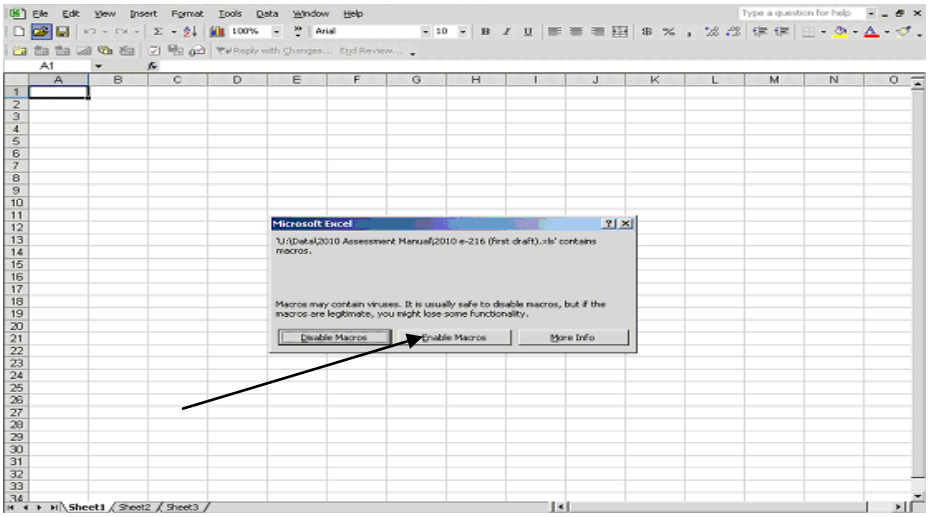
Always download a new e-216 from our website each time you need to complete another e-216. Mcare periodically improves Form e-216. Downloading a brand new Form e-216 each time will ensure the latest version is used. Form e-216, along with all applicable Worksheet Exhibits, is available by:

- Visiting our website at **www.insurance.pa.gov**
- **Selecting "Mcare" from menu on the left**
- Selecting "Assessment Rating Information" from menu on the left
- Selecting the link for the appropriate year's assessment manual
- Selecting the "e-216 Remittance Advice Form" link
- Opening or saving the file



Select "Assessment Rating Information" on website

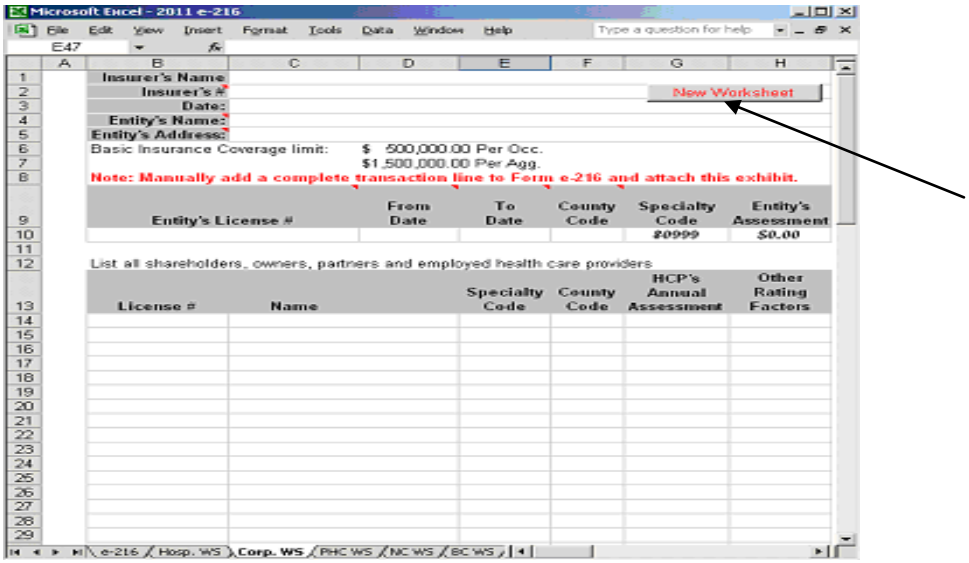
In addition to submitting a hardcopy Form 216, an electronic Form e-216 is also required. **It is important that the hardcopy 216 is identical to its corresponding e-216.** Form e-216 is a Microsoft Excel spreadsheet that contains macros which add functionality to the spreadsheet. When prompted to choose whether to "Disable Macros" or "Enable Macros," please choose the "Enable Macros" button. (Example on next page)



Select "Enable Macros"

TIP: If you are not prompted to "Disable Macros" or "Enable Macros," your macro security level is set too high. Go to "Tools", choose "Macro" and click on "Security." Please choose "Medium" or "Low" in order to enable macros.

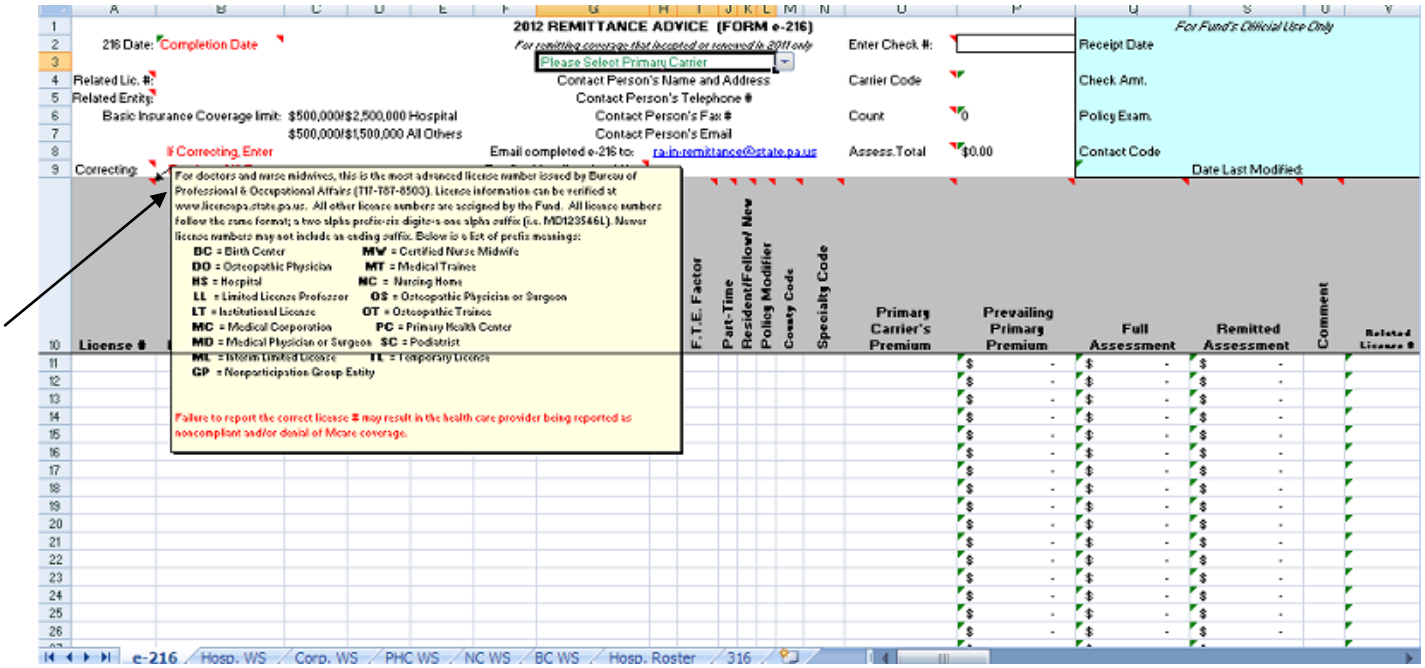
Form e-216 calculates the full assessment payable for physicians, podiatrists and certified nurse midwives based on the information provided in columns "A" through "N." The worksheets, Hospital Roster, and Form 316 are tabbed at the bottom of the Form e-216. The worksheets will calculate the assessment for hospitals (Hosp. WS), corporations (Corp. WS), birth centers (BC WS), nursing homes (NC WS) and primary health centers (PHC WC). Since the worksheet will not update the Form e-216 automatically, it is necessary for the coverage and assessment information to be added to the Form e-216 manually. The worksheets for these entities must be submitted in addition to and along with the completed Form e-216.



"New Worksheet" button

TIP: When submitting multiple worksheets, it is helpful to select the "new worksheet' button for each worksheet.

Placing the cursor on a field that has a small red triangle in the upper right-hand corner of the cell on the Form e-216 will cause a comment box to appear that describes in detail the information needed in that field. All applicable fields of information must be completed.



"Comment" box on the e-216

The 2012 Form e-216 is to be used to report coverage only for policies issued or renewed in 2012. This is because the 2012 Form e-216 will calculate the assessment based on 2012 rates. When reporting mid-term additions and deletions to an existing master policy, use the effective year of the master policy to determine the applicable assessment year and rates.

NOTE: FORM E-216 IS A TOOL TO ASSIST IN THE CALCULATION OF THE ASSESSMENT; HOWEVER, ALL ASSESSMENTS MUST BE REVIEWED FOR ACCURACY BEFORE SUBMITTING TO MCARE. TRANSACTIONS SHOULD BE REPORTED AND RECEIVED AT MCARE IN CHRONOLOGICAL ORDER.

TIP: Select a due date for your invoice which allows sufficient time for you to comply with the 60-day reporting requirement.

Coverage information along with collected assessment payments, if applicable, should be received by Mcare **within 60 days of the effective date of coverage in order to be considered timely.** Failure to remit a sufficient assessment within 60 days of the effective date of coverage may result in disciplinary action against a health care provider's medical license and the denial of Mcare coverage in the event of a claim against the health care provider or eligible entity.

Submitting hardcopy 216's with a check:

Please make checks payable to: Medical Care Availability and Reduction of Error Fund or "Mcare." Each check must be accompanied by a completed hardcopy Form 216 that is identical to the electronic e-216, a cover letter, and any applicable worksheets and supporting documentation. The remittance total must be equal to the check amount remitted unless the primary insurer or self-insurer has a prior credit balance and it is properly documented in the attached cover letter how Mcare is to use the credit. A Form 216 accompanied by a check that is post-dated after Mcare received the 216 will not be processed.

TIP: When money is due with a Form 216, the "received date" is the date that the hard copy 216 and check are received at Mcare. The "received date" is **not** the date of the e-mailed e-216.

Submitting hardcopy 216's without a check:

Even if no money is due, a hardcopy 216 must be received by Mcare. The hardcopy 216 must be identical to the corresponding e-216. A cover letter and any applicable worksheets and supporting documentation must be sent along with the hardcopy 216.

TIP: When no money is due with an e-216, the "received date" is the date the e-mail with attached e-216 is received by Mcare.

B. ELECTRONIC SUBMISSIONS. The standard for primary insurers and self-insurers submitting coverage and payment information to Mcare is to do so electronically via e-mail to Mcare at the following e-mail address: **ra-in-remittance@pa.gov**. Additionally, the hard copy and payment, if applicable, must be received by Mcare.

When preparing your electronic submission please keep the following in mind:

- The Commonwealth of Pennsylvania's e-mail system will not accept an e-mail with a file size of 10 megabytes or larger. Files 10 MB or larger must be placed on a disk and mailed or divided in smaller megabytes and e-mailed separately.
- For e-216s that require multiple e-mail submissions, please include in the body of the e-mail the number and total number (x of y) of e-mails pertaining to the submission. (i.e. 1 of 4, 3 of 3, etc.)

The formatting of the e-mail "Subject Line" is very important, as your e-mail will be electronically sorted based upon this information. The **Subject line** of the e-mail must be in the following format.

e-216's with a check:

Insurer's 3 digit Mcare assigned # Official e-216 Date of e-216 Check No.

EXAMPLE: 000 Official e-216 01/01/12 Check No. 123456

e-216's without a check:

Insurer's 3 digit Mcare assigned # Official e-216 Date of e-216 [Do not type anything after date]

EXAMPLE: 000 Official e-216 01/01/12

Electronic submissions may be sent in one of the following formats:

1. Exhibit 4 – Remittance Advice Form e-216.*

   Transmit the completed Form e-216 by e-mail to Mcare or send a CD or diskette by mail along with a hardcopy 216 and the check, if applicable.

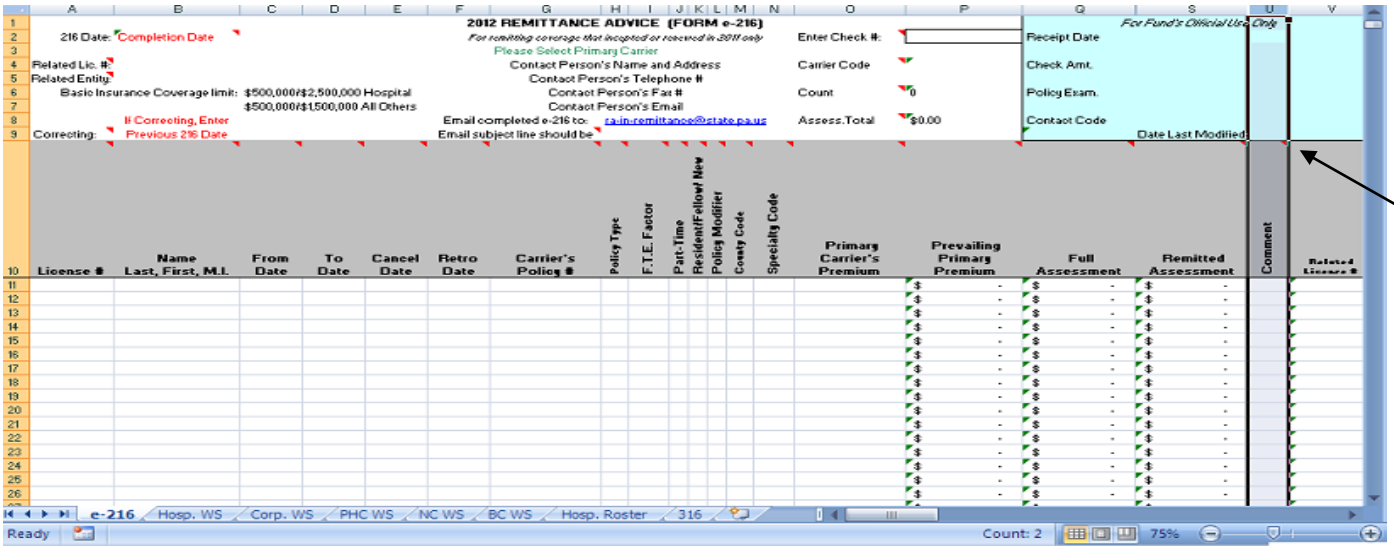
2. Fixed Width Text File Format.*
   Submissions in this format must be pre-approved by Mcare. Specifications for this format can be provided by your Mcare Coverage Specialist. Once approved, submissions can be transmitted by e-mail, tape or other electronic media. This type of electronic submission is limited to new, renewal, mid-term additions and tails. Cancellations, corrections and endorsements must be remitted separately via Form e-216.

3. Comma Separated Value Format.*
   Submissions in this format must be pre-approved by Mcare. Specifications for this format can be provided by your Mcare Coverage Specialist. Once approved, submissions can be transmitted by e-mail, tape or other electronic media. This type of electronic submission is limited to new, renewal, mid-term additions and tails. All cancellations, corrections and endorsements must be remitted separately via Form e-216.

TIP: Please allow 24-hours to receive a confirmation for e-216s submitted to the ra-in-remittance@pa.gov e-mail address. Issues with Internet Service Providers, e-mail providers, network traffic, and server/mailbox can degrade transmission of e-mails. If you do not receive a confirmation after 24-hours, please notify your Mcare Coverage Specialist..

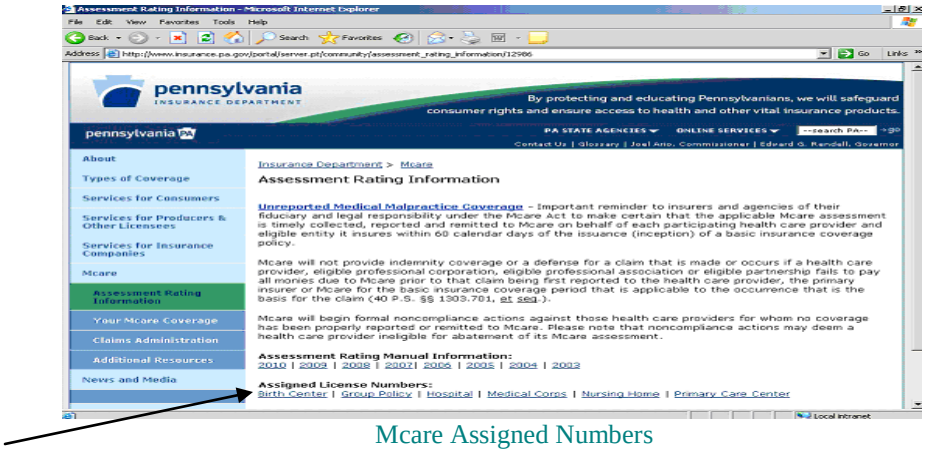
SECTION II - REPORTING GUIDELINES

A. COMMENT COLUMN. The Comment column is a required field and ***must*** be completed on each coverage line of the Form e-216. It is very important that this information be accurate. Please be mindful to use the "New" comment only for business that is new to your company. Please use the "Rnwl" comment only for business that is a renewal. (Example: HCP is with "Company A" 1/1/11-1/1/12, and then renews with same company for 1/1/12-1/1/13; coverage should be reported as "Rnwl".) Please use the "Cncl" comment only when basic insurance coverage is actually being cancelled. A description of each comment can be found on the Form e-216 by placing your cursor on the red triangle at the top of the Comment column.



Comment column on the e-216

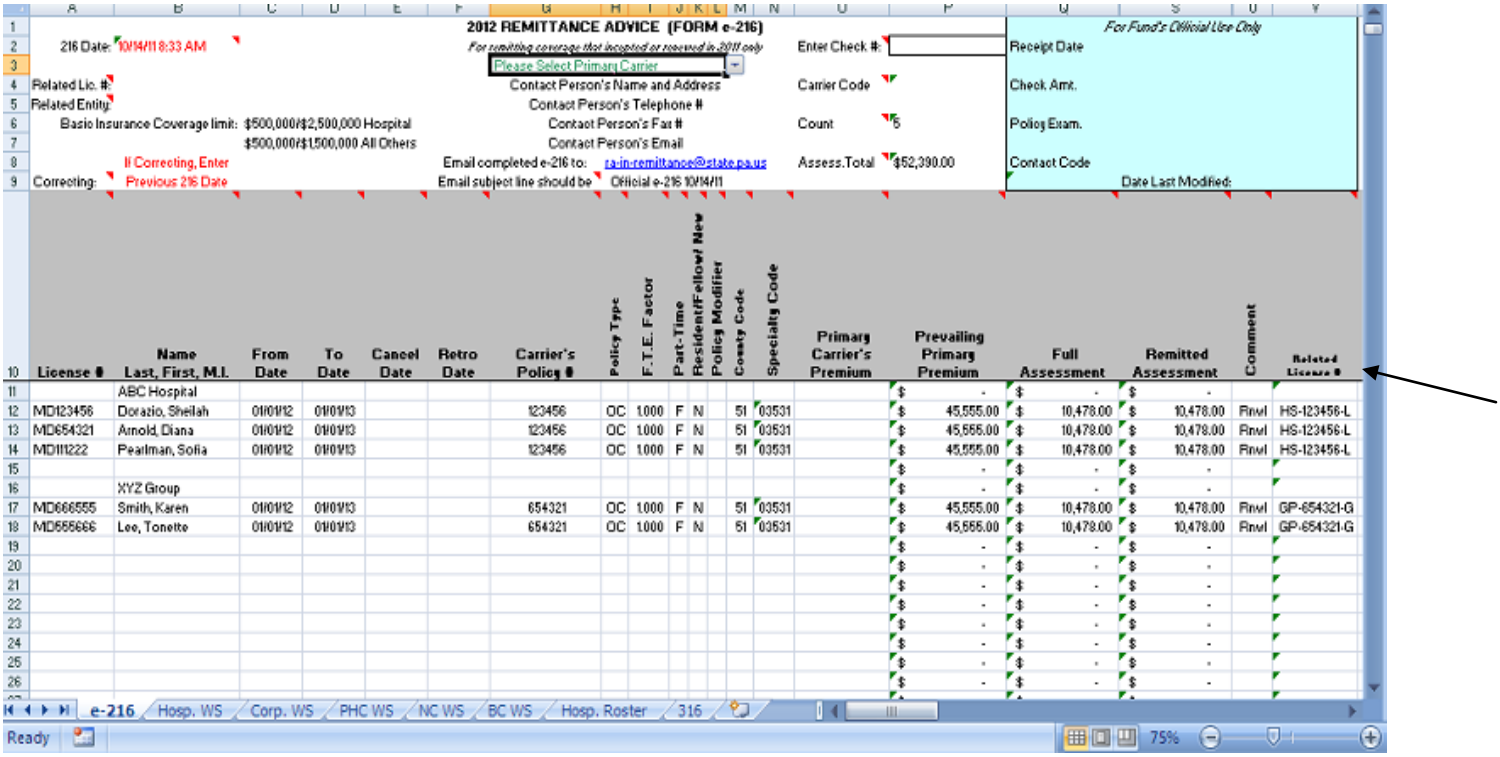
B. RELATED LICENSE NUMBERS are assigned by Mcare to identify specific hospitals (HS), corporations (MC) or groups (GP). Mcare assigns a GP number to a nonparticipating entity whenever a group of health care providers are reported under the same policy. Mcare identifies the specific related hospital, corporation, or group that individual health care providers are employed by or affiliated with for rating and statistical purposes. "Related License Numbers" can be found on our website by selecting "Mcare" and then selecting "Assessment Rating Information". If a related license number is not found on our website, input "TBD" (To Be Determined) in the related license number column only if you believe you will not meet the 60 day reporting requirement.



Mcare Assigned Numbers

When submitting a Form e-216 for health care providers employed by one related license number, indicate the Mcare issued related license number in the related license number field at the top of the Form e-216 (cell B4). This will automatically populate the related license number in the V column on the Form e-216. Complete cell B5 with the related entity name.

If submitting a Form e-216 with multiple related license numbers, please type the related license number in the V column of the Form e-216 corresponding with each line of coverage. One continuous Form e-216 per remittance should be e-mailed regardless of how many related license numbers are reported. If this is problematic, please contact the Coverage Specialist who handles your account. Please type the corresponding name of the hospital, corporation, or group as a heading in the name column on the line above each group of health care providers having the same related license number.



Mcare Related License Numbers

C. ENDORSEMENTS AND CANCELLATIONS must be received by Mcare within 60 calendar days of the effective date of the endorsement or cancellation. Extended reporting endorsements ("tail") are due to Mcare within 120 calendar days of the expiration or cancellation of the underlying claims-made coverage. When an endorsement or cancellation is reported to Mcare and the result is a credit, the credit shall be reported on the Form e-216 with parentheses to distinguish it from a debit. Mcare calculates transactions on a pro rata basis (i.e., for a partial year of coverage).

If the reporting of a cancellation, an endorsement or the sum of an endorsement falls beyond the 60-day reporting requirement and results in an assessment credit, the cancellation or endorsement shall still be reported, but no credit will be issued or accepted by Mcare.

There are five exceptions to the no credit rule for a cancellation or endorsement that is received by Mcare beyond 60 days from the effective date of the cancellation or endorsement:

- Cancellation due to suspension or revocation of the insured's license
- Cancellation by carrier due to nonpayment of premium
- Cancellation or endorsement submitted with the written consent of Mcare
- The health care provider is deceased or disabled ☑

ENDORSEMENTS (END) are a change to previously reported coverage that is not a cancellation or correction. Endorsements should be reported by simulating cancellation of the previously reported coverage effective the endorsement date. This is done by entering the original policy "From Date" and "To Date" and entering the endorsement date in the "Cancel Date" column, but indicates "**END**" in the "Comment" column. On the next line, show the endorsement date as the "From Date" and the expiration date as the "To Date." Also indicate "END" in the "Comment" column on this line. The Form e-216 will calculate the assessment for both of these lines. Should you have any questions or are in need of assistance, please contact your Coverage Specialist.

CANCELLATIONS (CNCL) should be reported by entering the full original policy period in the coverage "From Date" and "To Date" and entering the cancellation date in the "Cancel Date" column. Indicate "**CNCL**" in the "Comment" column of the Form e-216. The Form e-216 will calculate the return assessment credit.

TIP: Mcare will not honor request for credit for an endorsement or cancellation that is reported to Mcare more than 60 days after the effective date of the endorsement or cancellation. You may wish to inform those for whom you calculate the assessment that they must have endorsement and cancellation information to you in sufficient time for you to submit such information to Mcare within 60 days of the endorsement or cancellation effective date.

D. CORRECTIONS (CORR) Failure to provide correct information or full payment to Mcare may result in a health care provider being reported to the licensing board for noncompliance. A claim that is made prior to Mcare's receipt of correct information or full payment being reported to Mcare may result in the denial of Mcare coverage.

The Correction Form e-216 should include a copy of the correspondence from Mcare that identified the discrepancy(ies). To properly report a correction, reverse what was originally reported incorrectly and report a new line with the correct information. This will result in two line items on the Form e-216 per correction. The first line should show the "From Date" and the "To Date" that were originally reported, the effective date in the "Cancel Date" column, and the reverse of any information or assessment that was incorrectly submitted (if originally reported a debit, report a credit of the same amount and if originally reported as a credit, report a debit of the same amount). On the next line report the correct information with the correct assessment amount. Also, indicate "CORR" in the "Comment" column on both lines. A Correction Form e-216 should include only those health care providers being corrected. Do not resubmit entries that were previously reported correctly. The Correction Form e-216 should be

given a new remittance date but also insert the remittance date of the original remittance you are correcting on the line on the e-216 that states "Correcting (date)" (Cell B9).

SECTION III - CALCULATING MCARE ASSESSMENT

Mcare assessments are to be remitted to Mcare via the Form e-216 along with the cover letter and any other required documents. Always download a new e-216 from our website each time you need to complete another e-216. This section is designed to assist in the manual calculation of the Mcare assessment for the various types of health care providers and eligible entities participating in Mcare.

A. PHYSICIANS, PODIATRISTS AND CERTIFIED NURSE MIDWIVES

REQUIRED FORM: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)

NOTE: PENNSYLVANIA LAW REQUIRES PHYSICIANS, PODIATRISTS AND CERTIFIED NURSE MIDWIVES TO HAVE FULL ANNUALIZED, SEPARATE AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH AN MCARE PARTICIPATING PHYSICIAN, PODIATRIST OR CERTIFIED NURSE MIDWIFE.

1. Determine highest rated classification. (Refer to Exhibit 3)

2. Determine highest rated territory. (Refer to Exhibit 10)

   WHEN TWO OR MORE CLASSIFICATIONS AND/OR TERRITORIES ARE APPLICABLE TO COVERAGE BEING REPORTED, THE ASSESSMENT FOR THE HIGHEST RATED CLASSIFICATION AND/OR TERRITORY WILL APPLY.

3. Locate appropriate prevailing primary premium. The assessment for a physician, podiatrist or certified nurse midwife must be calculated by multiplying the prevailing primary premium by the 2012 annual assessment rate of 23%. (Refer to Exhibit 1)

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Submit a completed Form e-216.

B. PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND PARTNERSHIPS (SPECIALTY CODE 80999)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM e-216)
EXHIBIT 5 (WORKSHEET FOR PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND PARTNERSHIPS)

NOTE: PENNSYLVANIA LAW PROHIBITS PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND PARTNERSHIPS FROM SHARING LIMITS WITH ANY HEALTH CARE PROVIDER. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A PARTICIPATING PROFESSIONAL CORPORATION, PROFESSIONAL ASSOCIATION OR PARTNERSHIP.

Proof of Mcare eligibility is required for any entity that is newly reported to Mcare or that changes its professional corporation, professional association or partnership status. Copies of Articles of Incorporation, approved and stamped by the Pennsylvania Department of State, and a list of owners and

shareholders are required for professional corporations and professional associations. Copies of partnership agreements are required for partnerships. Professional corporations, professional associations and partnerships must be reported on the Form e-216 and submitted along with their applicable worksheets. Reporting of mid-term endorsements, additions and deletions is not required; however, if choosing to report mid-term changes to a policy, all mid-term changes must be reported.

TIP: For more information about Mcare participation for Professional Corporations, Professional Associations and Partnerships, please refer to Section 744 of Act 13 of 2002.

1. Calculate the assessment for a professional corporation, professional association or partnership by computing the sum of 15% of the total 2012 Mcare assessments for each shareholder, owner, partner, independent contractor and employed health care provider. (Refer to Example 1)

NOTE: ALL SHAREHOLDERS OF A PROFESSIONAL CORPORATION OR PROFESSIONAL ASSOCIATION, AND ALL PARTNERS OF A PARTNERSHIP MUST BE HEALTH CARE PROVIDERS AS DEFINED IN ACT 13 OF 2002; HOWEVER, THEY DO NOT NEED TO BE AN MCARE PARTICIPATING HEALTH CARE PROVIDER.

Example 1

Five health care providers are shareholders, owners, partners, independent contractors or employees of Professional Corporation "Y" which provides emergency room services in Territory 1.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD123456	John Smith	03531	51	$ 7,859	Y3
MD654321	Jane Smith	03531	51	$ 10,478	
MD012345L	Mark Jones	03531	51	$ 10,478	
MD054321E	Sally Jones	03531	51	$ 10,478	
MD246810	Joseph Miller	03531	51	$ 6,811	PT 16

The sum of the total 2012 assessments for all health care providers who are shareholders, owners, partners or employees of Professional Corporation "Y" is $46,104. ($7,859, $10,478, $10,478, $10,478 and $6,811 = $46,104). Thus, the 2012 assessment owed by Professional Corporation "Y" is $6,916 ($46,104 X 15% = $6,916).

If any of the shareholders, owners, partners, independent contractors or employees has different policy dates than the professional corporation, professional association or partnership policy, they shall be listed on the worksheet with their annual 2012 assessment that is effective or will be effective in the same calendar year as the professional corporation, professional association or partnership's policy. (Refer to Example 2)

Example 2

Professional Corporation "Z" has a policy effective from 7/01/12-7/01/13. The shareholders, owners, partners, independent contractors and employees have individual effective dates as follows:

John Smith	02/01/12-02/01/13	2012 Policy
Jane Smith	07/01/12-07/01/13	2012 Policy
*Mark Jones	11/01/12-11/01/13	2012 Policy

*When Mark Jones renews his 2012 policy on 11/01/12, his assessment will be $10,478. The corporation's assessment is based on his 2012 assessment even though it is not in effect at the time the corporation renews its coverage.

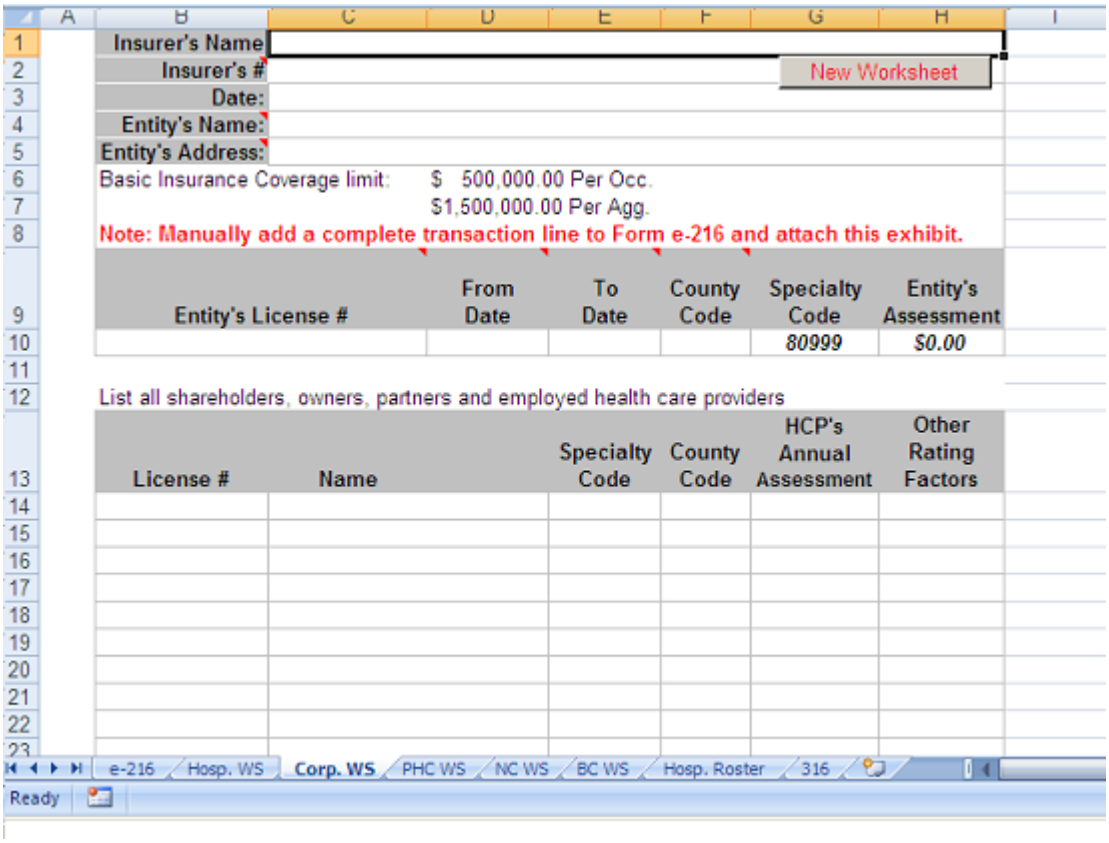
License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD123456	John Smith	03531	51	$ 7,859	Y3
MD654321	Jane Smith	03531	51	$ 10,478	
MD012345L	Mark Jones	03531	51	$ 10,478	

The sum of the total 2012 assessments for all health care providers who are shareholders, owners, partners, or employees of Professional Corporation "Z" is $28,815. ($7,859, $10,478 and $10,478= $28,815). The 2012 assessment owed by Professional Corporation "Z" is $4,322 ($28,815 X 15% = $4,322).

2. Apply other applicable assessment rating factors as outlined in Section IV.

3. Complete the Professional Corporation, Professional Association and Partnership Worksheet (Exhibit 5) and submit with completed Remittance Advice Form e-216. List the annual assessment for each health care provider on the worksheet. Indicate any discounts applied to a health care provider's assessment in the "Other Rating Factors" column. Also, indicate specific health care provider addition or deletion dates in the "Other Rating Factors" column if choosing to report mid-term changes.

NOTE: THE HEALTH CARE PROVIDER'S ANNUAL ASSESSMENT MUST BE LISTED ON THE WORKSHEET EVEN IF REPORTING A SHORT TERM COVERAGE PERIOD BECAUSE THE WORKSHEET WILL PRORATE THE ANNUAL ASSESSMENT BASED ON THE DATES PROVIDED.



Corporation worksheet

NOTE: PLEASE SUBMIT THE EXHIBIT 5 WORKSHEETS IN THE ORDER THEY APPEAR ON THE FORM e-216.

C. HOSPITALS (SPECIALTY CODE 80612)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM e-216)
EXHIBIT 6 (WORKSHEET FOR HOSPITALS)
EXHIBIT 6A (ROSTER FOR HOSPITALS)

NOTE: PENNSYLVANIA LAW REQUIRES HOSPITALS TO HAVE FULL ANNUALIZED, SEPARATE AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A HOSPITAL.

1. Determine highest rated territory. (Refer to Exhibit 10)

2. Calculate the total prevailing primary premium for a hospital by computing:

   a. The sum of the annual occupied bed count (patient days divided by 365 and rounded to the nearest **whole** number - no partial numbers) for each of the following bed types: Hospital (acute care), Mental Health/Mental Rehabilitation, Extended Care, Outpatient Surgical, and Health Institution, multiplied by the appropriate rate. (Refer to Exhibit 2)

NOTE: WHEN REPORTING THE LIST OF ANNUAL OCCUPIED BED COUNTS ON EXHIBIT 6 FOR THE HOSPITAL, PLEASE DO NOT INCLUDE THE NURSING HOME BEDS.

PLUS

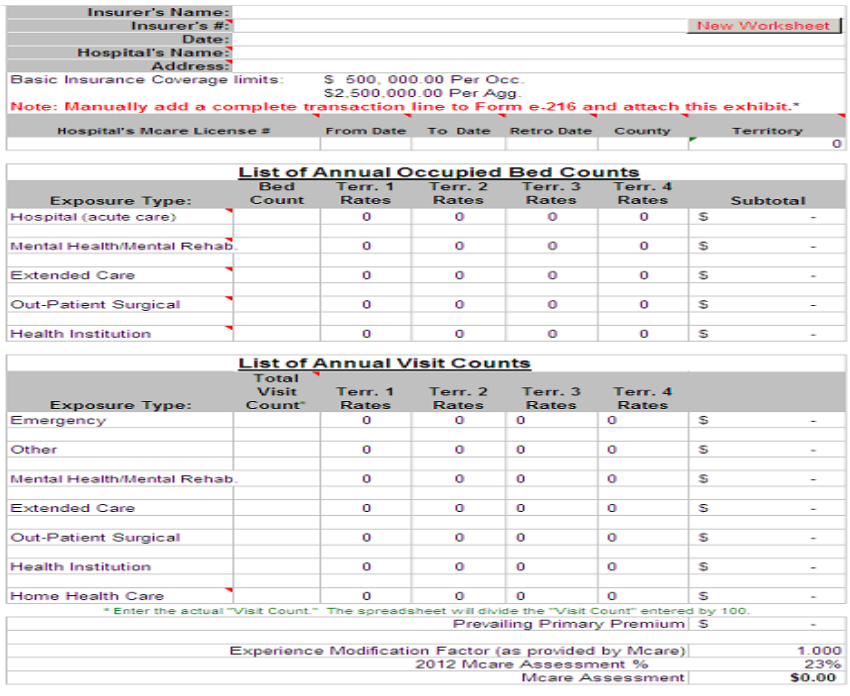
b. The sum of the annual visit count for each of the following visit types: Emergency, Other, Mental Health/Mental Rehabilitation, Extended Care, Outpatient Surgical, Health Institution, and Home Health Care, divided by 100 and rounded to the nearest **whole** number, then multiplied by the appropriate rate. (Refer to Exhibit 2)

3. Calculate the assessment for a hospital by multiplying the total prevailing primary premium ("PPP") (the sum of the annual occupied bed and visit counts) by the Experience Modification Factor ("EMF") (as provided by Mcare), then multiplied by the annual assessment of 23%. (Mcare assessment = PPP x EMF x 23%) See note at bottom of page.

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete Hospital Worksheet (Exhibit 6) and submit with completed Form e-216.

TIP: Experience Modification Factor must be entered as a number (decimal) and not as a percentage on the Hospital Worksheet, Exhibit 6 (98.9% should be entered as 0.989).



Insurer's Name:	
Insurer's #:	New Worksheet
Date:	
Hospital's Name:	
Address:	
Basic Insurance Coverage limits:	$ 500, 000.00 Per Occ. $2,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.*

Hospital's Mcare License #	From Date	To Date	Retro Date	County	Territory
					0

List of Annual Occupied Bed Counts

Exposure Type:	Bed Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Hospital (acute care)		0	0	0	0	$ -
Mental Health/Mental Rehab.		0	0	0	0	$ -
Extended Care		0	0	0	0	$ -
Out-Patient Surgical		0	0	0	0	$ -
Health Institution		0	0	0	0	$ -

List of Annual Visit Counts

Exposure Type:	Total Visit Count*	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	
Emergency		0	0	0	0	$ -
Other		0	0	0	0	$ -
Mental Health/Mental Rehab.		0	0	0	0	$ -
Extended Care		0	0	0	0	$ -
Out-Patient Surgical		0	0	0	0	$ -
Health Institution		0	0	0	0	$ -
Home Health Care		0	0	0	0	$ -

* Enter the actual "Visit Count." The spreadsheet will divide the "Visit Count" entered by 100.

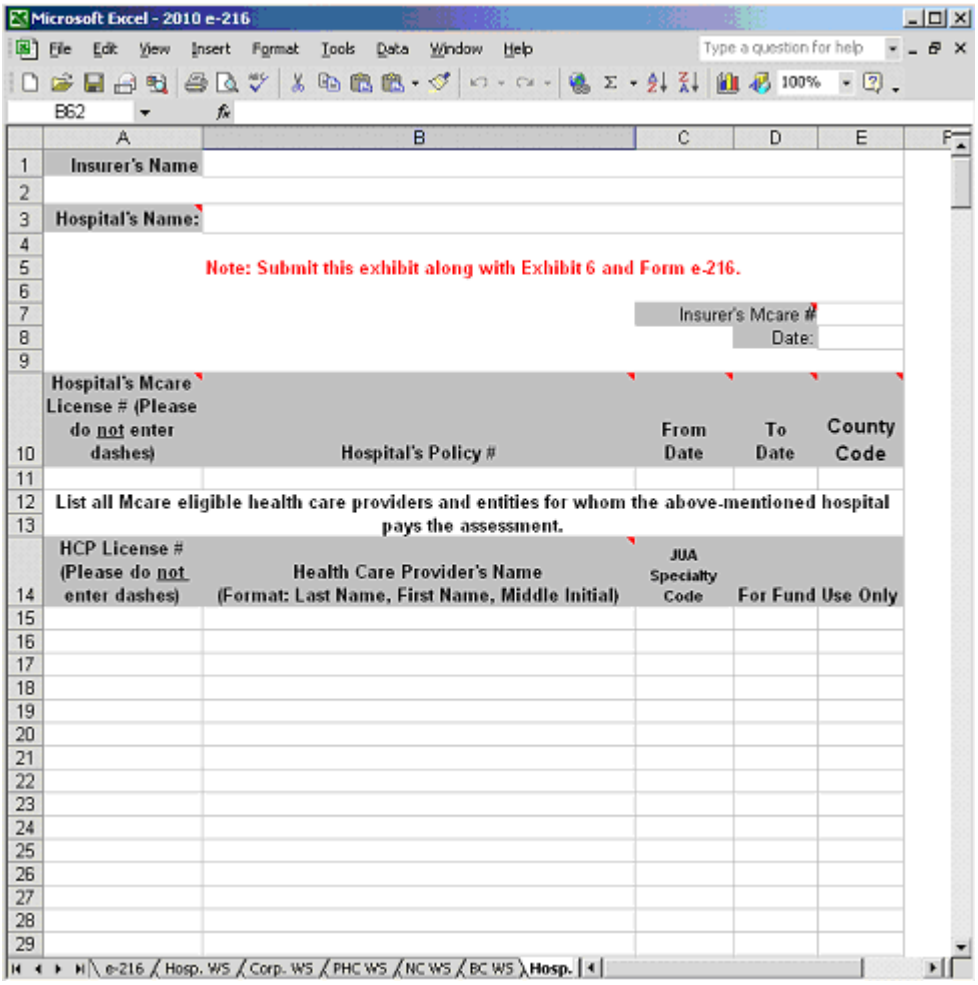
Prevailing Primary Premium	$ -
Experience Modification Factor (as provided by Mcare)	1.000
2012 Mcare Assessment %	23%
Mcare Assessment	$0.00

A copy of the Mcare's Experience Modification Factor letter sent to the hospital must be attached.

Hospital Worksheet

NOTE: THE HOSPITAL WORKSHEET MULTIPLIES THE BED COUNTS BY THE TERRITORY RATE TO REACH THE SUBTOTAL AMOUNT. IT DIVIDES THE VISIT COUNTS BY 100 FIRST, THEN MULTIPLIES BY THE TERRITORY RATE TO REACH THE SUBTOTAL AMOUNT. ALL COUNTS SHOULD BE ENTERED AS AN ANNUAL AMOUNT.

6. When health care providers and Mcare eligible professional corporations, professional associations and partnerships are covered under a policy issued to a hospital, a complete roster of all participating health care providers and those professional corporations, professional associations and partnerships covered under that hospital policy must be submitted along with the Form e-216 reporting the hospital coverage. In the case of a health system comprised of multiple hospitals, the roster for each hospital must include the health care providers at that hospital at the time of policy issuance or renewal. (Refer to Exhibit 6A)



Hospital Roster

TIP: A resident must participate in Mcare at the time the resident becomes eligible for an unrestricted license even if the resident does not receive an unrestricted license.

D. NURSING HOMES (SPECIALTY CODE 80924)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM e-216)
EXHIBIT 7 (WORKSHEET FOR NURSING HOMES)

NOTE: PENNSYLVANIA LAW REQUIRES NURSING HOMES TO HAVE FULL ANNUALIZED, SEPARATE AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A NURSING HOME.

1. Determine highest rated territory. (Refer to Exhibit 10)

2. Calculate the total prevailing primary premium by computing the sum of the annual occupied bed count (patient days divided by 365 and rounded to the nearest **whole** number) for the appropriate bed type: Convalescent or Skilled Nursing, multiplied by the appropriate rate. (Refer to Exhibit 2)

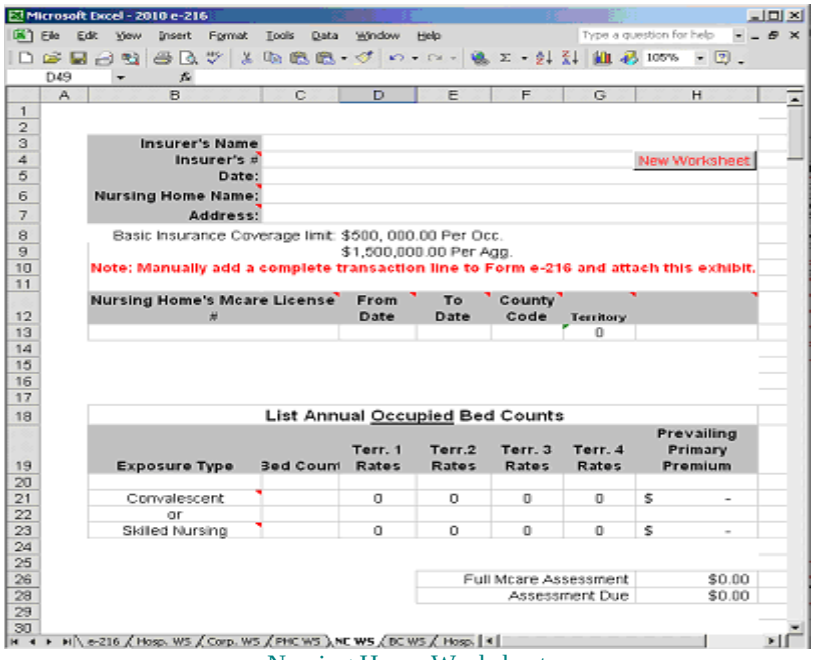
   Each nursing home must report either convalescent bed counts or skilled nursing bed counts, not both. If 50% or more of patients are age 65 and under, all bed counts must be reported as convalescent. If 50% or more of patients are over age 65, all bed counts must be reported as skilled nursing.

NOTE: WHEN REPORTING THE LIST OF ANNUAL OCCUPIED BED COUNTS, ON EXHIBIT 7, FOR THE NURSING HOME, PLEASE DO NOT INCLUDE ANY HOSPITAL BEDS.

3. Calculate the assessment for a nursing home by multiplying the total prevailing primary premium by the 2012 annual assessment of 23%.

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete Nursing Home Worksheet (Exhibit 7) and submit with completed Form e-216.



Nursing Home Worksheet

E. PRIMARY HEALTH CENTERS (SPECIALTY CODE 80614)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM e-216)
EXHIBIT 8 (WORKSHEET FOR PRIMARY HEALTH CENTERS)

NOTE: PENNSYLVANIA LAW REQUIRES PRIMARY HEALTH CENTERS TO HAVE FULL ANNUALIZED, SEPARATE AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A PRIMARY HEALTH CENTER.

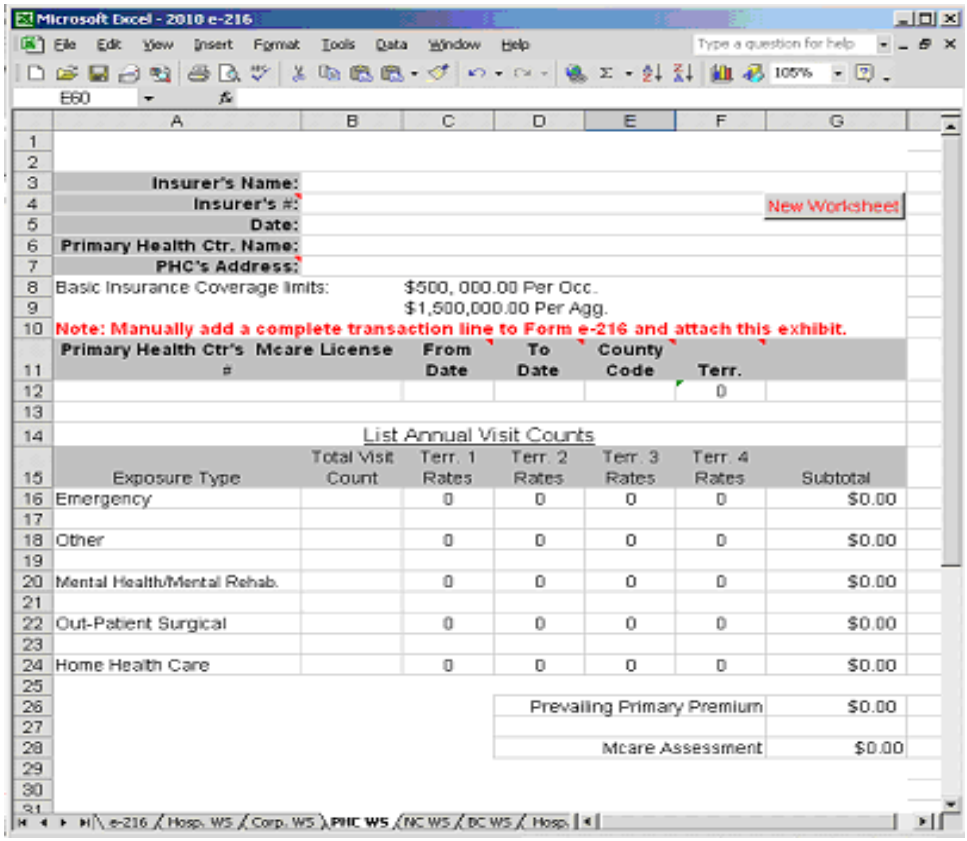
1. Determine highest rated territory. (Refer to Exhibit 10)

2. Calculate the total prevailing primary premium by computing the sum of the annual visit count for each of the following visit types: Emergency, Other, Mental Health/Mental Rehabilitation, Outpatient Surgical, and Home Health Care, divided by 100, then multiplied by the appropriate rate. (Refer to Exhibit 2)

3. Calculate the assessment for a primary health center by multiplying the total prevailing primary premium by the 2012 annual assessment of 23%.

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete Primary Health Center Worksheet (Exhibit 8) and submit with completed Form e-216.



Primary Health Center Worksheet

F. BIRTH CENTERS (SPECIALTY CODE 80402)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM e-216)
EXHIBIT 9 (WORKSHEET FOR BIRTH CENTERS)

NOTE: PENNSYLVANIA LAW REQUIRES BIRTH CENTERS TO HAVE FULL ANNUALIZED, SEPARATE AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A BIRTH CENTER.

1. Determine highest rated territory. (Refer to Exhibit 10)

2. Calculate the assessment by computing the sum of 25% of the total 2012 assessments for all health care providers who use the facility or who have an ownership interest. (Refer to Example 3)

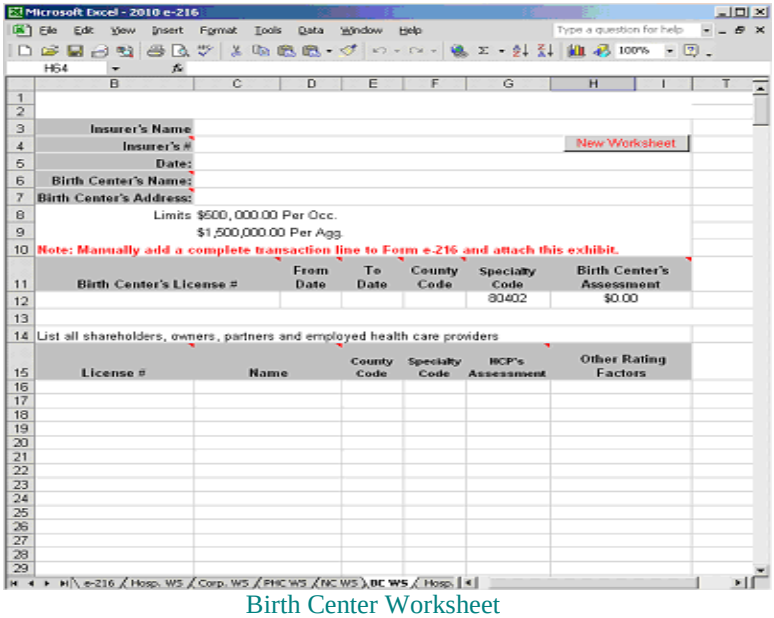
Example 3

Three health care providers whose specialty codes are 08029 use or have an ownership interest in Birth Center "X" in territory 1.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD654321	Jane Smith	08029	51	$ 21,357	
MD054321E	Sally Jones	08029	51	$ 10,678	PT 08
MD246810	Joseph Miller	08029	51	$ 21,357	

The sum of the total 2012 assessments for all health care providers who use the facility or who have an ownership interest in Birth Center "X" is $53,392 ($21,357, $10,678, $21,357=$53,392). The 2012 assessment owed by Birth Center "X" is $13,348 ($53,392 x 25% = $13,348).

3. Complete Birth Center Worksheet (Exhibit 9) and submit with completed Form e-216.



Birth Center Worksheet

G. SELF-INSUREDS

REQUIRED FORM: EXHIBIT 4 (REMITTANCE ADVICE FORM e-216)

NOTE: PENNSYLVANIA LAW REQUIRES SELF-INSUREDS TO HAVE FULL ANNUALIZED, SEPARATE AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A SELF-INSURED.

1. Self-insured entities should follow the same procedures as primary insurers when submitting the Form e-216. All renewals and endorsements to the policy, including additions and deletions, should be received by Mcare within 60 calendar days of the effective date of the renewal, additions and/or deletions in order to be considered timely.

2. The worksheets listed below are also to be used by self-insured entities, when applicable, and must be completed and submitted along with a completed Form e-216.

    - Exhibit 5 (Worksheet for Professional Corporations, Professional Associations and Partnerships)
    - Exhibit 6 (Worksheet for Hospitals)
    - Exhibit 7 (Worksheet for Nursing Homes)

H. TELEMEDICINE

For purposes of calculating the assessment, telemedicine is the electronic transmission of healthcare or medical services from a remote location by a health care provider licensed in Pennsylvania. Telemedicine could range from a telephone consultation to reading x-rays to robotic surgery.

If a health care provider is licensed in Pennsylvania and 50% or more of the patients to whom the health care provider renders healthcare services are in Pennsylvania, participation in Mcare is mandatory. If a health care provider is licensed in Pennsylvania and less than 50% but more than 0% of patients to whom the health care provider renders healthcare services are in Pennsylvania, the health care provider may choose to participate in Mcare. However, if the health care provider opts out of participating in Mcare the health care provider must still meet the mandatory insurance requirements of Act 13 of 2002. See the Non-Participating Transmittal Form 316.

SECTION IV - ADDITIONAL ASSESSMENT RATING FACTORS

In addition to the above information, there are other factors that affect the health care provider's assessment that are listed below:

A. PART-TIME. Physicians, podiatrists and certified nurse midwives who advise their primary insurer or self-insurer in writing that they practice on annual average:

- "08" 8 hours or less per week shall be charged 50% of the otherwise applicable Mcare assessment (50% discount).

- "16" 16 hours or less, but more than 8 hours, per week shall be charged 65% of the otherwise applicable Mcare assessment (35% discount).

- "24" 24 hours or less, but more than 16 hours, per week shall be charged 80% of the otherwise applicable Mcare assessment (20% discount).

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED WITH AN FTE FACTOR LESS THAN 1.000.

B. NEW PHYSICIANS AND NEW PODIATRISTS. These provide**rs** may receive the discount indicated from the otherwise applicable assessment:

- "Y1" Charge 25% of the otherwise applicable assessment for the first year of coverage (75% discount).
- "Y2" Charge 50% of the otherwise applicable assessment for the second year of coverage (50% discount).
- "Y3" Charge 75% of the otherwise applicable assessment for the third year of coverage (25% discount).

The first year of coverage for a new physician or a new podiatrist begins on the date medical liability coverage is effective if such coverage is effective within six months after:

1. The completion of (a) a residency program, (b) a fellowship program in their medical specialty or (c) podiatry school or
2. The fulfillment of a military obligation in remuneration for medical school tuition.

Such physicians or podiatrists must be either joining a medical group or opening their own medical practice. If the initial coverage is effective more than six months after (1) or (2) above first occurs, the physician or podiatrist will be considered to be in the year of coverage that would apply if coverage had been effective within six months after (1) or (2) above.

NOTE: A HEALTH CARE PROVIDER MAY ONLY USE ONE LIFETIME (Y1, Y2, Y3) SERIES OF NEW PHYSICIAN OR NEW PODIATRIST DISCOUNT. THIS DISCOUNT IS NOT AVAILABLE TO CERTIFIED NURSE MIDWIVES.

C. RESIDENTS AND FELLOWS may receive the discount indicated from the otherwise applicable assessment:

- "R" Charge 50% of the otherwise applicable assessment for a Resident (50% Discount).
- "F" Charge 50% of the otherwise applicable assessment for a Fellow (50% Discount).

A resident or fellow is a physician or podiatrist enrolled in a medical, osteopathic or podiatry residency or fellowship program who has successfully completed the prescribed period of postgraduate education that is necessary under applicable law to become eligible for unrestricted medical, osteopathic or podiatry licensure in the Commonwealth of Pennsylvania.

NOTE: RESIDENT/FELLOW AND NEW PHYSICIAN DISCOUNTS CANNOT BE USED TOGETHER.

D. SLOT POSITIONS. Slot rating is limited to (a) employees of an institution licensed as a hospital or (b) a physician practice plan owned by a hospital or that hospital's corporate parent organization. Slot rating is used to account for certain risks (see notation below) associated with a block of in-hospital clinical medical service exposures (i.e., several physicians rotating through one full-time equivalent position). The slot positions must be within the scope of duties and normal business of the institution and within a single medical specialty and job description. When added together, all health care providers within this one slot or block of exposure must equal one Full-Time Equivalent (FTE).

When multiple health care providers fill a slot-rated position, the assessment shall be appropriately divided among them on a pro rata basis for the FTE position. If the aggregate hours of clinical time of those filling a slot exceed 40 hours per week, a new slot must be created. Each health care provider in a slot must be reported to Mcare with full, separate and individual coverage limits. Such coverage is available only for the individual professional liability of the health care providers within the slot and is not available for entities. The number of health care providers in any one slot shall be limited to 12.

NOTE: Slot rating shall be limited to the following specialty codes:

Anesthesiology - Excl Maj S*	02083	Neurology - Excl Maj S	02511
General or Family Practice - NS	01520	Neurosurgery	10011
General Surgery and	07043	Obstetrics/Gynecology*	08029
Internal Medicine - Maj S		Orthopedic Surgery	09013
Hematology - NS	00508	Pathology - NS	00715
Hospitalist - NS	01522	Pediatrics - NS	01067
Infectious Diseases - NS	01540	Psychiatry - NS*	00619
Intensive Care Medicine	01589	Radiology - Excl Maj S*	02260
Internal Medicine - NS	01510	Rehabilitation/Physiatry - NS	00621
Internal Medicine*	03010	Trauma - Maj S	07084
Neonatology - NS	01541	Urgent Care - Excl Maj S*	03531

***See Exhibit 3 for Complete Specialty Code Description**

Slot coverage is not available to health care providers associated with group practices for non-hospital environments or to groups that contract to provide medical services within a hospital. Slot rating is not available to a health care provider who works full-time in one specialty (37.5 hours or more per week) at an institution, unless the position is a rotating resident position.

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED IN A SLOT.

When a health care provider leaves a slot-rated position, but the slot remains open, slot tail must be reported for the health care provider who is leaving. Please provide notification to Mcare in your cover letter when a new slot is opened or an existing slot is closed. If the last health care provider in a slot leaves and the slot closes, tail must be reported for the entire slot on that last health care provider's reported tail coverage. Indicate the retroactive date of the slot in the cover letter and the retroactive date of the health care provider on the e-216. If the retroactive date of the slot (not the last health care provider in the slot) is prior to January 1, 1997, a surcharge is due to Mcare based upon 1996 tail rates and surcharge percentage.

NOTE: SLOT TAIL COVERAGE MUST PROVIDE EACH HEALTH CARE PROVIDER A SEPARATE AND INDIVIDUAL COVERAGE LIMIT.

E. LOCUM TENENS. Taken from the Latin "to hold the place of, to substitute," a locum tenens health care provider is one who contracts with a medical facility or group to temporarily supply health care services while a permanent health care provider is absent for a specified length of time. This term also includes health care providers who are temporarily engaged to assist during peak periods of the year, test market new services in a community, expand services into new geographical areas and care for patients while new permanent health care providers are recruited.

INDIVIDUAL LOCUM TENENS POLICIES: For individual physicians, certified nurse midwives, and podiatrists who provide health care services in locum tenens and are participating health care providers, the assessment shall be reported on a short-term basis for the specific dates being covered. If basic insurance coverage is written on a claims-made basis, tail coverage or its substantial equivalent must be obtained and reported to Mcare upon termination of the claims-made coverage.

NOTE: A DECLARATION OF COMPLIANCE FORM (DOC) MAY NEED TO BE COMPLETED FOR ANY GAPS IN COVERAGE. TO COMPLETE THE DOC, GO ONLINE AT WWW.INSURANCE.PA.GOV/MCARE SELECT "YOUR MCARE COVERAGE ". CLICK ON THE LINK "COMPLIANCE FORM" UNDER "DECLARATION OF COMPLIANCE".

GROUP LOCUM TENENS POLICIES: The assessment for physicians, certified nurse midwives, and podiatrists groups, who provide health care services in locum tenens and are participating health care providers, shall be prorated through use of Full-Time Equivalents (FTE) and reported as follows:

NOTE: EACH HEALTH CARE PROVIDER MUST BE PROVIDED A SEPARATE AND INDIVIDUAL COVERAGE LIMIT.

1. **Annual Policy Period**: Calculate the FTE based on the estimated total number of days included for each locum tenens assignment. At the end of the policy period the FTE should be adjusted for actual total number of days included for each assignment. (Refer to Example 4) The "actual" total number of days worked during the prior year should be used, at minimum, to calculate the FTE for the next renewal period, or an insufficient assessment may result.

Example 4:
The policy period reported is 2/1/12 – 2/1/13. A health care provider has the following assignments in PA: 2/6/12-2/25/12 (20 days), 5/1/12-5/26/12 (26 days), 7/1/12-7/26/12 (26 days) = a total of 72 days of locum tenens assignment in PA divided by 365 days a year (72 ÷ 365 = 0.197). The FTE reported would be 0.197. Note: 365 days should also be used in a leap year.

2. **Mid-term Additions**: When adding a health care provider to a group locum tenens policy mid-term, the preferred method is to use the start date of the health care provider as the inception and retroactive date. Please note, the FTE must be based on the actual number of days in the policy period (health care provider's inception date to expiration date). At the end of the policy period the FTE should be adjusted for actual total number of days included for each assignment.

Example 5:
The group policy period is 7/1/12 – 7/1/13. The health care provider's start date is 10/1/12. The policy period reported for this health care provider is 10/1/12 – 7/1/13.

The health care provider has the following assignments in PA: 10/6/12 – 10/25/12 (20 days), 1/1/13 – 1/26/13 (26 days), 5/1/13 – 5/26/13 (26 days) = a total of 72 days of locum tenens assignment in PA divided by 273 days in the policy period (72 ÷ 273 = 0.264). The FTE reported would be 0.264.

NOTE: THE E-216 FURTHER PRORATES BASED ON THE DATES OF COVERAGE PROVIDED.

Tail coverage or its substantial equivalent must be provided and reported for health care providers who end their assignments in Pennsylvania with the locum tenens group if coverage is written on a claims-made basis. Tail coverage must provide each health care provider with separate and individual coverage limits.

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED WITH AN FTE FACTOR LESS THAN 1.000.

F. BIFURCATION (BIFU). If a health care provider changes the effective date of their professional liability coverage and that change results in a health care provider receiving more than 12 months of the same assessment rate, then the appropriate assessment will be bifurcated to include the assessment percentages applicable to each calendar year over which the new policy is in effect. This allows only 12 months maximum at the same assessment rate for the year that the policy effective date was changed. Report each portion of the bifurcated assessment on separate Form e-216's applicable to the rating year that is being paid (i.e., for the example below report 7/1/11 to 1/1/12 on a 2011 Form e-216 using the 2011 rates and report 1/1/12 to 7/1/12 on a 2012 Form e-216 using the 2012 rates). Indicate "BIFU" in the Comment column of the Forms e-216 on both lines of coverage. (Refer to Example 6)

TIP: Select a due date for your invoice for the second portion of the bifurcation which allows sufficient time for you to comply with the 60 day reporting requirement.

NOTE: THE ASSESSMENT FOR SUBSEQUENT ANNUAL RENEWALS SHOULD NOT BE BIFURCATED AGAIN AND MAY RESULT IN A HEALTH CARE PROVIDER RECEIVING MORE THAN 12 MONTHS OF THE SAME ASSESSMENT RATE.

THE 2ND PART OF THE BIFURCATED ASSESSMENT SHOULD BE RECEIVED BY MCARE NO LATER THAN 60 CALENDAR DAYS FROM THE BEGINNING OF THE SECOND PORTION OF THE COVERAGE PERIOD. IN EXAMPLE 6, THE 2ND PAYMENT IS DUE TO MCARE WITHIN 60 DAYS OF JANUARY 1, 2012.

Example 6:

A health care provider has a policy from February 1, 2011 to February 1, 2012. The 2011 assessment (19%) was reported on this policy. On July 1, 2011, the health care provider cancels his policy and purchases a new policy for the period of July 1, 2011 to July 1, 2012.

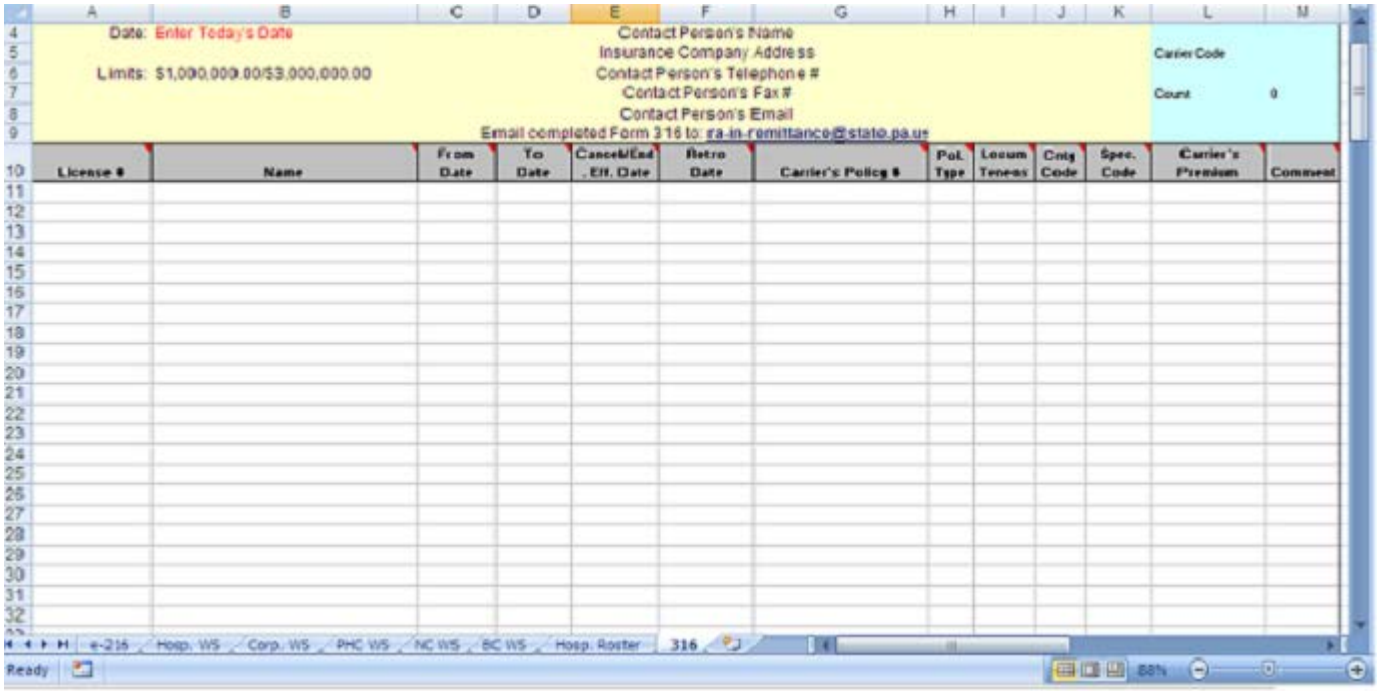
(1) The assessment shall be prorated from July 1, 2011 to January 1, 2012 using the 2011 assessment (19%).
(2) The policy period from January 1, 2012 to July 1, 2012 shall be prorated by using the 2012 assessment (23%).
(3) Upon renewal of the July 1, 2012 policy, the 2012 assessment (23%) will be applied for the full annual period.

2/1/2011 to 2/1/2012	(19%)	
Cancelled (7/1/2011 to 2/1/2012)	(19%)	
7/1/2011 to 1/1/2012	(19%)	Bifurcated
1/1/2012 to 7/1/2012	(23%)	Bifurcated
7/1/2012 to 7/1/2013	(23%)	

SECTION V - NONPARTICIPATING TRANSMITTAL (FORM 316)

A. GENERAL INFORMATION. The Nonparticipating Transmittal Form 316 is the form to be used by primary insurers and self-insurers who provide coverage to nonparticipating health care providers. A nonparticipating health care provider is a health care provider as defined in Section 103 of Act 13 that conducts less than 50% but more than 0% of their health care business or practice within this Commonwealth and does not choose to participate in Mcare. The health care business or practice, as defined in Section 702, is based on the number of patients to whom health care services are rendered by a health care provider within an annual period.

Nonparticipating health care providers must secure basic insurance coverage limits as required by and consistent with Act 13 of 2002. Current coverage limits are $1 million per occurrence or claim and $3 million per annual aggregate.



Nonparticipating Form 316

B. ELECTRONIC SUBMISSIONS. The Nonparticipating Transmittal Form 316 can be found as a tab (316) on the Exhibit 4 - Electronic Remittance Advice Form e-216 and is listed as Exhibit 4A in this Manual.

SECTION VI - PRIOR ACTS, RETRO AND TAIL COVERAGE

A. PRIOR ACTS ("NOSE") AND RETROACTIVE ("RETRO") COVERAGE. When prior acts coverage is written for claims-made coverage with a retroactive date before January 1, 1997, the surcharge associated with the Mcare prior acts coverage shall be 164% of the primary insurer's premium for the primary prior acts coverage, but only for that portion of the primary prior acts coverage prior to the 1997 policy. No additional assessment is due on retro coverage reported on claims-made policies. Please note that Mcare will not accept retro coverage that covers any period of time wherein previous underlying claims-made coverage has not been reported to Mcare.

B. EXTENDED REPORTING PERIOD ("TAIL") COVERAGE. Following cancellation, termination or nonrenewal of claims-made coverage in Pennsylvania, a primary insurer writing medical professional liability insurance on a claims-made basis is required to offer, for a period of 60 calendar days, liability protection to a health care provider, eligible professional corporation, professional association or partnership for the liability previously covered by the primary insurer, subsequent to the cancellation, termination or nonrenewal of the claims-made policy.

Tail coverage, regardless of whether it involves the payment of a surcharge, should be received by Mcare within 120 calendar days of the cancellation, termination, or nonrenewal of the underlying claims made coverage.

Claims-made coverage with a retro date prior to January 1, 1997 will have a surcharge due to Mcare. The tail surcharge shall be 164% of the tail premium calculated by the primary insurer using their 1996 rates for only that portion of the tail covering claims-made periods prior to the expiration of the 1996 coverage (See Example 7). A surcharge must be paid for tails written for claims-made policies with retro dates and periods of coverage for which a surcharge based on 1996 and prior years' surcharge rates has been paid even if the carrier offers the primary tail at no charge. For claims-made policies with retro dates for periods for which a surcharge or assessment based on 1997 and subsequent years' surcharge or assessment rates has been paid to Mcare, there is no surcharge or assessment due for the tail (See Example 8).

Example 7:

Claims made Policy:	7/1/95 - 7/1/96
Claims made Policy:	7/1/96 - 7/1/97
Claims made Policy:	7/1/97 - 7/1/98
Claims made Policy:	7/1/98 - 7/1/99
Tail Policy:	7/1/95 - 7/1/99

This Health Care Provider retiring on 7/1/99 would owe a surcharge equivalent to 164% of what the providerhe/she would have been charged for tail coverage for the period 7/1/95 -7/1/97.

Example 8:

Claims made Policy:	7/1/01 - 7/1/02
Claims made Policy:	7/1/02 - 7/1/03
Tail Policy:	7/1/01 - 7/1/03

This Health Care Provider retiring on 7/1/03 would owe no surcharge for tail coverage.

NOTE: FOR PRIMARY INSURERS WHO DID NOT HAVE APPROVED RATES IN PENNSYLVANIA PRIOR TO 1997, TAIL SHOULD BE CALCULATED BY USING THE 1996 RATES OF PMSLIC (FOR PHYSICIANS, PODIATRISTS, CERTIFIED NURSE MIDWIVES, PROFESSIONAL CORPORATIONS AND BIRTH CENTERS) AND PHICO (FOR HOSPITALS, NURSING HOMES AND PRIMARY HEALTH CENTERS). THE PMSLIC AND PHICO TAIL RATES ARE AVAILABLE ON OUR WEBSITE AT WWW.INSURANCE.PA.GOV (CLICK ON LINK TO MCARE ASSESSMENT RATING INFORMATION THEN 2012 ASSESSMENT YEAR AND SCROLL TO LOCATE THE PMSLIC AND PHICO RATES)

Mcare recognizes two types of extended reporting period (tail) coverage. Primary insurers must report on Form e-216 the type of tail coverage provided the insured, either a policy type of "ERP" for Extended Reporting Period Endorsement Tail coverage or "SAT" for Stand Alone Tail coverage.

"ERP" **EXTENDED REPORTING ENDORSEMENT.** Extended Reporting Period endorsements provide coverage wherein the aggregate limit of liability is shared with the last underlying claims made coverage. A separate Mcare aggregate limit for Extended Reporting Period endorsements does not exist. The tail shares the aggregate limit of the terminating claims made coverage.

"SAT" **STAND-ALONE TAIL.** Generally, a primary insurer other than the primary insurer of record for the last claims made policy will underwrite this type of tail policy, although a primary carrier providing a new aggregate limit of liability on an endorsement tail is not precluded from reporting it as Stand Alone Tail coverage. Mcare provides a separate aggregate limit for Stand Alone Tail coverage.

SECTION VII - JUA DEFINITIONS

The definitions supplied in this Section are in accordance with the Pennsylvania Professional Liability Joint Underwriting Association ("JUA"). When completing the necessary forms and/or worksheets, it is important that you keep the following definitions in mind:

1. **Beds**
   The number of beds equals the daily average number of occupied beds, cribs and bassinets used for patients during the previous policy period. The unit of exposure is each bed, computed by dividing the sum of the daily numbers of beds, cribs and bassinets used for patients for each day of the policy period, by the number of days in such period.

2. **Convalescent Facilities**
   Convalescent Facilities are free-standing facilities which provide skilled nursing care and treatment for patients requiring continuous health care but do not provide any hospital services (such as surgery) and 50% or more of their patients are under 65.

3. **Extended Care**
   All beds located within a hospital, licensed by the state and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous and extended basis.

4. **Health Institutions**
   Health Institutions are facilities that provide non-surgical medical treatment other than as described under Mental Health/Mental Rehabilitation.

5. **Home Health Care**
   Home Health Care Services are organizations which provide nursing, physical therapy, housekeeping and related services to patients at their residences.

6. **Hospital**
   Hospitals are facilities treating all general or special medical and surgical cases, including sanitariums with surgical operating room facilities.

7. **Mental Health/Mental Rehabilitation**
   Mental Health and Mental Rehabilitation are facilities that provide non-surgical medical intervention for:

   a. Short term crisis stabilization for mental health and substance abuse; and
   b. Long-term mental health rehabilitation.

   This includes facilities that assist individuals to develop or improve task and role-related skills, and social and environmental supports needed to perform as successfully and independently as possible at home, family, school, work, socialization, recreations and other community living roles and environments.

8. **Outpatient Surgical**
   Outpatient Surgical Facilities are facilities that provide surgical procedures on an outpatient (same day) basis. Beds are used primarily for recovery purposes, and overnight stays, if any, are the exception.

9. **Primary Health Center**
   Primary Health Center means a community-based, non-profit corporation meeting standards prescribed by the Department of Health which provides preventive, diagnostic, therapeutic, and basic emergency health care by licensed practitioners who are employees of the corporation or under contract to the corporation.

10. **Skilled Nursing Facilities**
    Skilled Nursing Facilities are freestanding facilities which provide the same service as a Convalescent Facility, except that 50% or more of their patients are over 65.

11. **Visits**
    The number of visits equals the total number of visits to the institution (regardless of the number of visits to particular departments within such institution) by outpatients (patients not receiving bed and board services), during the previous policy period. The unit of exposure is each 100 visits.

SECTION VIII. FORM e-216 CHECKLIST

Checklist - Finalizing Your Submission

- ✓ Are you using the correct e-216 year?
  (e-216 year = rates used)
- ✓ Have you filled in the carrier name, carrier code, and contact information?
- ✓ Have you completed the contact information fields using the information of the person who should be contacted in case there are any questions with the e-216?
- ✓ License numbers? (www.licensepa.state.pa.us)
  Have MT/OT's changed to MD/OS's?
  Have they been validated for accuracy?
- ✓ Have specialties, classes & territories changed from last year?
- ✓ Are related license numbers placed in Cell B4 or Column V?
  Are they correct?? (BC#, GP#, HS#, MC #, NC#, PC#)
- ✓ Midterm additions
  Are they being added to a master policy?
  If so, are you using the correct e-216 for the policy year?
- ✓ Corrections
  Have you entered the date of the 216 that you are correcting in cell B9?
  Have you included a copy of the problem letter with the hardcopy 216?
- ✓ Do all pages of the e-216 submission have the same date for this submission/check in upper left-hand corner of Form 216?
- ✓ Does the Assessment Total (in blue box) equal the total of each 216?
- ✓ Do you have a cover letter?
  Have you summarized the accounting information?
  (i.e., assessment totals, check amount, credit balance information)
  Are there any unique situations for HCPs?
- ✓ Have you included all applicable worksheets or Articles of Incorporation?
  Experience modification letter & hospital roster? (Hospital only)
- ✓ Slots (Hospital only)
  Are the specialties eligible to be slot rated?
  At renewal, do the FTEs add up to a whole number for each slot?
- ✓ Have you e-mailed your e-216 to the remittance e-mail address and mailed the hardcopy?
  E-mail address: ra-in-remittance@pa.gov
  Is the format of the Subject Line correct?

SECTION IX. CHANGES TO MEDICAL SPECIALTIES/TERRITORIES

A. CHANGES TO JUA CLASSES FOR 2012:

None

B. CHANGES TO JUA MEDICAL SPECIALTIES FOR 2012:

None

C. CHANGES TO TERRITORIES FOR 2012:

1. Physician, Surgeons and other Health Care Professionals

- Chester Co (15)	Moved from Territory 4 to Territory 6
- Dauphin Co (22)	Moved from Territory 6 to Territory 3
- Lackawanna Co (35)	Moved from Territory 6 to Territory 4
- Luzerne Co (40)	Moved from Territory 6 to Territory 4
- Mercer Co (43)	Moved from Territory 6 to Territory 4

2. Hospitals, Nursing Homes and Primary Health Centers

None

SECTION IX. LIST OF EXHIBITS

EXHIBIT 9	**WORKSHEET for Birth Centers** Electronic form available on our website www.insurance.pa.gov Exhibit 4 – Electronic Remittance Advice Form e-216 Tab "BC WS"	Rates by Individual Health Care Providers Policy Information	53
EXHIBIT 10	**COUNTY CODE LIST**	Lists all County Codes & Territory Distribution	54

Exhibit 1

Year 2012

23%

Physicians, Surgeons, Podiatrists, and Certified Nurse Midwives

Prevailing Primary Premium / Assessment

Class	*Territory 1*		*Territory 2*		*Territory 3*		*Territory 4*		*Territory 5*		*Territory 6*		
	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	
005	4,816	1,108	2,452	564	2,804	645	3,427	788	3,873	891	3,039	699	***005***
006	7,618	1,752	3,630	835	4,231	973	5,296	1,218	6,020	1,385	4,634	1,066	***006***
007	16,370	3,765	7,271	1,672	8,642	1,988	11,072	2,547	12,724	2,927	9,561	2,199	***007***
010	10,998	2,530	5,037	1,159	5,935	1,365	7,527	1,731	8,610	1,980	6,537	1,504	***010***
011	15,037	3,459	6,613	1,521	7,504	1,726	9,757	2,244	11,703	2,692	8,811	2,027	***011***
012	26,945	6,197	11,670	2,684	13,972	3,214	18,052	4,152	20,824	4,790	15,515	3,568	***012***
015	20,248	4,657	8,884	2,043	10,597	2,437	13,632	3,135	15,695	3,610	11,745	2,701	***015***
017	21,996	5,059	9,611	2,211	11,478	2,640	14,786	3,401	17,034	3,918	12,734	2,929	***017***
020	25,482	5,861	11,062	2,544	13,235	3,044	17,087	3,930	19,704	4,532	14,692	3,379	***020***
022	30,862	7,098	13,300	3,059	15,946	3,668	20,638	4,747	23,825	5,480	17,721	4,076	***022***
025	29,504	6,786	12,735	2,929	15,262	3,510	19,741	4,540	22,785	5,241	16,956	3,900	***025***
030	32,719	7,525	14,072	3,237	16,882	3,883	21,863	5,028	25,247	5,807	18,766	4,316	***030***
035	45,555	10,478	19,412	4,465	23,351	5,371	30,335	6,977	35,080	8,068	25,993	5,978	***035***
050	45,059	10,364	19,206	4,417	23,101	5,313	30,007	6,902	34,700	7,981	25,713	5,914	***050***
060	54,447	12,523	23,111	5,316	27,833	6,402	36,203	8,327	41,891	9,635	30,999	7,130	***060***
070	81,996	18,859	34,572	7,952	41,718	9,595	54,386	12,509	62,994	14,489	46,509	10,697	***070***
080	92,858	21,357	39,090	8,991	47,192	10,854	61,555	14,158	71,314	16,402	52,624	12,104	***080***
090	60,818	13,988	25,761	5,925	31,044	7,140	40,408	9,294	46,771	10,757	35,372	8,136	***090***
100	152,545	35,085	63,920	14,702	77,275	17,773	100,948	23,218	117,034	26,918	86,228	19,832	***100***
120	5,074	1,167	2,572	592	2,949	678	3,617	832	4,071	936	3,202	736	***120***
130	28,982	6,666	12,518	2,879	14,999	3,450	19,397	4,461	22,385	5,149	16,662	3,832	***130***
900	28,129	6,470	12,163	2,797	14,569	3,351	18,834	4,332	21,732	4,998	16,182	3,722	***900***

Certified Nurse Midwife = 900 80116

Podiatrist Non-surgical = 120 80993

Podiatrist Surgical = 130 80994

Territory 1= Philadelphia (51)

Territory 2= Reminder of State (01, 04-06, 08, 10-14, 16-18, 21, 24, 27-32, 34, 36, 38, 41-42, 44, 47, 49-50, 52-53, 55-62, 64, 66-67)

Territory 3= Allegheny (02), Armstrong (03), Dauphin (22), Jefferson (33), Washington (63), Westmoreland (65)

Territory 4= Bucks (09), Fayette (26), Lackawanna (35), Luzerne (40), Mercer (43), Montgomery (46)

Territory 5= Delaware (23)

Territory 6= Blair (07), Chester (15), Columbia (19), Crawford (20), Erie (25), Lawrence (37), Lehigh (39), Monroe (45), Northampton (48), Schuykill (54)

EXHIBIT 2

Year 2012 Prevailing Primary Premiums
Rates for Hospitals, Nursing Homes and Primary Health Centers

EXPOSURE BASE	EXPOSURE TYPE	RATE	RATE	RATE	RATE
			Territory		
	HOSPITALS	1	2	3	4
Per Occ Bed	Hospital (Acute Care)	6,876.07	3,052.97	3,823.09	6,112.83
Per Occ Bed	Mental Health/Mental Rehabilitation	3,440.98	1,527.80	1,913.18	3,059.03
Per Occ Bed	Extended Care	306.12	135.91	170.20	272.13
Per Occ Bed	Outpatient Surgical	6,876.07	3,052.97	3,823.09	6,112.83
Per Occ Bed	Health Institution	1,377.58	611.64	765.93	1,224.65
Per 100 Visits	Emergency	687.32	305.18	382.15	611.03
Per 100 Visits	Other	274.93	122.07	152.86	244.42
Per 100 Visits	Mental Health/Mental Rehabilitation	171.84	76.29	95.52	152.75
Per 100 Visits	Extended Care	15.26	6.78	8.47	13.58
Per 100 Visits	Outpatient Surgical	687.32	305.18	382.15	611.03
Per 100 Visits	Health Institution	103.08	45.78	57.32	91.65
Per 100 Visits	Home Health Care	171.84	76.29	95.52	152.75
	NURSING HOMES				
Per Occupied Bed	Convalescent	467.56	207.61	259.98	415.67
Per Occupied Bed	Skilled Nursing	385.06	170.98	214.10	342.33
	PRIMARY HEALTH CENTERS				
Per 100 Visits	Emergency	676.34	300.28	376.05	601.26
Per 100 Visits	Other	270.54	120.10	150.42	240.51
Per 100 Visits	Mental Health/Mental Rehabilitation	169.10	75.09	94.02	150.35
Per 100 Visits	Outpatient Surgical	676.34	300.28	376.05	601.26
Per 100 Visits	Home Health Care	169.10	75.09	94.02	150.35

Territory 1: Delaware (23), Philadelphia (51)
Territory 2: Remainder of State
Territory 3: Allegheny (02), Crawford (20), Erie (25), Lackawanna (35), Lawrence (37), Luzerne (40), Mercer (43)
Territory 4: Bucks (09), Chester (15), Montgomery (46)

EXHIBIT 3

SPECIALTY CLASSIFICATION CODES FOR PHYSICIANS, SURGEONS AND OTHER HEALTH CARE PROVIDERS (JUA)

CLASS 005 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00534	Administrative Medicine – No Surgery
00508	Hematology – No Surgery
00582	Pharmacology – Clinical
00537	Physicians – Practice limited to Acupuncture (other than acupuncture anesthesia)
00556	Utilization Review
00599	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 006 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00689	Aerospace Medicine
00602	Allergy/Immunology – No Surgery
00688	Independent Medical Examiner
00609	Industrial/Occupational Medicine – No Surgery
00687	Laryngology – No Surgery
00649	Nuclear Medicine – No Surgery
00685	Nutrition
00624	Occupational Medicine – Including MRO or Employment Physicals
00612	Ophthalmology – No Surgery
00613	Orthopedics – No Surgery
00665	Otolaryngology or Otorhinolaryngology – No Surgery
00684	Otology – No Surgery
00617	Preventive Medicine – No Surgery
00618	Proctology – No Surgery
00619	Psychiatry – No Surgery, including Psychoanalysts who treat physical ailments, perform electro- convulsive procedures or employ extensive drug therapy.

(Class 006 continues on next page)

00650	Psychoanalysts who do not treat physical ailments, do not perform electro-convulsive procedures and whose use of medication is minimal in order to support the analytic treatment and is never the primary or sole form of treatment shall be eligible for this classification. Except, practitioners of this medical specialty are ineligible for this classification if 25% or more of their patients receive medication.
00621	Rehabilitation/Physiatry – No Surgery
00645	Rheumatology – No Surgery
00681	Rhinology – No Surgery
00623	Urology – No Surgery
00699	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 007 Physicians - No Surgery

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00758	Hematology/Oncology – No Surgery
00786	Neoplastic Diseases – No Surgery
00743	Oncology – No Surgery
00715	Pathology – No Surgery
00799	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 010 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01035	Bariatrics – No Surgery
01004	Dermatology – Excluding Major Surgery
01037	Endocrinology – No Surgery
01074	Geriatrics – No Surgery
01007	Gynecology – No Surgery
01067	Pediatrics – No Surgery
01098	Physicians – Practice limited to Hair Transplants (Plug or Flap Technique or Split Mini Grafts)
01089	Psychosomatic Medicine
01020	Public Health – No Surgery
01059	Radiation Oncology excluding Deep Radiation – No Surgery
01088	Reproductive Endocrinology – No Surgery – No Obstetrical Delivery
01005	Sports Medicine – No Surgery
01099	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 011 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01142	Nephrology – No Surgery
01144	Pulmonary Medicine – No Surgery
01199	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 012 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01206	Gastroenterology – No Surgery
01253	Radiology excluding Deep Radiation – No Surgery
01299	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 015 PHYSICIANS - NO SURGERY

This classification applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01582	Anesthesiology – Pain Management only– No Surgery
01520	General or Family Practice – No Surgery
01522	Hospitalist – No Surgery
01540	Infectious Diseases – No Surgery
01589	Intensive Care Medicine
01510	Internal Medicine – No Surgery
01541	Neonatology – No Surgery
01559	Radiation Oncology including Deep Radiation – No Surgery
01599	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 017 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
01755	Ophthalmology – Surgery
01799	Physicians Not Otherwise Classified – Excluding Major Surgery (NOC)

CLASS 020 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02002	Allergy – Excluding Major Surgery
02083	Anesthesiology – Other than Pain Management only – Excluding Major Surgery
02022	Cardiology – No Surgery or Excluding Major Surgery – No Catheterization other than Swan-Ganz
02037	Endocrinology – Excluding Major Surgery
02006	Gastroenterology – Excluding Major Surgery
02038	Geriatrics – Excluding Major Surgery
02007	Gynecology – Excluding Major Surgery
02008	Hematology – Excluding Major Surgery
02009	Industrial Medicine – Excluding Major Surgery
02089	Neoplastic Diseases – Excluding Major Surgery
02042	Nephrology – Excluding Major Surgery
02049	Nuclear Medicine – Excluding Major Surgery
02028	Obstetrics – Excluding Major Surgery
02029	Obstetrics/Gynecology, No Obstetrical Delivery – Excluding Major Surgery
02043	Oncology – Excluding Major Surgery
02013	Orthopedics – Excluding Major Surgery
02065	Otolaryngology/Otorhinolaryngology – Excluding Major Surgery
02087	Otology – Excluding Major Surgery
02015	Pathology – Excluding Major Surgery
02016	Pediatrics – Excluding Major Surgery
02017	Preventive Medicine – Excluding Major Surgery
02018	Proctology – Excluding Major Surgery
02019	Psychiatry – Excluding Major Surgery
02020	Public Health – Excluding Major Surgery
02044	Pulmonary Medicine – Excluding Major Surgery
02069	Pulmonary Medicine – No Surgery except Bronchoscopy
02053	Radiology including Deep Radiation – No Surgery
02021	Rehabilitation/Physiatry – Excluding Major Surgery
02086	Reproductive Endocrinology – Excluding Major Surgery – No Obstetrical Delivery
02085	Rhinology – Excluding Major Surgery
02023	Urology – Excluding Major Surgery

(Class 020 continues on next page)

02068	Wound Care Physician – Excluding Major Surgery
02099	Physicians Not Otherwise Classified – Excluding Major Surgery (NOC)

CLASS 022 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02223	Cardiology – Including Right Heart or Left Heart Catheterization
02221	General or Family Practice – Excluding Major Surgery
02210	Internal Medicine – Excluding Major Surgery
02259	Radiation Oncology – Excluding Major Surgery
02260	Radiology including interventional radiology - Excluding Major Surgery
02299	Physicians Not Otherwise Classified (NOC)

CLASS 025 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02540	Infectious Diseases – Excluding Major Surgery
02511	Neurology – Excluding Major Surgery
02599	Physicians Not Otherwise Classified – Excluding Major Surgery (NOC)

CLASS 030 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed; and to other specialists who assist in major surgery on other than their own patients; who perform normal obstetrical deliveries; or who perform extra-hazardous medical techniques as determined by the Association.

JUA CODES	SPECIALTY DESCRIPTION
03017	General or Family Practice – Assist in Major Surgery on other than their own patients or performing normal obstetrical deliveries
03007*	Gynecology – Assist in Major Surgery on other than their own patients
03010	Internal Medicine – Assist in Major Surgery on other than their own patients
03029	Obstetrics/Gynecology, Assist in Major Surgery on other than their own patients-No obstetrical delivery
03043	Oncology – Including Major Surgery
03018	Proctology – Major Surgery
03045	Urological Surgery
03099	Surgeons Not Otherwise Classified (NOC)

*Obstetrical delivery is rated as Class 08029

CLASS 035 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to Urgent Care physicians and other specialists who work in an urgent care environment more than eight (8) hours per week, physicians who work in a prison environment more than eight (8) hours per week; or to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
03591	Laryngology – Including Major Surgery
03590	Otology – Including Major Surgery
03565	Otorhinolaryngology or Otolaryngology – Including Major Surgery
03586	Prison Physicians – Excluding Major Surgery
03570	Rhinology – Including Major Surgery
03531	Urgent Care including Emergency Medicine, Fast Track and similar services – Excluding Major Surgery
03599	Physicians Not Otherwise Classified (NOC)

CLASS 050 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
05015	Colon-Rectal Surgery if 75% or more of total surgical practice
05004	Dermatology – Major Surgery (including such plastic and cosmetic surgery that is consistent with the Dermatology medical specialty)
05007	Gynecology – Major Surgery
05089	Reproductive Endocrinology – Major Surgery – No Obstetrical Delivery
05099	Surgeons Not Otherwise Classified (NOC)

CLASS 060 SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
06047	Colon-Rectal Surgery when 26% or more of the physician's surgical practice is for non colon-rectal surgery
06030	Plastic Surgery
06099	Surgeons Not Otherwise Classified (NOC)

CLASS 070 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
07089	Abdominal – Major Surgery
07003	Cardiac Surgery
07053	Cardio-Thoracic Surgery
07046	Cardiovascular Surgery
07048	Cardio-Vascular-Thoracic Surgery
07088	Endocrinology – Major Surgery
07087	Gastroenterology – Major Surgery
07017	General or Family Practice – Major Surgery
07001	General Practice – Major Surgery
07043	General Surgery and Internal Medicine – Major Surgery
07086	Geriatrics – Major Surgery
07085	Peripheral Vascular Surgery
07025	Thoracic Surgery
07084	Trauma – Major Surgery
07054	Vascular and Thoracic Surgery
07026	Vascular Surgery
07099	Surgeons Not Otherwise Classified (NOC)

CLASS 080 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
08001	General Practice – Major Surgery
08028	Obstetrics – Major Surgery
08029	Obstetrics/Gynecology, Full Range of Procedures
08089	Perinatology, including C-Sections, Amniocentesis and Episiotomies
08087	Reproductive Endocrinology – Major Surgery – Including Obstetrical Delivery
08099	Surgeons Not Otherwise Classified (NOC)

CLASS 090 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
09013	Orthopedic Surgery
09099	Surgeons Not Otherwise Classified (NOC)

CLASS 100 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
10011	Neurosurgery
10099	Surgeons Not Otherwise Classified (NOC)

CLASS 120 PODIATRISTS - NON-SURGICAL

JUA CODES	SPECIALTY DESCRIPTION
80993	Podiatry – No Surgery

CLASS 130 PODIATRISTS - SURGICAL

JUA CODES	SPECIALTY DESCRIPTION
80994	Podiatry - Surgery

CLASS 900 CERTIFIED NURSE MIDWIVES

JUA CODES	SPECIALTY DESCRIPTION
80116	Certified Nurse Midwife (CNM)

ADDITIONAL SPECIALTY CODES

JUA CODES	SPECIALTY DESCRIPTION
80402	Birth Centers
80999	Corporate/Association/Partnership Liability
80612	Hospitals
80924	Nursing Homes
80614	Primary Health Centers
80289	Prison Corporate/Association/Partnership/Other Third Party Entities Liability

MEDICAL PROCEDURES

Medical procedures typically are employed as one of many components of a physician's medical practice. This rule applies to those physicians who limit their medical practice to a single medical procedure. If the medical practice of a physician is solely limited to a medical procedure described herein, the physician shall be classified and rated as follows:

JUA CODES	MEDICAL PROCEDURE
07099	*Broncho – Esophagology* – Major Surgery; Rate as Class 070, Surgeon Not Otherwise Classified (NOC)
00699	*Broncho – Esophagology* – No Surgery; Rate as Class 006, Physician Not Otherwise Classified (NOC)
02099	*Cardiology – Angiography*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Cardiology – Arteriography*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
07099	*Colonoscopy and Resection*; Rate as Class 070, Surgeon Not Otherwise Classified (NOC)
02099	*Colonoscopy*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Diskography/Myelography*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Endoscopic Retrograde Cholangiopancreatography;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
00699	*Hypnosis;* Rate as Class 006, Physician Not Otherwise Classified (NOC)
07099	*Laparoscopy/Peritoneoscopy;* Rate as Class 070, Surgeon Not Otherwise Classified (NOC)
02099	*Lymphagiography/Phlebography;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Manipulator* - Minor Surgery*;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Pneumatic or Mechanical Esophageal Dilatation;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
01099	*Pneumoencephalography;* Rate as Class 010, Physician Not Otherwise Classified (NOC)
02099	*Radiopaque Dye Injection;* Rate as Class 020, Physician Not Otherwise Classified (NOC)

If the physician's medical practice is not solely limited to a medical procedure described herein, the medical specialty of the physician shall be used to determine the applicable rate classification. If the physician's medical practice includes multiple medical specialties, the highest rated classification shall be used.

For Example:

Laparoscopy/Peritoneoscopy are medical procedures which are performed by practitioners of several medical specialties. The rating classification of physicians performing these procedures shall correspond with that of the physician's medical specialty:

Colon-Rectal Surgery	–	Shall be rated as either Class 050 or 060
Gastroenterology	–	Shall be rated as Class 070
General Surgery	–	Shall be rated as Class 070
Obstetrics/Gynecology (Performing the Full Range of Procedures)	–	Shall be rated As Class 080
Obstetrics/Gynecology (Who Assist in Major Surgery on Other Than Their Own Patients)	–	Shall be rated as Class 030
Surgeons – Gynecology	–	Shall be rated as Class 050

EXHIBIT 4
REMITTANCE ADVICE (FORM e-216)

2012 REMITTANCE ADVICE (FORM e-216)

For remitting coverage first incepted or renewed in 2012 only

216 Date: Completion Date

Please Select Primary Carrier

Related Lic #:

Related Entity:

Basic Insurance Coverage limit: $500,000/$2,500,000 Hospital

$500,000/$1,500,000 All Others

If Correcting, Enter Previous 216 Date

Correcting

Contact Person's Name and Address

Contact Person's Telephone #

Contact Person's Fax #

Contact Person's Email

Email completed e-216 to: ra-in-remittance@pa.gov

Email subject line should be

Enter Check #:

Carrier Code

Count 0

Assess.Total $0.00

For Fund's Official Use Only

Receipt Date

Check Amt.

Policy Exam

Contact Code

Date Last Modified:

	License #	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Carrier's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
11																$ -	$ -	$ -		
12																$ -	$ -	$ -		
13																$ -	$ -	$ -		
14																$ -	$ -	$ -		
15																$ -	$ -	$ -		
16																$ -	$ -	$ -		
17																$ -	$ -	$ -		
18																$ -	$ -	$ -		
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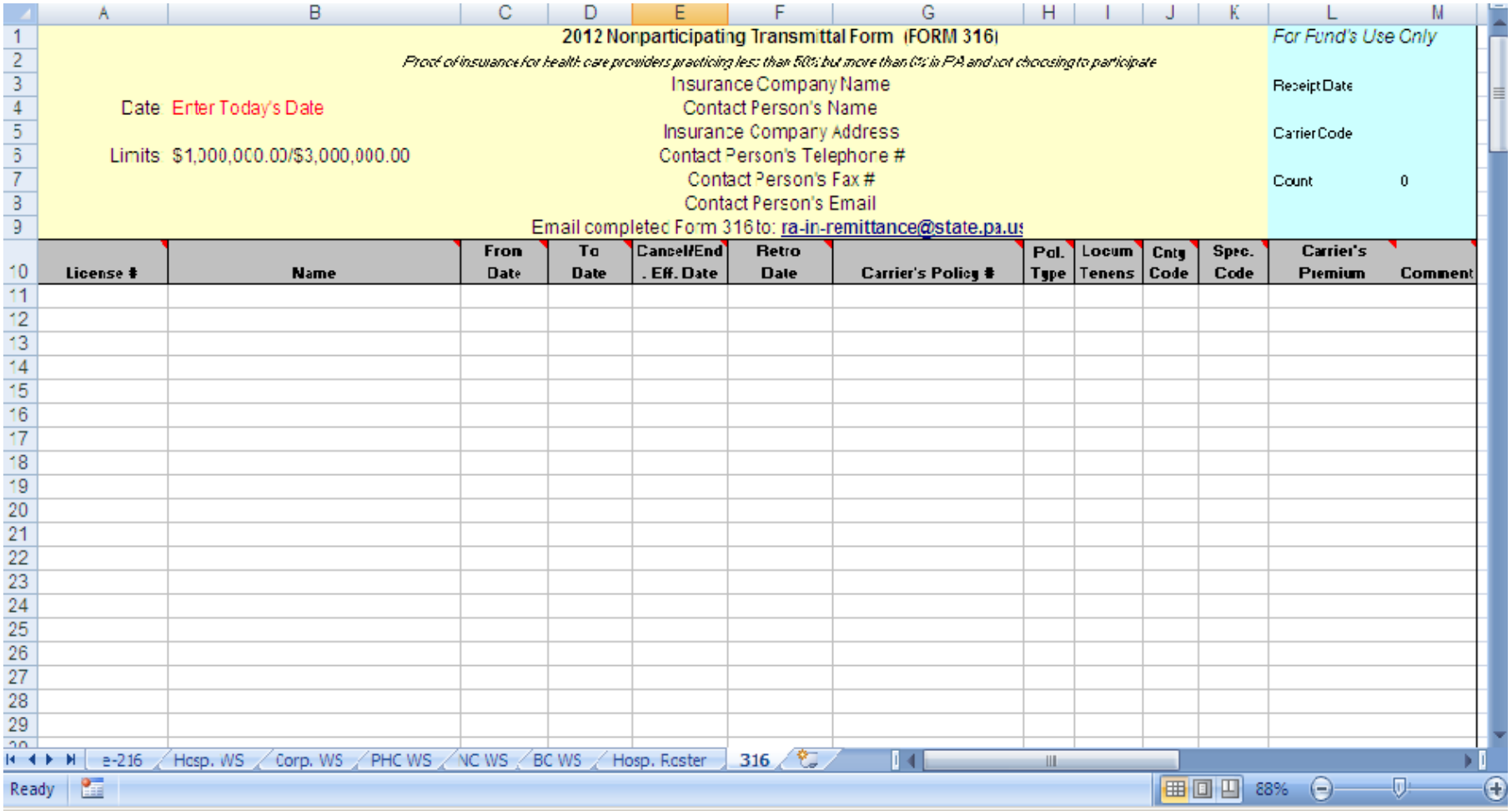
20																$ -	$ -	$ -		
21																$ -	$ -	$ -		
22																$ -	$ -	$ -		
23																$ -	$ -	$ -		
24																$ -	$ -	$ -		
25																$ -	$ -	$ -		
26																$ -	$ -	$ -		

e-216 | Hosp. WS | Corp. WS | PHC WS | NC WS | BC WS | Hosp. Roster | 316

Ready 75%

EXHIBIT 4A
NONPARTICIPATING TRANSMITTAL (FORM 316)



2012 Nonparticipating Transmittal Form (FORM 316)

Proof of insurance for health care providers practicing less than 50% but more than 0% in PA and not choosing to participate

Insurance Company Name
Contact Person's Name
Insurance Company Address
Contact Person's Telephone #
Contact Person's Fax #
Contact Person's Email
Email completed Form 316 to: ra-in-remittance@state.pa.us

Date Enter Today's Date

Limits $1,000,000.00/$3,000,000.00

For Fund's Use Only

Receipt Date

Carrier Code

Count 0

License #	Name	From Date	To Date	Cancel/End. Eff. Date	Retro Date	Carrier's Policy #	Pol. Type	Locum Tenens	Cntg Code	Spec. Code	Carrier's Premium	Comment

e-216 | Hosp. WS | Corp. WS | PHC WS | NC WS | BC WS | Hosp. Roster | 316

Ready 88%

EXHIBIT 5
WORKSHEET for Partnerships, Professional Associations and Professional Corporations

Insurer's Name	
Insurer's #	New Worksheet
Date:	
Entity's Name:	
Entity's Address:	

Basic Insurance Coverage limit: $ 500,000.00 Per Occ.
$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Entity's License #	From Date	To Date	County Code	Specialty Code	Entity's Assessment
				80999	*$0.00*

List all shareholders, owners, partners and employed health care providers

License #	Name	Specialty Code	County Code	HCP's Annual Assessment	Other Rating Factors

EXHIBIT 6
WORKSHEET for Hospitals

Insurer's Name:	
Insurer's #:	New Worksheet
Date:	
Hospital's Name:	
Address:	

Basic Insurance Coverage limits: $ 500, 000.00 Per Occ.
$2,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.*

Hospital's Mcare License #	From Date	To Date	Retro Date	County	Territory
					0

List of Annual Occupied Bed Counts

Exposure Type:	Bed Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Hospital (acute care)		6,876.07	3,052.97	3,823.09	6,112.83	$ -
Mental Health/Mental Rehab.		3,440.98	1,527.80	1,913.18	3,059.03	$ -
Extended Care		306.12	135.91	170.20	272.13	$ -
Out-Patient Surgical		6,876.07	3,052.97	3,823.09	6,112.83	$ -
Health Institution		1,377.58	611.64	765.93	1,224.65	$ -

List of Annual Visit Counts

Exposure Type:	Total Visit Count*	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	
Emergency		$ 687.32	$ 305.18	$ 382.15	$ 611.03	$ -
Other		$ 274.93	$ 122.07	$ 152.86	$ 244.42	$ -
Mental Health/Mental Rehab.		$ 171.84	$ 76.29	$ 95.52	$ 152.75	$ -
Extended Care		$ 15.26	$ 6.78	$ 8.47	$ 13.58	$ -
Out-Patient Surgical		$ 687.32	$ 305.18	$ 382.15	$ 611.03	$ -
Health Institution		$ 103.08	$ 45.78	$ 57.32	$ 91.65	$ -
Home Health Care		$ 171.84	$ 76.29	$ 95.52	$ 152.75	$ -

* Enter the actual "Visit Count." The spreadsheet will divide the "Visit Count" entered by 100.

Prevailing Primary Premium	$ -
Experience Modification Factor (as provided by Mcare)	1.000
2012 Mcare Assessment %	23%
Mcare Assessment	$0.00

*A copy of the Mcare's Experience Modification Factor letter sent to the hospital must be attached.

EXHIBIT 6A
HOSPITAL ROSTER for Hospitals

Insurer's Name				
Hospital's Name:				
Note: Submit this exhibit along with Exhibit 6 and Form e-216.				
		Insurer's Mcare #		
		Date:		
Hospital's Mcare License # (Please do not enter dashes)	Hospital's Policy #	From Date	To Date	County Code
List all Mcare eligible health care providers and entities for whom the above-mentioned hospital pays the assessment.				
HCP License # (Please do not enter dashes)	Health Care Provider's Name (Format: Last Name, First Name, Middle Initial)	JUA Specialty Code	For Fund Use Only	

EXHIBIT 7
WORKSHEET for Nursing Homes

Insurer's Name	
Insurer's #	New Worksheet
Date:	
Nursing Home Name:	
Nurs.Home's Address:	

Basic Insurance Coverage limit: $500, 000.00 Per Occ.
$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Nursing Home's Mcare License #	From Date	To Date	County Code	Territory	
			0	0	

List Annual Occupied Bed Counts

Exposure Type	Bed Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Prevailing Primary Premium
Convalescent		$ 467.56	$ 207.61	$259.98	$415.67	$ -
or						
Skilled Nursing		$ 385.06	$ 170.98	$214.10	$342.33	$ -

Full Mcare Assessment	$0.00
Assessment Due	$0.00

EXHIBIT 8
WORKSHEET for Primary Health Centers

Insurer's Name:	
Insurer's #:	New Worksheet
Date:	
Primary Health Ctr. Name:	
PHC's Address:	

Basic Insurance Coverage limits: $500, 000.00 Per Occ.
$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Primary Health Ctr's Mcare License #	From Date	To Date	County Code	Terr.	
				0	

List Annual Visit Counts

Exposure Type	Total Visit Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Emergency		$676.34	$300.28	$376.05	$601.26	$0.00
Other		$270.54	$120.10	$150.42	$240.51	$0.00
Mental Health/Mental Rehab.		$169.10	$75.09	$94.20	$150.35	$0.00
Out-Patient Surgical		$676.34	$300.28	$376.05	$601.26	$0.00
Home Health Care		$169.10	$75.09	$94.02	$150.35	$0.00

Prevailing Primary Premium	$0.00
Mcare Assessment	$0.00

EXHIBIT 9
WORKSHEET for Birth Centers

Insurer's Name	
Insurer's #	New Worksheet
Date:	
Birth Center's Name:	
Birth Center's Address:	

Limits $500, 000.00 Per Occ.
$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Birth Center's License #	From Date	To Date	County Code	Specialty Code	Birth Center's Assessment
				80402	$0.00

List all shareholders, owners, partners and employed health care providers

License #	Name	County Code	Specialty Code	HCP's Annual Assessment	Other Rating Factors

EXHIBIT 10
COUNTY CODE LIST

01 Adams	24 Elk	47 Montour
02 Allegheny	25 Erie	48 Northampton
03 Armstrong	26 Fayette	49 Northumberland
04 Beaver	27 Forest	50 Perry
05 Bedford	28 Franklin	51 Philadelphia
06 Berks	29 Fulton	52 Pike
07 Blair	30 Greene	53 Potter
08 Bradford	31 Huntingdon	54 Schuylkill
09 Bucks	32 Indiana	55 Snyder
10 Butler	33 Jefferson	56 Somerset
11 Cambria	34 Juniata	57 Sullivan
12 Cameron	35 Lackawanna	58 Susquehanna
13 Carbon	36 Lancaster	59 Tioga
14 Centre	37 Lawrence	60 Union
15 Chester	38 Lebanon	61 Venango
16 Clarion	39 Lehigh	62 Warren
17 Clearfield	40 Luzerne	63 Washington
18 Clinton	41 Lycoming	64 Wayne
19 Columbia	42 McKean	65 Westmoreland
20 Crawford	43 Mercer	66 Wyoming
21 Cumberland	44 Mifflin	67 York
22 Dauphin	45 Monroe	
23 Delaware	46 Montgomery	

TERRITORY DISTRIBUTION:

For Hospitals, Nursing Homes and Primary Health Centers:

Territory 1: Delaware (23), Philadelphia (51)
Territory 2: Remainder of State (01, 03-08, 10-14, 16-19, 21-22, 24, 26-34, 36, 38-39, 41-42, 44-45, 47-50, 52-67)
Territory 3: Allegheny (02), Crawford (20), Erie (25), Lackawanna (35), Lawrence (37), Luzerne (40), Mercer (43)
Territory 4: Bucks (09), Chester (15), Montgomery (46)

For All Other Health Care Providers:

Territory 1: Philadelphia (51)
Territory 2: Remainder of State (01, 04-06, 08, 10-14, 16-18, 21, 24, 27-32, 34, 36, 38, 41-42, 44, 47, 49-50, 52-53, 55-62, 64, 66-67)
Territory 3: Allegheny (02), Armstrong (03), Dauphin (22), Jefferson (33), Washington (63), Westmoreland (65)
Territory 4: Bucks (09),Fayette (26),Lackawanna (35),Luzerne (40),Mercer (43),Montgomery(46)
Territory 5: Delaware (23)
Territory 6: Blair (07), Chester (15), Columbia (19), Crawford (20), Erie (25), Lawrence (37), Lehigh (39), Monroe (45), Northampton (48), Schuylkill (54)