Massachusetts Medical Malpractice Reinsurance Plan

Rules of Operation

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Rules of Operation

Rule 1 - General Provisions

These Rules of Operation (Rules) are adopted in accordance with the Plan of Operation in order to carry out the provisions of the Plan of Operation and shall apply to all Medical Malpractice Insurance policies ceded.

The purpose of the Rules of Operation is to provide the detailed instructions needed to operate the Massachusetts Medical Malpractice Reinsurance Plan successfully. They supplement the Plan of Operation but do not add any new policy requirements beyond those contained in the Plan of Operation. The Rules contain instructions to Members concerning the processing of policies which are ceded to the Plan. They also contain specific material designed to regulate the conduct of Members in ceding policies to the Plan. The Rules should provide for a better understanding and more consistency by the Members in performing the various operations required in connection with policies ceded to the Plan. They also provide information concerning the responsibilities of all Members and their participation in the results of the Plan.

The Rules have been organized into numbered Rules which deal with a particular subject. For example, the chapter on cessions contains the information needed to carry out the intent of the Rules applicable to ceding policies to the Plan. The Rules assign necessary responsibilities to both the Member and the Plan staff and define their duties. By referring to this chapter, the user of the Rules is able to learn the requirements applicable to ceding policies to the Plan. Other chapters dealing with other subjects have been similarly organized.

The Rules will be monitored by the Plan staff working with advisory committees under the authority of the Governing Committee. Revisions will be made as needs dictate, and suggestions for improvement are solicited. Suggestions should be sent to the Plan, attention of the Chairman.

Rules of Operation

Rule 2 - Definitions

A. "Act" means Chapter 330 of the Acts of 1994, as amended.

B. "Commissioner" means the Commissioner of Insurance of the Commonwealth of Massachusetts.

C. "Direct Written Premiums" - synonymous with the term Net Direct Premiums defined below.

D. "Division" means the Division of Insurance of the Commonwealth of Massachusetts.

E. "Governing Committee" means the committee created pursuant to Section 10 of the Act.

F. "Health Care Provider", any category of heath care provider that was authorized to obtain Medical Malpractice Insurance from the Joint Underwriting Association established by Section 6 of Chapter 362 of the Acts of 1975, including, but not limited to, a doctor of medicine, osteopathy, optometry, dental science, podiatry, chiropractic, physical therapists and physical therapist assistants, or registered nurse licensed under Massachusetts General Laws Chapter 112, an intern, fellow or medical officer licensed under Massachusetts General Laws Chapter 112, § 9 or a licensed hospital, clinic, or nursing home, and its agents and employees, and any other category of health care provider as the commissioner of insurance may from time to time designate as eligible for being ceded to the Medical Malpractice Reinsurance Plan.

   a. A “doctor of medicine” or “osteopathy” means any individual licensed as a physician or osteopath pursuant to Massachusetts General Laws Chapter 112, § 2.

   b. A "doctor of optometry" means any person licensed as an optometrist pursuant to Massachusetts General Laws Chapter 112, § 68.

   c. A "doctor of dental science" means any person licensed pursuant to Massachusetts General Laws Chapter 112, §§ 45, 45A, 48.

d. A "doctor of podiatry" means any person licensed pursuant to Massachusetts General Laws Chapter 112, §§ 16, 16 A-C.

e. A "doctor of chiropractic" means any person licensed pursuant to Massachusetts General Laws Chapter 112, §§ 92, 94.

f. A "Physical Therapist" means any person licensed pursuant to Massachusetts General Laws Chapter 112, §§ 23I.

g. A "Physical Therapist Assistant" means any person licensed pursuant to Massachusetts General Laws Chapter 112, §§ 23J.

h. A "registered nurse" means any person licensed as a registered nurse pursuant to Massachusetts General Laws Chapter 112, §§ 74, 76A, 76B.

i. An "intern, fellow or medical officer" means any intern, fellow or officer registered pursuant to Massachusetts General Laws Chapter 112, § 9.

j. A "hospital" means any hospital licensed pursuant to Massachusetts General Laws Chapter 111, § 51, the teaching hospital of the University of Massachusetts and any psychiatric inpatient facility licensed under Massachusetts General Laws Chapter 19, § 29.

k. A "clinic" means any entity licensed as a clinic pursuant to Massachusetts General Laws Chapter 111, § 51.

l. A "nursing home" means any entity licensed as a nursing home pursuant to Massachusetts General Laws Chapter 111, § 71.

j. A "physician assistant" means any person licensed as a physician assistant pursuant to Massachusetts General Laws Chapter 112, § 9.

k. A "advanced practice registered nurse (APRN)" also known as "nurse practitioner" means any person licensed as an advanced practice registered nurse, nurse practitioner pursuant to Massachusetts General Laws Chapter 112, §§ 74, 76A, 76B.

G. "Inactive Member" means any Medical Malpractice Insurer which did not, in fact, issue any Medical Malpractice Insurance policies in Massachusetts during the most recent calendar year and which is not the issuing company on any outstanding Massachusetts Medical Malpractice Insurance policies.

H. "Massachusetts Medical Malpractice Reinsurance Plan" or "Plan" means the non-profit entity established by Section 10 of the Act.

I. "Medical Malpractice Insurance" means insurance coverage against the legal liability of the insured for loss, damage or expense incident to a claim arising out of the death or

injury of any person as the result of negligence or malpractice in the rendering or failing to render professional services by any Health Care Provider. This definition is intended to include coverage incidental to and in addition to the Medical Malpractice Insurance of any Health Care Provider.

J. "Medical Malpractice Insurer", any corporation that is licensed, admitted, authorized or approved to write liability other than auto insurance on risks within the commonwealth on a direct basis. The term "Medical Malpractice Insurer" shall not include: (1) a corporation or other entity that is formed under the laws of any jurisdiction other than a state of the United States or the District of Columbia and that is engaged in writing (i) Medical Malpractice Insurance for the members, shareholders or owners of such corporation or other entity, including affiliates of such members, shareholders, owners and persons employed by, affiliated with or providing professional services to such members, shareholders, owners or affiliates, and any servicing carrier thereof, or (ii) reinsurance on Medical Malpractice Insurance written by a fronting company for the members, shareholders or owners of such corporation or other entity, including affiliates
of such members, shareholders, owners or affiliates, and any servicing carrier thereof; (2) a trust maintained by the University of Massachusetts to self fund medical malpractice risks; (3) a risk retention group, as defined in the Liability Risk Retention Act of 1986, 15 U.S.C. 390; or (4) a surplus lines insurer, so-called, insuring under Massachusetts General Laws Chapter 175, § 168.

K. "Member" means any Medical Malpractice Insurer on and after April 1, 1995, that does not qualify for inactive membership status.

L. "Net Direct Premiums" means gross direct premiums, including any credits against premiums by virtue of the application of a deductible and any payments within a deductible or self-insured retention level made by insureds, written on risks within the Commonwealth on medical malpractice, including the Medical Malpractice Insurance component of multiple peril package policies, as approved by the Commissioner of Insurance less all premiums and dividends credited or returned by policyholders of the

unused or unabsorbed portions of premiums deposited. This term is synonymous with the term Direct Written Premiums.

It is arithmetically expressed as the sum of lines 11.1 and 11.2; Column #4, entitled Net Premiums Written of Underwriting and Investment Exhibit, Part 2B – Premiums Earned of the member company's Annual Statement.

M. "Notice of Cession" is a form provided by the Plan and submitted by the Member noticing the cession of a policy.

N. "Plan of Operation" means the Plan of Operation referred to in Section 10 of the Act.

O. "Policy Year" means the method of compiling insurance statistics whereby all premium and loss transactions are grouped according to the calendar year in which the related insurance policies take effect, regardless of the date premiums are earned or the date losses are reported or paid.

P. "Policy Effective Date" the policy effective date for the Plan shall be based on the effective date of the policy, if the cession notification is received by the Plan within 30 days subsequent to the effective date. If the cession notification is received more than 30 days after the policy effective date, then the Plan's policy year will be determined based on the date the cession is received by the Plan.

Q. "Primary Insurance" means an insurance policy or policies for medical malpractice coverage other than umbrella coverage, written by a Medical Malpractice Insurer or insurers under common "control" as such term is defined pursuant to Massachusetts General Laws Chapter 175, § 206 which (i) requires a direct relationship between such insurer(s) and the insured and which requires the insurer to adjust any claim under such policies in accordance with its customary and usual practices and (ii) which policies' coverage limits ceded shall not exceed (a) $2,000,000 per occurrence and $6,000,000 in the aggregate for an individual or (b) $2,000,000 per occurrence and $20,000,000 in the aggregate for a facility.

R. "Rules of Operation" means this document and any subsequent amendments.

Massachusetts Medical Malpractice Reinsurance Plan

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Rule 3 - Obligations of Members

All Members shall be required to meet standards for treatment of ceded risks, claims practices and other criteria as established by the Governing Committee.

A. Each Member shall pay an annual fee in an amount not to exceed $1000.00 to be determined by the Governing Committee on an annual basis or from time to time, which shall be credited to the expense of operating the Plan. Each Inactive Member shall pay an annual fee in an amount not to exceed $500.00 to be determined by the Governing Committee on an annual basis or from time to time, which shall be credited to the expenses of operating the Plan.

B. Each Member is obligated to remit premiums for risks ceded and to pay assessments levied against it for losses or expenses or any combination thereof incurred under policies reinsured through the Plan as established by the Governing Committee; to pay assessments levied against it for the operating expenses of the Plan as established by the Governing Committee; to pay penalties levied against it under any rules adopted by the Governing Committee; and to submit in a timely and accurate fashion all statistics, records and accounting required by the Plan.

C. Each Member, in recognition of the absolute necessity for timely payments of balances owed the Plan shall pay late payment fees at the prime rate as published from time to time in the Wall Street Journal, compounded monthly for late payment of any assessment or late payment of fees levied in accordance with the Plan. Each Member shall also compensate the Plan for all damages and expenses incurred by the Plan as a result of the failure of any Member to pay any assessments owed the Plan which remain unpaid as of the tenth calendar day following the invoice due date, written notice of the default having been mailed by certified mail to the company by the Plan on or after the first business day following the invoice due date. Damages and expenses as used herein shall include but not be limited to the Plan's attorney's fees incurred directly or indirectly with the collection of the balance due, all costs of borrowing incurred as a result of the nonpayment, the cost of all staff time spent in connection with efforts to collect the balance outstanding, all financial losses resulting from nonpayment and all other expenses and losses relating thereto.

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Rule 3 - Obligations of Members

D. Any Member shall be entitled to appeal to the Governing Committee any assessment, or late payment fees, damages or expenses which were levied in accordance with the Plan. However, the Member will be required to pay the amount billed by the Plan before such appeals will be considered. If the Governing Committee rules in favor of the Member, a proper adjustment, including interest at the prime rate and any damages and expenses assessed, will be made by the Plan to the Member's account. Before exercising any other right of appeal provided pursuant to the Plan's enabling legislation, the Member shall pay all amounts owed to the Plan.

With respect to Members which have failed to pay assessments, late payment fees or compensatory damages or expenses within forty-five (45) calendar days of the postmark date of the overdue payment notice, a report will be submitted to the Division of Insurance setting forth the fact of such nonpayment for its consideration and, if it deems appropriate, action.

E. When a Member is merged or consolidated into another insurer, or another insurer has reinsured a Member's entire Medical Malpractice Insurance business in Massachusetts, such Member and its successor in interest or such other insurer shall be liable for such Member's obligations hereunder.

F. A Member may terminate its membership in the Plan as of the close of the Plan's fiscal year upon the delivery of its notice of intent to cease writing medical malpractice policies in Massachusetts and assume Inactive Member status. Terminations of membership shall not discharge or otherwise affect liabilities of the Member incurred prior to the termination of membership or in any way affect the Member's obligation to make payments and assessments pursuant to the provisions of the Plan of Operation and the Member shall be charged or credited in due course with its proper share of all premium, losses and expenses allocable to it under the Plan.

G. If any Member is declared insolvent by a court of competent jurisdiction, its membership in the Plan shall terminate as of the date it is declared insolvent, but it shall be liable to the Plan for all obligations incurred under the Plan prior to the date it is declared insolvent. The Plan shall compute the amount of such obligations in accordance with the Plan of Operation and shall be entitled to offset any liabilities of the

Member of the Plan against any liabilities of the Plan to the Member.

Any unsatisfied net liability of an insolvent Member shall be assumed by and apportioned among the remaining Members of the Plan in the same manner in which underwriting results are apportioned by the Plan. The Plan shall have all rights allowed by law on behalf of the remaining Members against the estate or funds of such insolvent Member for sums due the Plan.

H. No judgment against the Plan shall create any direct liability against the individual Members.

I. A member company shall provide the same level and type of service, and in no event less service than the minimum standard established by the Governing Committee to policies reinsured through the Plan as they provide to policies issued voluntarily. Every member shall be bound by the Plan of Operation and all rules adopted pursuant to the Plan of Operation.

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Rule 4 - Assessments and Participation

Members shall be assessed their share of the operating profit or loss related to policies reinsured by the Plan, as determined by the Plan following the close of each fiscal year, in the manner provided by this Rule.

For the purpose of this Rule, the Plan's operating profit or loss shall include but not be limited to the net of:

- all income to the Plan including premiums, investment income earned by the Plan, and any other miscellaneous income items such as finance charge income, and

- all costs of operating the Plan including Plan administrative expenses, reinsured losses and allocated loss adjustment expenses, any applicable ceding expense allowances, and any other miscellaneous cost items.

1. Participation Ratio

Each Member's share of the Plan's operating results shall be based on its direct written premiums as defined in Rule 2.

The equation depicting the **Member Participation Ratio** for a Member for a given calendar year is as follows:

$$\frac{\text{Member's Net Direct Premiums Written During the Previous Calendar Year}}{\text{Aggregate Members' Net Direct Premiums Written During the Previous Calendar Year}}$$

2. Assessment Method

Pursuant to Article XIII, Section 4 of The Plan of Operation the Governing Committee establishes the following rules of assessment.

The Plan's actuary will prepare policy year estimates based on the Plan's Statutory Annual Statements. The Annual Statement data will be allocated to policy year based on information for each ceded policy and claim.

Calendar year accounting will be converted to a policy year basis. Premiums and paid losses will be based on the effective date of the individual ceded policies. Loss reserves will be based on actuarial estimates of loss ratios by policy year. Expenses will be based on a ratio of expenses to policy year premiums. Investment income will be based on estimated cash flows by policy year.

As the estimated deficit will change as policy years mature the following confidence weighting will be utilized for assessments.

Policy Year Age	Weighting %
1st year	**25%**
2nd year	**50%**
3rd year	**75%**
4th year & beyond	**100%**

Refer to INFORMATIONAL BULLETIN #10 (March 2001) for a hypothetical example of the application of assessment methodology.

3. Companies Who Become Non-Members

Companies which cease to be eligible to be Members, or which cease to be eligible to cede policies to the Plan shall remain liable with respect to the operating results of all policy years during which they were participants. This obligation continues until all claims for such policy years are closed, and final assessments are made.

4. Member Reporting

The following reports will be available to Members upon request;

Report
Income Statement
Balance Sheet
Loss Reserve Analysis
Annual Report
Policies in Force Report
Participation Ratio Report
Statement of Balances
Assessment Analysis

Rule 5 - Cession Rules and Procedures

A. Reporting Requirements

To place business with the Plan, Members must notify the Plan using forms provided (copies allowed) by the Plan.

Individual cessions from a multiple risk policy must provide the schedule of risks, with related premium, form which the individual risk is ceded. Specific names of individual risks not ceded may be redacted.

All cessions ceded under this Rule 5 shall be in accordance with Article 16 of the Plan of Operations.

Notice of Cession form must be complete independent of any accounting notifications for premium.

No cession may be for a period greater than one year.

B. Cession Effective Dates

Cessions will be accepted by the Plan with an effective cession date equal to the policy inception date, as long as the date selected is within 45 days of the date of receipt of the Notice of Cession.

Cession notification may not be submitted more than 90 calendar days prior to the policy effective date.

Decessions occurring during the policy period are not permissible unless due to cancellation of the primary insurance policy. Notice of policies no longer subject to cession mid-term shall be made on the same form as for cessions.

Cessions will only be received at the Plan during regular Plan business days. Cessions will be assigned a receipt date equal to the business day during which they are received at the Plan.

Notice of Cession can only be filed by a Member or its designee.

D. **Procedures for Ceding**

1. **Paper Form Specifications MMMRP-1**

The paper Notice of Cession is a form provided by the Plan or may be photocopied. The parts will be distributed and utilized as follows:

a. The original copy shall be submitted to the Plan which shall date-stamp them, returning a copy to the Member with an authorized Plan signature.

Members may submit cessions via telefax on the form described above. (Form MMMRP-1).

2. **Instruction For Completing Notice of Cessions Forms**

The following information shall be required on all Cession Forms:

A. Member Information

1. Member name and address
2. NAIC Code #

B. Insured Information

1. Insured's name and business address
2. ISO Classification code

C. Policy Information

1. Member's policy #
2. Claims made or Occurrence form
3. Policy effective date
4. Policy expiration date
5. Cession effective date
6. Policy limits
7. Deductibles
8. Declaration page attached
9. Total premium
10. Amount of premium remitted herewith

E. **Ceding Commission**

1. For policies with an effective date of January 1, 2005 or after, the Plan will pay a ceding commission of fifteen percent (15%) of the policy premium.
2. The commission will be paid quarterly to the ceding company.
3. Endorsements will be treated as a policy with the ceding commission paid or debited quarterly.

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Rule 6 - Premium

A. **Rating**

Each Member shall rate all polices reinsured through the Plan in accordance with its own manual of classifications, rules, rates and rating plans filed on its behalf with the Division of Insurance.

For extended reporting endorsements that fall under death, disability and retirement, the ceding carrier shall remit to the MMMRP the greater of the full filed extended reporting endorsement premium which is or would have been charged the insured, or the per centum of the full filed extended reporting endorsement premium due as scheduled below. The months referred to in the following schedule are consecutive months the underlying policy was ceded to the MMMRP immediately preceding the ceding of the extended reporting endorsement.

# OF MONTHS	% PREMIUM DUE
1 – 24 Months	100%
25 – 36 Months	80%
37 – 48 Months	60%
49 – 60 Months	40%
61 – 72 Months	20%
Over 73 Months	0%

"The premium rates for reinsurance through the Plan will not be reduced by any premium dividends the Member may grant to a reinsured policyholder, whether the dividend is issued independent of the reinsured policy or applied as a premium credit toward reinsured policy."

B. **Reporting**

Each Member shall report and pay premiums on policies reinsured through the Plan on Form MMMRP-2, Account of Premium Transactions, monthly. Premiums so reported shall include initial down payments, installments, audit adjustments, return and additional premiums arising from endorsement changes to the policies, as well as netted return premiums in the event of mid-term policy cancellation.

The Plan shall process each Member's monthly detail ceded premium reportings against the cession record from MMMRP-1, Monthly Report of Cessions to ensure that premium is reported on a timely basis for each policy for which a notice of cession has been reported.

Failure to pay the premium, when due, with respect to individual cessions may result in the cancellation of the reinsurance for that particular cession. See C. Cancellation.

Premiums for cessions shall be paid in accordance with the premium payment terms found in the reinsured policy and remitted in accordance with Rule 11.

C. **Cancellation**

A policy for which a Notice of Cessions has been filed and for which a schedule of premium payments has been established shall be canceled if subsequent payments are not received in a timely fashion.

Notice of Cancellation of Reinsurance (MMMRP-3) shall be sent to the Member stating when, not less than thirty days thereafter, cancellation shall become effective. Payment of premium prior to the effective date of cancellation shall result in the rescinding of the cancellation.

Cancelled reinsurance cannot be reinstated following the effective date of such cancellation (unless the cancellation is the result of a processing error by the Plan).

RESERVED FOR FUTURE REFERENCE

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Rule 9 - Claim Practices

The Governing Committee, or its designated Sub-Committee shall establish and supervise procedures for the review of claim practices of Members.

A. Members shall notify the Plan within 5 working days of notice or knowledge of a claim on the Notice of Claim Form.

B. Claim practices of each Member shall correspond with those followed for voluntary business, and Members shall:

1. Adopt and implement reasonable standards for prompt investigation of claims;

2. Affirm or deny coverage of claims within a reasonable period of time;

3. Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear;

4. Maintain claim reserving procedures for claims arising out of Plan business commensurate with their procedures for claims arising out of voluntary business;

5. Conduct internal claim quality audit of a reasonably representative number of claim files on Plan business, commensurate with their procedures for audit of claims on voluntary business, in order to verify compliance with established procedures and standards. Members shall prepare internal reports summarizing the efforts and conclusions of their claim department quality audit with sufficient frequency to reflect reasonable continuity of their quality controls. Reports may, at the option of each Member, consolidate comments relative to both Plan and voluntary claim adjustment, or cover Plan claim adjustment only. Report format shall be at the discretion of each Member, or as may be requested from time to time on an individual basis by the Governing Committee.

6. Establish complaint handling procedures, and maintain complete records of all complaints received on claims arising out of Plan business, or, at the option of each Member, on all complaints received arising out of all medical malpractice claims related to both Plan and voluntary business. Servicing Carriers shall maintain records reflecting the number of complaints received annually.

7. Acknowledge and act promptly upon communications regarding claims;

8. Promptly provide a reasonable explanation for denial of a claim or for the refusal of an offer of a compromise settlement.

C. In the handling of Plan claims, Members shall not:

1. Misrepresent pertinent facts or policy provisions relating to the coverage at issue;

2. Refuse to pay claims without having conducted a reasonable investigation based upon all available information;

3. Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.

D. Failure to meet the standards or requirements described in this Rule may prevent reimbursement of loss or expense or may result in such other penalties as may be imposed by the Governing Committee.

E. Dishonesty

Loss or expense resulting from the dishonesty of those employed by the Member to handle claims shall be the sole responsibility of the Member.

F. Claim Contingency Procedures

1. Terminations

A Member which terminates its membership as provided in Rule 3 shall, subject to the provisions of Rule 9 – Claim Practices, service to a conclusion all claims against all policies issued by it in its capacity as a Member and in effect prior to the date of termination.

G. Claims Payment

A Member will be reimbursed for a claim upon written request and such documentation as the Plan may reasonably require.

2. Other Terminations

Upon notice from the Governing Committee of the termination, other than voluntary, of a Member, the Chairman or designee shall examine a representative sample of open claim files to determine the amount of work completed, to estimate the future cost of servicing the claims to a conclusion, and to verify compliance with Rule 9 - Claim Practices. He shall review his findings with the Compliance Committee and shall present to the Governing Committee for its consideration the recommendations of the Compliance Committee for the further servicing of said Member claims.

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Massachusetts Medical Malpractice Reinsurance Plan

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Rule 11 - Premium Collection Standards

A. Remittance of Premium

1. Premiums received in a given month by a Member for a policy ceded to the Plan shall be remitted to the Plan by the 15th of the following month.

2. Any installment charges to the insured shall be remitted to the Plan.

B. Member Responsibility for Ceded Business

Each Member shall:

a. Give the same type of service to ceded insureds that it provides for its retained business including the same premium payment plans available to non-ceded insureds.

b. Bill, collect and refund premiums when due according to its usual marketing procedures.

c. Record premium and loss transactions as direct written business and pay taxes and all assessments thereon.

1) Record ceded transactions first as direct business of the company and then make a subsequent entry for reinsurance to the Plan. Detailed records shall be kept available to support all transactions involving the Plan.

d. Compensate the insurance producers in accordance with the company's voluntary business.

e. Code and prepare data processing input for all required transactions.

f. Prepare and promptly file all accounting and statistical reports as requested by the Plan.

g. Use forms in the performance of accounting and/or billing services to the Plan's insureds which are the same as forms used for non-ceded insureds. This applies to forms used for billing, nonpayment of premium, cancellation, checks, drafts, and claims.

Rule 12 - Expense Allowance to Members on Ceded Business

A. **Allocated Loss Adjustment Expense**

1. Allocated Loss Adjustment Expense, as defined below, will be paid to the Member within 30 days of submission to the Plan. Appropriate supporting documentation will accompany the submission.

2. Allocated Loss Adjustment Expenses are the following types of expenses of a Member in connection with claim settlements which can be directly allocated to a particular claim. The following are allowable allocated loss adjustment expenses:

   a. External Attorney's fees for claims in suit.

   b. House counsel fees for claims in suit (excluding subrogation claims, see Section C, a).

   These fees may be reported provided that:

   (i) the fees are computed at the same rate and by the same method as non-ceded claims, and

   (ii) the fees reflect the total operational cost, including labor, on an individual suit basis and are substantiated by time statistics.

   NOTE: Operational costs are defined as expenses which are normally contained in company overhead, such as rent, heat, electricity, benefits, etc., but excludes any items of profit.

(iii) Arbitration, court, and other specific items of expense such as:

Examinations under oath

Accident reconstruction services
Medical examination
Preferred Provider Network/Organization expenses incurred on a particular claim
Expert medical or other evidence
Laboratory and x-ray
Autopsy
Stenographic
Witnesses and summonses
Copies of documents not to exceed the lesser of the Member's cost or $0.05 per copy
Public record/police/fire reports (to the limit provided for by law)
Special investigation of a claimant's background (including asset/credit reports)
Medical records

B. **Unallocated Loss Adjustment Expenses**

1. The following items are unallocated expenses and shall not be allowed:

a. Overhead, salaries, and traveling expenses of company employees (other than amounts allocated as attorney's fees for claims in suit).

b. Special investigations (concerning the facts of the loss).

c. Adjuster's fees (including those paid to independent adjusters and/or attorneys for adjusting claims).

NOTE: The term "adjusting" includes the investigation and adjustment of claims, the disposition of salvage, and the recovery of sub-rogation claims not in suit.

C. **Subrogation Recoveries/Expenses**

Certain expenses incurred in effecting recovery, not to exceed the original loss amount, may be allowed.

a. Subrogation expenses that may be reported or deducted from the recovered amount with prior written permission of the Plan:

1. attorney's fees and associated costs for claims in suit
2. court costs
3. location/address reports

b. Subrogation expenses that are not to be reported or deducted from the recovery amount:

1. cost of company employees
2. collection agency fees
3. subrogation recovery services

Any Health Care Provider ceded to the Plan shall be an aggrieved health care provider under Massachusetts General Laws Chapter 175A, § 7 with respect to any filing. Any Health Care Provider ceded to the Plan shall be an authorized representative under Massachusetts General Laws Chapter 175A, § 11 with respect to any rate or rating system that affects its members.

Except as otherwise provided for proceedings under Massachusetts General Laws Chapter 175A, any Medical Malpractice Insurer and any other person aggrieved by any unfair, unreasonable or improper

act or practice resulting from the operation of the Plan, or as a result of the conduct of any other Medical Malpractice Insurer, may request relief from the Governing Committee. Any such person may appeal to the Commissioner from any ruling or decision of the Governing Committee with respect to the requested relief, and the Governing Committee, may on behalf of the Plan apply to the Commissioner for relief with respect to any act or practice of any Medical Malpractice Insurer with respect to the operation of the Plan. If the Governing Committee fails to issue a ruling or decision on any request for relief within thirty days after the request is made, the aggrieved person may proceed in the same manner as if his request had been rejected. Upon a finding by the Commissioner of any unfair, unreasonable or improper act or practice resulting from the operation of the Plan or as the result of the conduct of any Medical Malpractice Insurer, the Commissioner may order for such person relief which need not be consistent with the operation of the Plan or the provisions of the Plan of Operation. Nothing in this provision shall affect the power of the Commissioner as otherwise permitted by law.