Commonwealth of Pennsylvania

Mcare Assessment Manual

January 1

2015

Tom Wolf, Governor
Teresa Miller, Acting Insurance Commissioner

12%

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Commonwealth of Pennsylvania
Insurance Department

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

2015 ASSESSMENT MANUAL

Introduction

This manual should be used to calculate the Mcare assessment for 2015 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 2015 Mcare assessment calculation purposes the JUA rates to be used are the base rates that are effective January 1, 2015. It has been determined that the 2015 assessment rate is 12%.

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

MCARE PARTICIPATION

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

Although not defined as a "health care provider," those professional corporations, professional associations and partnerships that are entirely owned by HCPs and which elect to purchase basic insurance coverage must also participate in Mcare.

2015 MCARE LIMITS

Act 13 provides that the total required amounts of medical professional liability coverage, including primary and Mcare coverage, for HCPs, 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 HCPs will be required in 2015 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 HCPs 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.

USPS Mailing Address:

Mcare
Division of Administration and Coverage Compliance
P.O. Box 566
Harrisburg, PA 17108-0566

For Non-USPS Deliveries:

Mcare
Division of Administration and Coverage Compliance
1010 North 7th Street, Suite 201
Harrisburg, PA 17102-1410

Phone:
(717) 783-3770

Fax:
(717) 705-7342

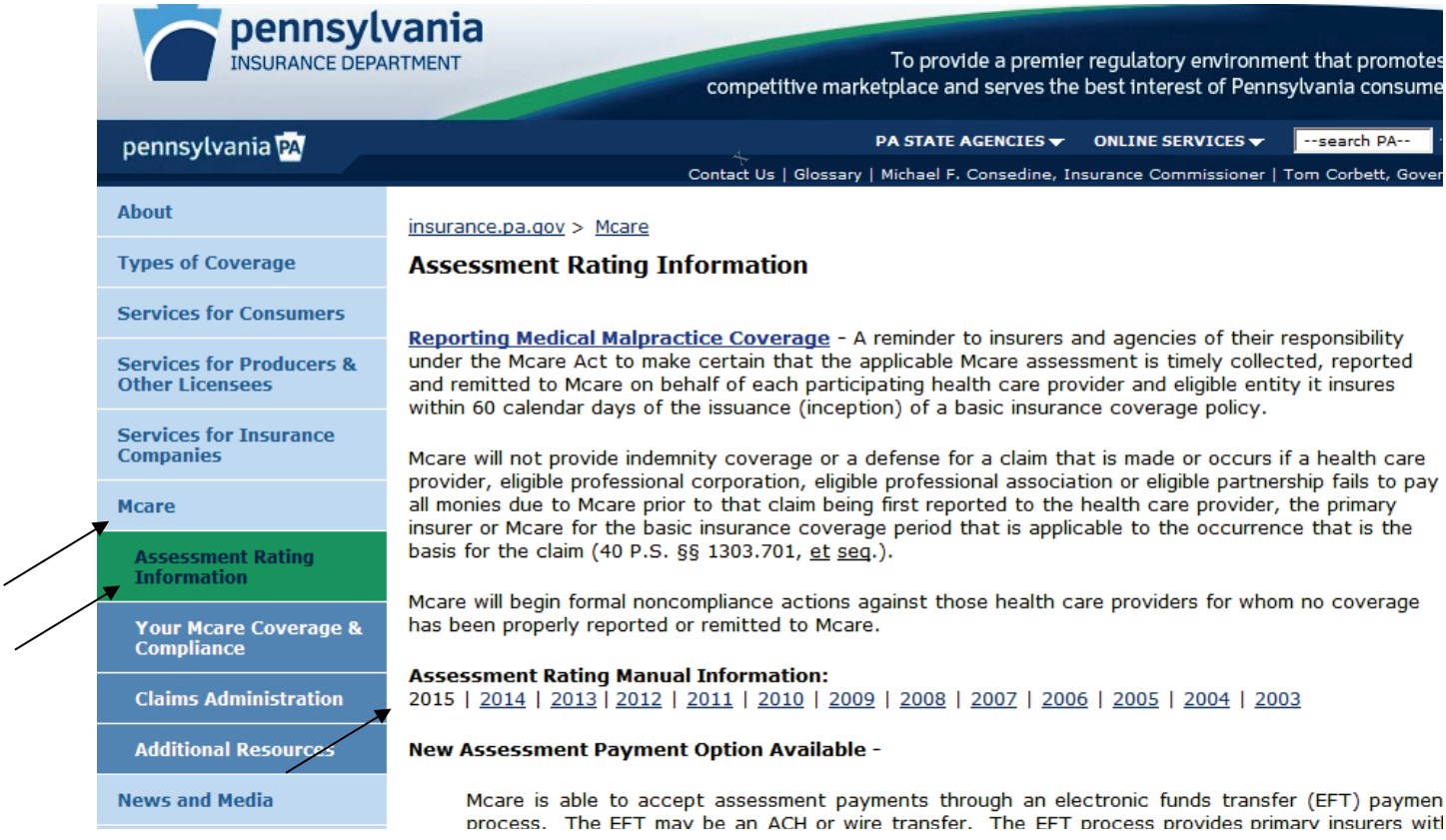
Form e-216 submission e-mail:
ra-in-remittance@pa.gov

SECTION I - REMITTANCE ADVICE FORM e-216

A. FORM 216 GENERAL INFORMATION Form e-216 serves as both a coverage reporting form and an accounting form. Electronic submission of Excel type e-216 is the preferred method of reporting basic insurance coverage to Mcare. Prior written permission must be obtained from Mcare before alternate electronic submissions will be accepted. A hard copy 216 is no longer required when submitting your e-216 with or without payment.

Always download a new Form e-216 from our website each time you need to complete another Form 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:

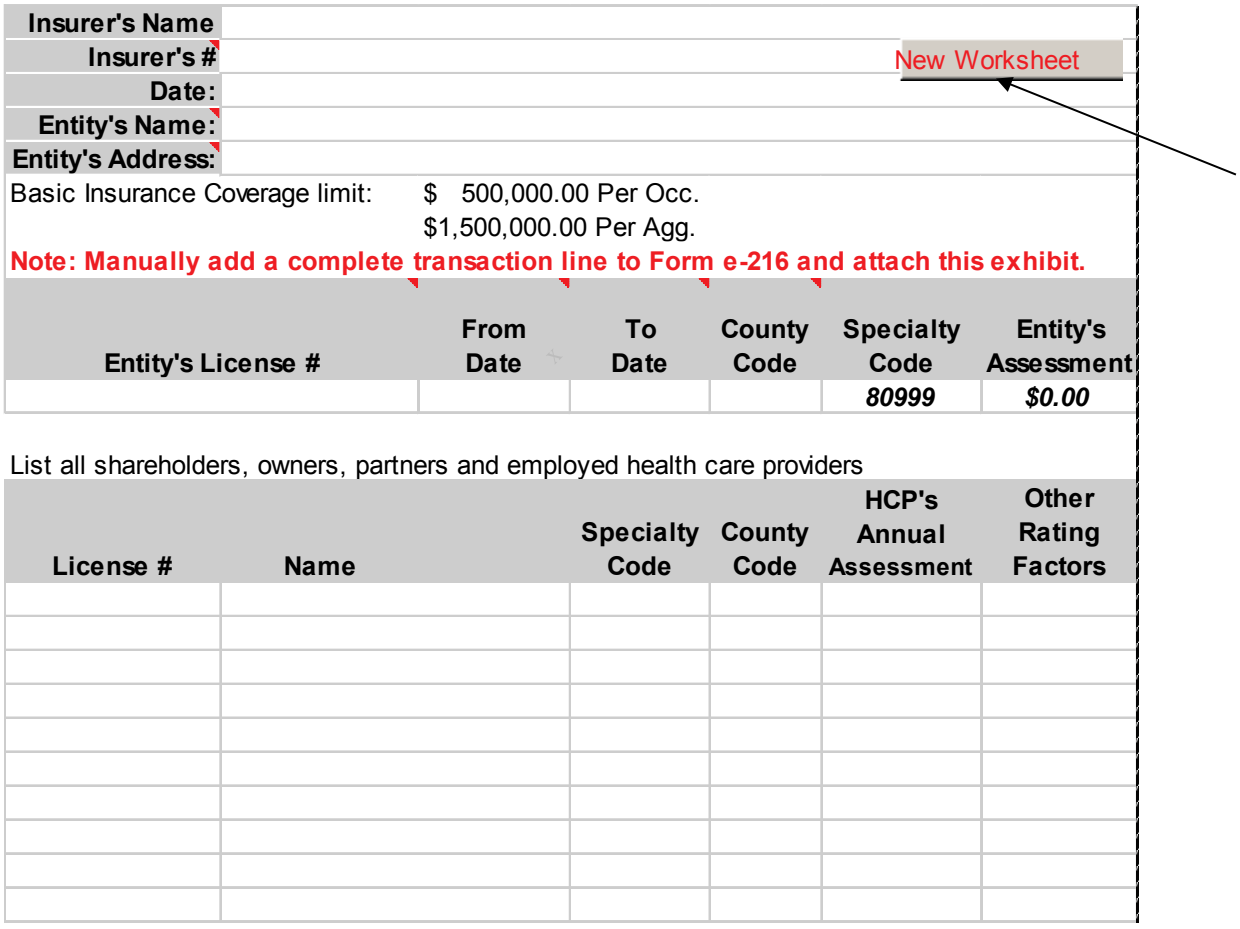
- Visiting our website at **www.insurance.pa.gov**
- Selecting "Mcare" from menu on the left
- Selecting "Assessment Rating Information" from menu on the left
- Selecting the link for the appropriate year's assessment manual
- Selecting the "e-216 Remittance Advice Form" link
- Opening or saving the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



Select "Assessment Rating Information" on website

Form e-216 is a Microsoft Office Excel Worksheet that contains macros which add functionality to the spreadsheet. The version of Microsoft Excel you are using will determine how macros are enabled.

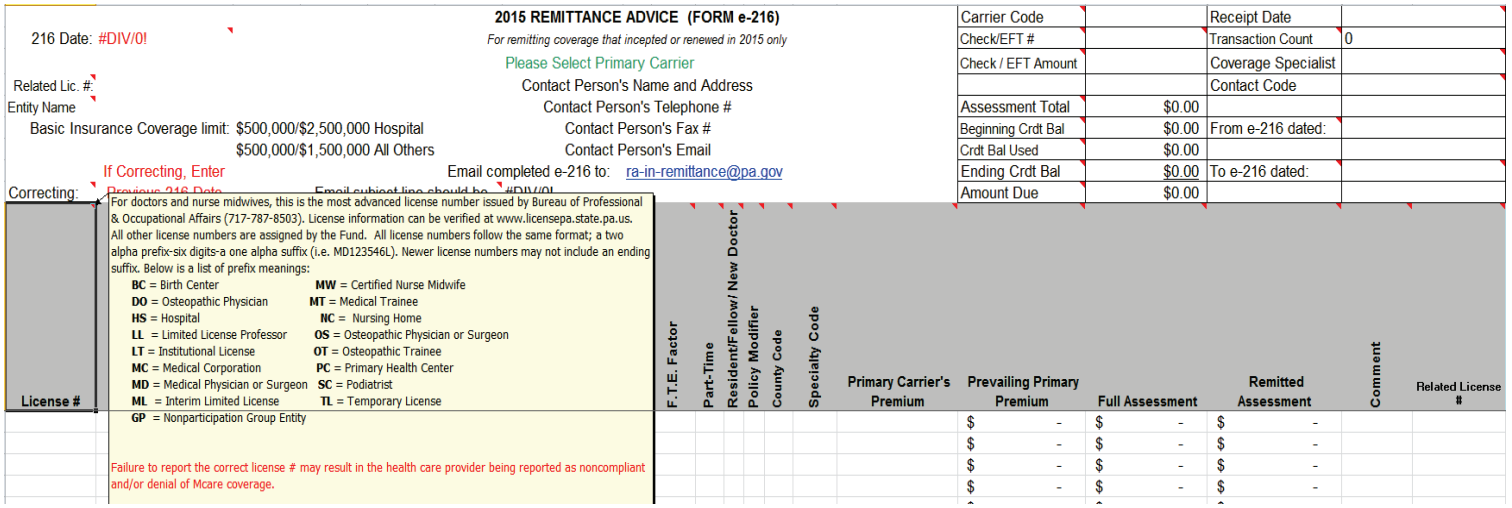
Form e-216 calculates the assessment payable for physicians, podiatrists and certified nurse midwives based on the information provided in columns "A" through "N." The worksheets, Hospital Roster, and Form e-316 are tabbed at the bottom of the Form e-216. The worksheets will calculate the assessment for hospitals (Hosp. WS), corporations (Corp. WS), birth centers (BC WS), nursing homes (NC WS) and primary health centers (PHC WS). 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 tab manually. If the facility provides services in multiple territories, the assessment from all of the facility's worksheets must be totaled and the total added manually to the Form e-216 tab. The worksheets for these entities must be submitted along with the completed Form e-216.



"New Worksheet" button

NOTE: WHEN SUBMITTING MULTIPLE WORKSHEETS, 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.



2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: #DIV/0!

Please Select Primary Carrier

Related Lic. #:

Contact Person's Name and Address

Entity Name

Contact Person's Telephone #

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

Contact Person's Fax #

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

Contact Person's Email

If Correcting, Enter

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

Correcting:

Carrier Code		Receipt Date	
Check/EFT #		Transaction Count	0
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	$0.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$0.00		

For doctors and nurse midwives, this is the most advanced license number issued by Bureau of Professional & Occupational Affairs (717-787-8503). License information can be verified at www.licensepa.state.pa.us. All other license numbers are assigned by the Fund. All license numbers follow the same format; a two alpha prefix-six digits-a one alpha suffix (i.e. MD123546L). Newer license numbers may not include an ending suffix. Below is a list of prefix meanings:

BC = Birth Center
DO = Osteopathic Physician
HS = Hospital
LL = Limited License Professor
LT = Institutional License
MC = Medical Corporation
MD = Medical Physician or Surgeon
ML = Interim Limited License
GP = Nonparticipation Group Entity
MW = Certified Nurse Midwife
MT = Medical Trainee
NC = Nursing Home
OS = Osteopathic Physician or Surgeon
OT = Osteopathic Trainee
PC = Primary Health Center
SC = Podiatrist
TL = Temporary License

Failure to report the correct license # may result in the health care provider being reported as noncompliant and/or denial of Mcare coverage.

License #	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		

"Comment" box on the e-216

The 2015 Form e-216 is to be used to report coverage only for policies issued or renewed in 2015. This is because the 2015 Form e-216 will calculate the assessment based on 2015 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.

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 pay a sufficient assessment within 60 days of the effective date of coverage may result in disciplinary action against a HCP's medical license and the denial of Mcare coverage in the event of a claim against the HCP or eligible entity.

TIP: When sending an insured an invoice for the Mcare assessment, select a due date for your invoice which allows sufficient time for you to comply with the 60-day reporting requirement.

B. ELECTRONIC SUBMISSIONS Electronic submission of Form e-216s is the preferred method of reporting basic insurance coverage to Mcare. Each submission must have a unique 216 date. A hard copy 216 is no longer required when submitting your e-216 with or without payment. These improvements apply to all submissions regardless of the assessment year. The e-216 and accompanying documentation must be sent to ra-in-remittance@pa.gov with the appropriate subject line as discussed on page 9.

New Assessment Payment Option Available Assessment payments may be made through an electronic funds transfer ("EFT") payment process. The EFT payment method is an alternative to a check payment method; however, checks will still be accepted. To learn more about this new payment option and the required minimum standards, please send an e-mail to Mcare's Fiscal Unit at ra-in-mcare-exec-web@pa.gov expressing your interest.

If payment is due, the payment must be sent to Mcare at or about the same time as the e-216 is e-mailed, but within 60 days of the effective date of coverage. Since no hard copy 216 is required, the check, ACH (if available) or wire number and payment amount must be included in your e-216 and the carrier code must be included on the face of the check or in the designated space of your ACH or wire so we can match the e-216 with the payment. **Please make payment methods payable to: Medical Care Availability and Reduction of Error Fund or "Mcare".**

Although a hard copy Form 216 will be accepted in isolated circumstances that are preapproved by Mcare, submitting both an electronic and hard copy of purportedly the same Form 216 is unacceptable. The submission of a hard copy Form 216 with or instead of a Form e-216 will hinder processing, which may cause your insured to be subject to noncompliance or delay the processing of claims.

If payment is due with your Form e-216, the assessment total must be equal to the payment amount remitted unless the primary insurer or self-insurer has a prior credit balance and it is properly documented in the e-216. If utilizing a credit, the payment amount should equal the amount due.

NOTE: When payment is due with an e-216, the "received date" is the date the valid funds and the valid e-216 are received by Mcare.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 2/11/15 12:00 AM

Related Lic. #: **HS654321L**

Entity Name

Basic Insurance Coverage limit: $500,000/$2,500,000 Hospital
$500,000/$1,500,000 All Others

If Correcting, Enter Previous 216 Date

Correcting:

Please Select Primary Carrier

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 999 Official e-216 02/11/15 Check/EFT No. 123456

Carrier Code	999	Receipt Date	
Check/EFT #	123456	Transaction Count	1
Check / EFT Amount	$3,177.00	Coverage Specialist Contact Code	
Assessment Total	$6,177.00		
Beginning Crdt Bal	($3,000.00)	From e-216 dated:	12/01/14
Crdt Bal Used	$3,000.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$3,177.00		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related Licens #
MD123456	Doe, John Q.	01/01/15	01/01/16			ABC2015	OC	1.000	F	N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	Rnwl	HS654321L

This remittance results in an assessment total of $6,177.00. The carrier has an existing credit balance of ($3,000.00) from remittance dated 12/01/14. They are using their existing credit to offset this submission resulting in a payment amount of $3,177.00.

If payment is not required because a credit is being utilized, you must document it in the Form e-216.

NOTE: When no payment is due with an e-216, the "received date" is the date the valid e-216 is received by Mcare.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 2/11/15 12:00 AM

Related Lic. #: **HS654321L**

Entity Name

Basic Insurance Coverage limit: $500,000/$2,500,000 Hospital
$500,000/$1,500,000 All Others

If Correcting, Enter Previous 216 Date

Correcting:

Please Select Primary Carrier

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 999 Official e-216 02/11/15

Carrier Code	999	Receipt Date	
Check/EFT #		Transaction Count	1
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	$6,177.00		
Beginning Crdt Bal	($13,000.00)	From e-216 dated:	12/01/14
Crdt Bal Used	$6,177.00		
Ending Crdt Bal	($6,823.00)	To e-216 dated:	
Amount Due	$0.00		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
MD123456	Doe, John Q.	01/01/15	01/01/16			ABC2015	OC	1.000	F	N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00		HS654321L

This remittance results in an assessment total of $6,177.00 The carrier has an existing credit balance of ($13,000.00) from remittance dated 12/01/14. They are using their existing credit to pay the assessment of this submission and carrying forward a new credit balance of ($6,823.00) to their next submission.

If payment is not required because a credit is being generated, you must document the use of the credit in the cell Q7 on Form e-216.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 2/11/15 12:00 AM

Related Lic. #: **HS654321L**

Entity Name

Basic Insurance Coverage limit: $500,000/$2,500,000 Hospital
$500,000/$1,500,000 All Others

If Correcting, Enter Previous 216 Date

Correcting:

Please Select Primary Carrier

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 999 Official e-216 02/11/15

Carrier Code	999	Receipt Date	
Check/EFT #		Transaction Count	1
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	($3,114.00)		
Beginning Crdt Bal	($1,000.00)	From e-216 dated:	12/01/14
Crdt Bal Used	$0.00		
Ending Crdt Bal	($4,114.00)	To e-216 dated:	
Amount Due	($3,114.00)		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
MD123456	Doe, John Q.	01/01/15	01/01/16			ABC2015	OC	1.000	F	N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00		HS654321L

This remittance results in a credit assement total of ($3,114.00). The carrier has an existing credit balance of ($1,000.00) from remittance dated 12/01/14. They are adding the existing credit balance with this submission indicating a new credit balance of ($4,114.00) which should be carried forward to their next submission.

When remitting to Mcare, please include the following in your e-mail:

1. A subject line with proper formatting. (See formatting instructions on next page)
2. A brief description of what is being submitted in the body of the e-mail. A cover letter is no longer required, but information formerly contained in the cover letter should be provided in the body of the e-mail.
3. An attached Form e-216 with credit balances being tracked when appropriate.
4. Supporting documentation provided as separate attachments.

When money is due to Mcare, the check, ACH, or wire number, and payment amount must be included in the Form e-216 and the carrier code must be included on the face of the check or in the designated space of your ACH or wire.

TIP: Please allow 2 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 2 hours, please notify your Mcare Coverage Specialist.

Proper subject line formatting for your e-216 submission 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-216s with a payment:

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

EXAMPLE: 000 Official e-216 01/01/15 Check No. 123456

e-216s without a payment:

Insurer's 3-digit Mcare-assigned # Official e-216 Date of e-216 [No Check, ACH, or Wire No. is needed when there is no payment]

EXAMPLE: 000 Official e-216 01/01/15

The correct subject line format is automatically populated on your e-216 in cell H9. Copy and paste this cell to the subject line of the e-mail.

Additional information on electronic submissions:

- 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 CD or external storage device and mailed.
- Do not use the recall feature to cancel an incorrect submission. Once it is received, it is considered an official submission. If you need to make a change to a submission that was already e-mailed to ra-in-remittance@pa.gov please contact your Mcare Coverage Specialist for further instructions.
- Electronic submissions may be sent in one of the following formats:

1. **Form e-216.** Transmit the completed Form e-216 by e-mail to Mcare. If the file size exceeds 10 megabytes send a CD or external storage device by mail.

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. If the file size exceeds 10 megabytes send a CD or exernal storage device by mail.

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. If the file size exceeds 10 megabytes send a CD or external storage device by mail.

SECTION II - REPORTING GUIDELINES

A. CREDIT BALANCES When the total of a Form e-216 results in a credit that is due to the carrier, the credit will be used as payment toward a future Form e-216. All credit balances must be carried forward to the next Form e-216 until the credit balance is exhausted.

Credit balances belong to the carrier of record. One credit balance per carrier may be maintained. Mcare does not maintain separate credit balances per insured and Mcare does not transfer credit balances for an insured from one carrier to another.

The heading of the Form e-216 tracks credit balances. Please utilize the fields as outlined below.

Carrier Code	Carrier code selected from drop down box	Receipt Date	Mcare's official use
Enter Check/EFT#:	Check/EFT # must be entered if sending payment	Transaction Count	The number of transactions on this e-216
Enter Check/EFT Amnt	*Enter the amount of the check. This should match the Amount Due below	Covg Specialist	Mcare's official use
		Contact Code	Mcare's official use
Assessment Total	This is the e-216 total		
Beginning Crdt Bal	Enter your current credit balance as a **credit**	From e-216 dated:	Enter the e-216 date the credit balance is being transferred from
Crdt Bal Used	Enter amount of credit being applied to this submission as a **debit**		
Ending Crdt Bal	This is the credit balance that should be carried over to your next e-216	To e-216 dated:	Mcare's official use
Amount Due	This will be the amount due or the new credit balance		

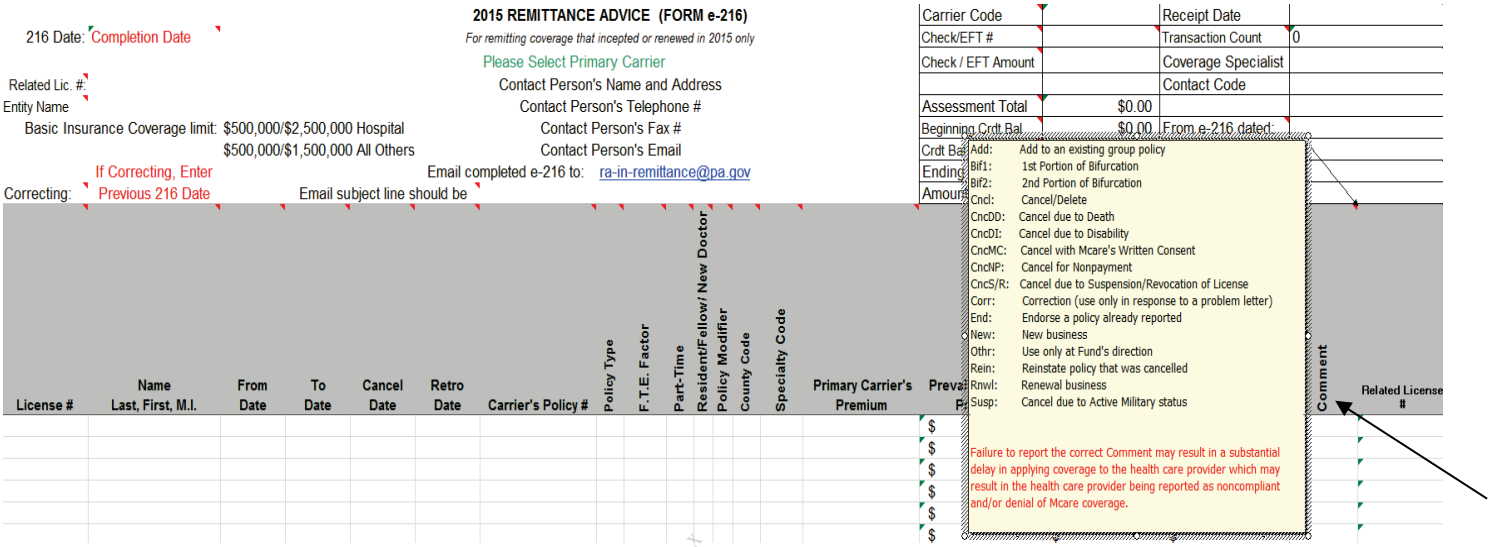
*The check/EFT amount should be equal to the Assessment Total minus the Credit Balance being used.

Entered by submitter
Automatically populated
For Mcare's official use only

e-216 heading information

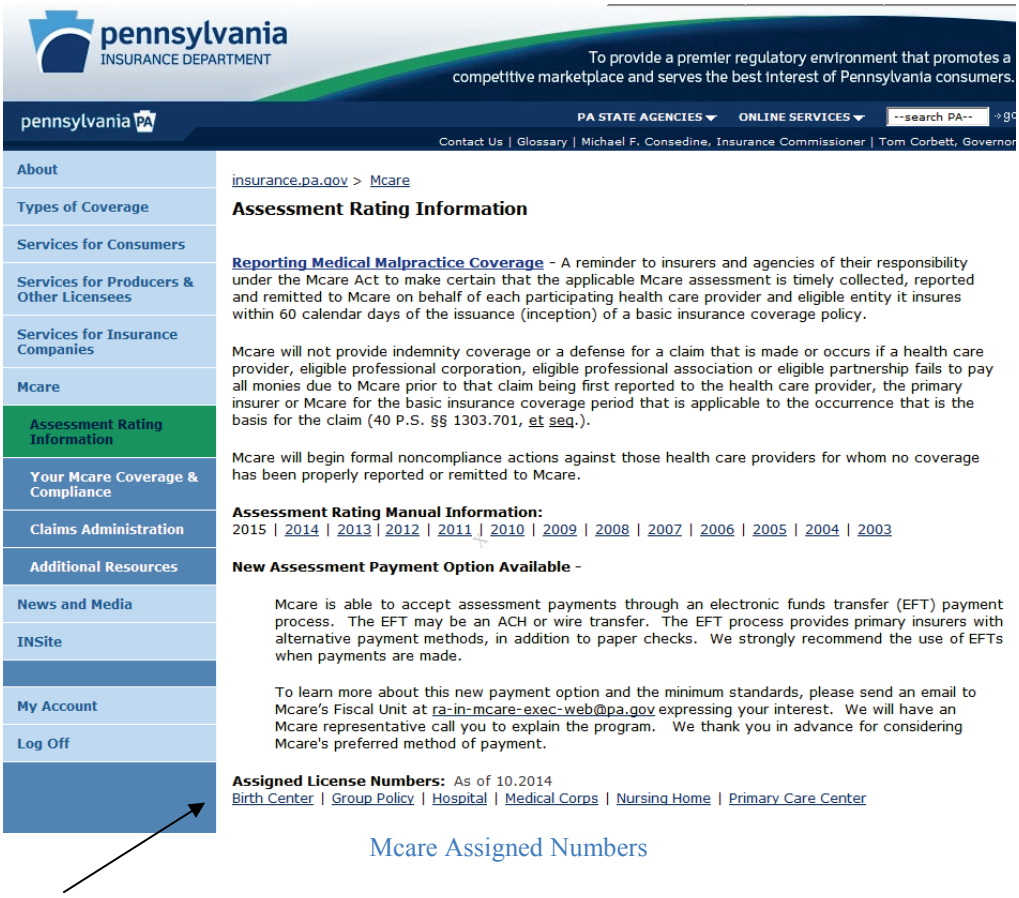
Our preferred method is one e-216 per submission. Multiple e-216s per submission are acceptable; however, completion of the information in the heading may become more complex.

B. 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" 1/1/14-1/1/15, and then renews with same company for 1/1/15-1/1/16; 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

C. 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 HCPs are reported under the same policy. Mcare identifies the specific related hospital, corporation, or group that individual HCPs 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 HCPs 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.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 2/15/15 12:00 AM

Please Select Primary Carrier

Related Lic. #: **HS123456L**

Entity Name: ABC Hospital

Contact Person's Name and Address

Contact Person's Telephone #

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

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

Contact Person's Fax #

Contact Person's Email

If Correcting, Enter Previous 216 Date

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

Email subject line should be 999 Official e-216 02/15/15 Check/EFT No. 654321

Carrier Code	999	Receipt Date	
Check/EFT #	654321	Transaction Count	3
Check / EFT Amount	$17,770.00	Coverage Specialist	
		Contact Code	
Assessment Total	$17,770.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$17,770.00		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related Licens #
	ABC Hospital														$ -	$ -	$ -		
MD654321	Arnold, Diana	01/01/15	01/01/16		07/01/12	ABC2015	CM	1.000		N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	Rnwl	HS123456L
OS123456	Pearlman, Sofia	01/01/15	01/01/16		01/01/15	ABC2015	CM	1.000		N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	New	HS123456L
OS654321	Lee, Tonette	02/15/15	01/01/16		02/15/15	ABC2015	CM	1.000		N		51	03531		$ 51,478.00	$ 5,416.00	$ 5,416.00	New	HS123456L

One Mcare Related License Number

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 HCPs having the same related license number.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 2/15/15 12:00 AM

Please Select Primary Carrier

Related Lic. #:

Entity Name:

Contact Person's Name and Address

Contact Person's Telephone #

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

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

Contact Person's Fax #

Contact Person's Email

If Correcting, Enter Previous 216 Date

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

Email subject line should be 999 Official e-216 02/15/15 Check/EFT No. 123456

Carrier Code	999	Receipt Date	
Check/EFT #	123456	Transaction Count	5
Check / EFT Amount	$30,885.00	Coverage Specialist	
		Contact Code	
Assessment Total	$30,885.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$30,885.00		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related Licens #
	ABC Hospital														$ -	$ -	$ -		
MD654321	Arnold, Diana	01/01/15	01/01/16		07/01/12	ABC2015	CM	1.000		N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	Rnwl	HS123456L
OS123456	Pearlman, Sofia	01/01/15	01/01/16		01/01/15	ABC2015	CM	1.000		N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	New	HS123456L
															$ -	$ -	$ -		
															$ -	$ -	$ -		
	XYZ Group														$ -	$ -	$ -		
OS654321	Lee, Tonette	01/01/15	01/01/16			XYZ2015	OC	1.000		N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	Rnwl	GP123456L
MD123456	Lane, Matt	01/01/15	01/01/16			XYZ2015	OC	1.000		N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	Rnwl	GP123456L
MD111111	Shellhammer, Patty	01/01/15	01/01/16			XYZ2015	OC	1.000		N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	New	GP123456L

Multiple Mcare Related License Numbers

D. CANCELLATIONS AND ENDORSEMENTS must be received by Mcare within 60 calendar days of the effective date of the cancellation or endorsement. 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
- Cancellation due to the health care provider is deceased
- Cancellation due to the health care provider is disabled

NOTE: IF THE DATE IN THE CANCEL DATE FIELD IS **BOLD**, *ITALIC* AND ~~LINED THROUGH~~ THE DATE IN THE CANCEL DATE FIELD IS NOT WITHIN 60 DAYS OF THE 216 DATE.

CANCELLATIONS (CNCL) should be reported when the primary policy cancels.

1. Enter the full original policy period in the coverage "From Date" and "To Date" and the cancellation effective date in the cancel date column.
2. Complete all other applicable coverage information.
3. The Form e-216 will calculate the return assessment credit.
4. CNCL should be coded in the Comment column of the Form e-216.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 7/15/15 12:00 AM

Please Select Primary Carrier

Related Lic. #:

Contact Person's Name and Address

Entity Name

Contact Person's Telephone #

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

Contact Person's Fax #

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

Contact Person's Email

If Correcting, Enter

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

Correcting: Previous 216 Date

Email subject line should be 999 Official e-216 07/15/15

Carrier Code	999	Receipt Date	
Check/EFT #		Transaction Count	2
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	($4,146.00)		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	($4,146.00)	To e-216 dated:	
Amount Due	($4,146.00)		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
															$ -	$ -	$ -		
MD654321	Smith, John J.	01/01/15	01/01/16	07/01/15		654321	OC	1.000	08	N		51	03531		$ 51,478.00	$ (1,557.00)	$ (1,557.00)	Cncl	
OS123456	Doe, Jane A.	01/01/15	01/01/16	08/01/15	01/01/12	123456	CM	1.000	F	N		51	03531		$ 51,478.00	$ (2,589.00)	$ (2,589.00)	Cncl	

John J. Smith was cancelled effective 7/01/15
Jane A. Doe was cancelled effective 8/01/15

ENDORSEMENTS (END) are changes to previously reported coverage and typically require the use of two lines of the Form e-216 to calculate the assessment.

1. The first line is a simulation of a cancellation of the previously reported coverage. Enter the full original policy period in the coverage "From Date" and "To Date" and the endorsement effective date in the "Cancel Date" column.
2. On the second line, use the endorsement effective date as the "From Date" and the expiration date as the "To Date" and complete the Form e-216 with the amended coverage information.
3. Both lines should be coded as END in the Comment column of the Form e-216.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 7/15/15 12:00 AM

Please Select Primary Carrier

Related Lic. #: **HS654321L**

Entity Name

Contact Person's Name and Address

Contact Person's Telephone #

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

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

Contact Person's Fax #

Contact Person's Email

If Correcting, Enter Previous 216 Date

Correcting:

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

Email subject line should be 999 Official e-216 07/15/15 Check/EFT No. 123456

Carrier Code	999	Receipt Date	
Check/EFT #	123456	Transaction Count	4
Check / EFT Amount	$769.00	Coverage Specialist	
		Contact Code	
Assessment Total	$769.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$769.00		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
MD123456	Smith, John J.	01/01/15	01/01/16	07/01/15		ABC2015	OC	1.000	08	N		51	03531		$ 51,478.00	$ (1,557.00)	$ (1,557.00)	End	HS654321L
MD123456	Smith, John J.	07/01/15	01/01/16			ABC2015	OC	1.000	F	N		51	03531		$ 51,478.00	$ 3,114.00	$ 3,114.00	End	HS654321L
															$ -	$ -	$ -		
OS123456	Doe, Jane A.	01/01/15	01/01/16	06/24/15	01/01/12	ABC2015	CM	1.000	F	N		51	02210		$ 34,532.00	$ (2,168.00)	$ (2,168.00)	End	HS654321L
OS123456	Doe, Jane A.	06/24/15	01/01/16		01/01/12	ABC2015	CM	1.000	F	N		51	01510		$ 21,972.00	$ 1,380.00	$ 1,380.00	End	HS654321L

John J. Smith was endorsed effective 7/01/15 from part time to full time

Jane A. Doe was endorsed effective 6/24/15 from specialty code 02210 to 01510

NOTE: MCARE WILL NOT HONOR REQUEST FOR CREDIT FOR A CANCELLATION OR ENDORSEMENT THAT IS REPORTED TO MCARE MORE THAN 60 DAYS AFTER THE EFFECTIVE DATE OF THE CANCELLATION OR ENDORSEMENT. 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.

E. CORRECTIONS (CORR) are typically reported in a similar manner as are endorsements, i.e. the use of two lines on the Form e-216. To properly report a correction, reverse what was originally reported incorrectly and report a new line with the correct information.

1. On the first line reverse what was originally reported incorrectly.
2. On the second line complete the Form e-216 with the corrected coverage information.
3. Both lines should be coded as CORR in the Comment column of the Form e-216 unless instructed otherwise by the Coverage Specialist.

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: 2/15/15 12:00 AM

Please Select Primary Carrier

Related Lic. #:

Contact Person's Name and Address

Entity Name

Contact Person's Telephone #

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

Contact Person's Fax #

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

Contact Person's Email

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

Correcting: February 1, 2015 CORR Email subject line should be 999 Official e-216 02/15/15

Carrier Code	999	Receipt Date	
Check/EFT #		Transaction Count	2
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	$0.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$0.00		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
MD123456	Smith, John J.	01/01/15	01/01/16	01/01/15	01/01/12	ABC2015	CM	1.000	F	N		51	03531		$ 51,478.00	$ (6,177.00)	$ (6,177.00)	Corr	HS654321L
MD123456	Smith, John J.	01/01/15	01/01/16		01/01/13	ABC2015	CM	1.000	F	N		51	03531		$ 51,478.00	$ 6,177.00	$ 6,177.00	Corr	HS654321L

John J. Smith was reported with an incorrect retro date of 1/01/12 on remittance dated 2/01/15
His correct retro date is 1/01/13

A correction Form e-216 should include only those HCPs being corrected. Do not resubmit entries that were previously reported correctly. Additionally, a correction Form e-216 should have a new remittance date since it is not a replacement of a previous submission. A correction Form e-216 should only include HCPs which have been identified by Mcare as having discrepancies. In cell B9, enter the date of the Form e-216 that you are correcting.

Please note that failure to provide correct information or full payment to Mcare may result in a health care provider being reported to their licensing authority for noncompliance. A claim that is made prior to Mcare's receipt of correct information or full payment may result in the denial of Mcare coverage.

SECTION III - CALCULATING THE MCARE ASSESSMENT

Mcare assessment payments are to be sent to Mcare at the same time as the Form e-216 and any other required documents are e-mailed. 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 HCPs 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. 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. (Refer to Exhibit 10)

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 2015 annual assessment rate of 12%. (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.

Although not defined as a "health care provider," those professional corporations, professional associations, and partnerships that are entirely owned by HCPs and which elect to purchase basic insurance coverage must participate in Mcare.

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. Copies of Articles of Incorporation and partnership agreements should be e-mailed to the Coverage Specialist prior to submitting coverage so that eligibility can be determined. Eligible 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 2015 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	$ 4,633	Y3
MD654321	Jane Smith	03531	51	$ 6,177	
MD012345L	Mark Jones	03531	51	$ 6,177	
MD054321E	Sally Jones	03531	51	$ 6,177	
MD246810	Joseph Miller	03531	51	$ 4,015	PT 16

The sum of the total 2015 assessments for all health care providers who are shareholders, owners, partners, or employees of Professional Corporation "Y" is $27,179. ($4,633, $6,177, $6,177, $6,177 and $4,015 = $27,179). Thus, the 2015 assessment owed by Professional Corporation "Y" is $4,077 ($27,179 X 15% = $4.077).

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 2015 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 7/01/15-7/01/16. The shareholders, owners, partners, independent contractors, and employees have individual effective dates as follows:

John Smith	02/01/15-02/01/16	2015 Policy
Jane Smith	07/01/15-07/01/16	2015 Policy
*Mark Jones	11/01/15-11/01/16	2015 Policy

*When Mark Jones renews his 2015 policy on 11/01/15, his assessment will be $6,177. The corporation's assessment is based on his 2015 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	$ 4,633	Y3
MD654321	Jane Smith	03531	51	$ 6,177	
MD012345L	Mark Jones	03531	51	$ 6,177	

The sum of the total 2015 assessments for all health care providers who are shareholders, owners, partners, or employees of Professional Corporation "Z" is $16,987. ($4,633, $6,177 and $6,177= $16,987). The 2015 assessment owed by Professional Corporation "Z" is $2,548 ($16,987 X 15% = $2,548).

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 Form e-216. List the annual assessment for each HCP on the worksheet. Indicate any discounts applied to a HCP's assessment in the "Other Rating Factors" column. Also, indicate specific HCP addition or deletion dates in the "Other Rating Factors" column if choosing to report mid-term changes.

NOTE: THE HCPS ANNUAL ASSESSMENT MUST BE LISTED ON THE WORKSHEET EVEN IF REPORTING A SHORT TERM COVERAGE PERIOD FOR THE CORPORATION BECAUSE THE WORKSHEET WILL PRORATE THE HCPS ANNUAL ASSESSMENT BASED ON THE DATES PROVIDED.

2015 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

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 all of the territories in which the hospital provides services under the same license. (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 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 2015 annual assessment of 12%. (Mcare assessment = PPP x EMF x 12%) See note at bottom of page.

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

5. Complete Hospital Worksheet (Exhibit 6) for each territory in which the hospital provides services, under the same license, listing the bed and visit counts separately for each territory and submit with completed Form e-216.

NOTE: 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).

2015 Exhibit 6
Worksheet for Hospitals

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

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

Hospital's Mcare License #	Date	To Date	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)		7,600.44	3,374.58	4,225.83	6,756.80	$ -
Mental Health/Mental Rehab.		3,803.48	1,688.75	2,114.73	3,381.28	$ -
Extended Care		338.37	150.23	188.13	300.80	$ -
Out-Patient Surgical		7,600.44	3,374.58	4,225.83	6,756.80	$ -
Health Institution		1,522.70	676.07	846.62	1,353.66	$ -

List of Annual Visit Counts

Exposure Type:	Total Visit Count*	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Emergency		$ 759.73	$ 337.33	$ 422.41	$ 675.40	$ -
Other		$ 303.89	$ 134.93	$ 168.97	$ 270.16	$ -
Mental Health/Mental Rehab.		$ 189.95	$ 84.32	$ 105.58	$ 168.84	$ -
Extended Care		$ 16.86	$ 7.50	$ 9.36	$ 15.01	$ -
Out-Patient Surgical		$ 759.73	$ 337.33	$ 422.41	$ 675.40	$ -
Health Institution		$ 113.94	$ 50.60	$ 63.36	$ 101.30	$ -
Home Health Care		$ 189.95	$ 84.32	$ 105.58	$ 168.84	$ -

* 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
2015 Mcare Assessment %	12%
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. ALTHOUGH HOSPITALS' ASSESSMENTS ARE BASED ON A TOTAL OF BEDS AND VISIT COUNTS PER TERRITORY, ASSESSMENTS FOR PHYSICIANS, PODIATRISTS, AND CERTIFIED NURSE MIDWIVES EMPLOYED BY HOSPITALS ARE BASED ON THE HIGHEST RATED TERRITORY IN WHICH THE HEALTH CARE PROVIDER PRACTICES.

6. When HCPs and Mcare eligible professional corporations, professional associations, and partnerships are covered under a policy issued to a hospital, a complete roster of all participating HCPs 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 HCPs at that hospital at the time of policy issuance or renewal.

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**	

Hospital Roster

NOTE: 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 all of the territories in which the nursing home provides services under the same license. (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 2015 annual assessment of 12%.

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

5. Complete a Nursing Home Worksheet (Exhibit 7) for each territory in which the nursing home provides services, under the same license, listing the bed counts separately for each territory and submit with completed Form e-216.

2015 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	

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		$ 516.81	$229.49	$287.37	$459.46	$ -
or						
Skilled Nursing		$ 425.63	$188.99	$236.65	$378.39	$ -

Prevailing Primary Premium	$ -
Mcare Assessment	$0.00

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 all of the territories in which the primary health center provides services under the same license. (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
3. Calculate the assessment for a primary health center by multiplying the total prevailing primary premium by the 2015 annual assessment of 12%.
4. Apply other applicable assessment rating factors as outlined in Section IV.
5. Complete a Primary Health Center Worksheet (Exhibit 8) for each territory in which the primary health center provides services, under the same license, listing the visit counts separately for each territory and submit with completed Form e-216.

2015 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		$747.59	$331.91	$415.67	$664.60	$0.00
Other		$299.04	$132.76	$166.27	$265.85	$0.00
Mental Health/Mental Rehab.		$186.92	$83.00	$103.93	$166.18	$0.00
Out-Patient Surgical		$747.59	$331.91	$415.67	$664.60	$0.00
Home Health Care		$186.92	$83.00	$103.93	$166.18	$0.00

Prevailing Primary Premium	$0.00
Mcare Assessment	$0.00

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 all of the territories in which the birth center provides medical or healthcare services under the same license. (Refer to Exhibit 10)

2. Calculate the assessment by computing the sum of 25% of the total 2015 assessments for all HCPs 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	$12,303	
MD054321E	Sally Jones	08029	51	$ 6,152	PT 08
MD246810	Joseph Miller	08029	51	$12,303	

The sum of the total 2015 assessments for all health care providers who use the facility or who have an ownership interest in Birth Center "X" is $30,758 ($12,303, $6,152, $12,303=$30,758). The 2015 assessment owed by Birth Center "X" is $7,690 ($30,758 x 25% = $7,690).

3. Complete a Birth Center Worksheet (Exhibit 9) for each territory in which the birth center provides services, under the same license and submit with completed Form e-216.

2015 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

Birth Center Worksheet

G. SELF-INSURED ENTITIES

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 plan, 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 services from a remote location by a HCP licensed in Pennsylvania. Telemedicine could range from a telephone consultation to reading x-rays to robotic surgery.

SECTION IV - ADDITIONAL ASSESSMENT RATING FACTORS

In addition to the above information, there are other factors that affect the HCP'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 OR NEW PODIATRISTS These providers 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 HCPs within this one slot or block of exposure must equal one Full-Time Equivalent ("FTE").

When multiple HCPs 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 HCP 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 HCPs within the slot and is not available for entities. The number of HCPs in any one slot shall be limited to 12.

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 Internal Medicine - Maj S	07043	Obstetrics/Gynecology*	08029
		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 HCPs 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 HCP 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 HCP leaves a slot-rated position, but the slot remains open, slot tail must be reported for the HCP who is leaving. Please provide notification to Mcare in the e-mail transmitting the e-216 when a new slot is opened or an existing slot is closed. If the last HCP in a slot leaves and the slot closes, tail must be reported for the entire slot on that last HCP's reported tail coverage. Indicate the retroactive date of the slot in the e-mail transmitting the e-216 and the retroactive date of the HCP on the e-216. If the retroactive date of the slot (not the last HCP in the slot) is prior to January 1, 1997, a surcharge is due to Mcare, when and only if there would have been a primary premium greater than $0 due for the basic insurance coverage tail for periods prior to 1997.

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 HCP is absent for a specified length of time. This term also includes HCPs 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 HCPs 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 HCPs, 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 AND COMPLIANCE". 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 HCPs, 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 2/1/15 – 2/1/16. A health care provider has the following assignments in PA: 2/6/15-2/25/15 (20 days), 5/1/15-5/26/15 (26 days), 7/1/15-7/26/15 (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 HCP to a group locum tenens policy mid-term, the preferred method is to use the start date of the HCP as the inception and retroactive date. Please note, the FTE must be based on the actual number of days in the policy period (HCP'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 7/1/15 – 7/1/16. The health care provider's start date is 10/1/15. The policy period reported for this health care provider is 10/1/15 – 7/1/16.

The health care provider has the following assignments in PA: 10/6/15 – 10/25/15 (20 days), 1/1/16 – 1/26/16 (26 days), 5/1/16 – 5/26/16 (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 HCP changes the effective date of their professional liability coverage and that change results in a HCP 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-216s applicable to the rating year that is being paid (i.e., for the example the report on the next page 7/1/15 to 1/1/16 on a 2015 Form e-216 using the 2016 rates and report 1/1/16 to 7/1/16 on a 2016 Form e-216 using the 2016 rates). Indicate "BIF1" or "BIF2" in the Comment column of the Forms e-216 on the respective line of coverage. (Refer to Example 6)

Mcare will consider the assessment for the second portion of a bifurcated assessment as being timely remitted when paid to Mcare within 60 days of the beginning date of the second portion of the bifurcated period. In example 6, the second payment is due to Mcare within 60 days of January 1, 2016.

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.

Example 6:

A health care provider has a policy from February 1, 2015 to February 1, 2016. The 2015 assessment (12%) was reported on this policy. On July 1, 2015, the health care provider cancels his policy and purchases a new policy for the period of July 1, 2015 to July 1, 2016.

(1) The assessment shall be prorated from July 1, 2015 to January 1, 2016 using the 2015 assessment (12%).
(2) The policy period from January 1, 2016 to July 1, 2016 shall be prorated by using the 2016 assessment (%TBD)*.
(3) Upon renewal of the July 1, 2016 policy, the 2016 assessment (%TBD)* will be applied for the full annual period.

	2/1/2015 to 2/1/2016	(12%)
Cancelled	(7/1/2015 to 2/1/2016)	(12%)
	7/1/2015 to 1/1/2016	(12%) Bifurcated
	1/1/2016 to 7/1/2016	(%TBD) Bifurcated
	7/1/2016 to 7/1/2017	(%TBD)

* This rate has yet to be determined.

SECTION V - NONPARTICIPATING TRANSMITTAL (FORM e-316)

A. GENERAL INFORMATION The Nonparticipating Transmittal Form e-316 is the form to be used by primary insurers and self-insurers who provide coverage to nonparticipating HCPs. A nonparticipating HCP is a HCP 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 HCP within an annual period.

Nonparticipating HCPs 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.

2015 Nonparticipating Transmittal Form (FORM e-316)

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

Insurance Company Name
Contact Person's Name
Insurance Company Address
Contact Person's Telephone #
Contact Person's Fax #
Contact Person's Email

Email completed e-316 to: ra-in-remittance@pa.gov

Date: Enter Today's Date

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

For Fund's Use Only
DO NOT CREATE HEADER
Receipt Date
Carrier Code
Count 0

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

Nonparticipating Form e-316

B. ELECTRONIC SUBMISSIONS The Nonparticipating Transmittal Form e-316 can be found as a tab (e-316) on the Exhibit 4 - Electronic Remittance Advice Form e-216 and is listed as Exhibit 4A in this Manual. The preferred method for primary insurers and self-insurers submitting coverage to Mcare is to do so electronically via the following e-mail address: ra-in-remittance@pa.gov. A hard copy Nonparticipating Transmittal Form 316 is no longer required when submitting your e-316/e-216. e-316s submitted electronically in a .pdf format will be rejected.

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 that 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. A surcharge is due when and only if there is a primary premium greater than $0 due for the basic insurance coverage prior acts. 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. Mcare's limits for prior acts coverage are restricted to the statutory limits of liability.

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 HCP, 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 at 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, when and only if there is a primary premium greater than $0 due for the basic insurance coverage tail for periods prior to 1997. The tail surcharge shall be 164% of the tail primary premium calculated by the basic insurance coverage insurer using their current tail rates for only that portion of the tail covering claims-made periods prior to the expiration of the 1996 coverage (See Example 7). 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 Mcare surcharge or assessment due for the primary 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 provider is currently 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 Mcare surcharge for the basic insurance coverage tail

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 PERIOD 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:

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.

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 65 and under.

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.

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.

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.

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 100 visits each.

SECTION VIII - FORM e-216 CHECKLIST

Checklist - Finalizing Your Submission

- ☑ Are you using the correct Form e-216 year?
  (Form 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 Form e-216?
- ☑ If money is due to Mcare, does the Form e-216 submission have the check, ACH or Wire # in cell Q2 of the Form e-216?
- ☑ Does the Form e-216 have the check, ACH or Wire amount in cell Q3 of the Form e-216?
- ☑ If you are utilizing a credit, have you completed the credit balance fields on the Form e-216?
- ☑ 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#)

License numbers? (www.licensepa.state.pa.us)

- ☑ Have MT/OT's changed to MD/OS's?
- ☑ Have they been validated for accuracy?

Midterm additions

- ☑ Are they being added to a master policy?
- ☑ If so, are you using the correct Form e-216 for the policy year?

Corrections

- ☑ Have you used CORR in the comment column?
- ☑ Did you include a description of what is being submitted in the body of the email? A cover letter is no longer required, but information formerly contained in the cover letter should be provided here.

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 included the Hospital Roster?

Support Documents

- ☑ Have you included all supporting documentation as a separate attachment, such as Articles of Incorporation?
- ☑ Have you included all applicable worksheets?

Sending

- ☑ Have you e-mailed your Form e-216 to the remittance e-mail address with the correct subject line? E-mail address: ra-in-remittance@pa.gov
- ☑ If you are sending a payment it must be sent to Mcare at the same time the Form e-216 is e-mailed
- ☑ If you are sending a payment or documents to Mcare are you using the **new street address** as noted under the Contact Information?

SECTION IX - CHANGES TO MEDICAL SPECIALTIES/TERRITORIES

A. CHANGES TO A DIFFERENT CLASS FOR 2015:

NONE

B. CHANGES TO TERRITORIES FOR 2015:

NONE

SECTION X - LIST OF EXHIBITS

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Exhibit 1

Year 2015

12%

Physicians, Surgeons, Podiatrists, and Certified Nurse Midwives

Prevailing Primary Premium / Assessment

Class	*Territory 1*		*Territory 2*		*Territory 3*		*Territory 4*		*Territory 5*		*Territory 6*		*Territory 7*		*Class*
	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	
005	4,243	509	2,309	277	2,703	324	3,324	399	3,573	429	2,838	341	3,324	399	***005***
006	8,310	997	4,099	492	4,956	595	6,309	757	6,851	822	5,249	630	6,221	747	***006***
007	14,812	1,777	6,960	835	8,558	1,027	11,082	1,330	12,092	1,451	9,105	1,093	11,082	1,330	***007***
010	10,682	1,282	5,143	617	6,270	752	8,051	966	8,763	1,052	6,656	799	8,051	966	***010***
012	30,762	3,691	13,978	1,677	17,395	2,087	22,790	2,735	24,948	2,994	18,564	2,228	21,404	2,568	***012***
015	21,972	2,637	10,110	1,213	12,525	1,503	16,337	1,960	17,862	2,143	13,351	1,602	15,616	1,874	***015***
017	21,506	2,581	9,905	1,189	12,267	1,472	15,995	1,919	17,487	2,098	13,074	1,569	15,853	1,902	***017***
020	24,916	2,990	11,405	1,369	14,156	1,699	18,498	2,220	20,236	2,428	15,097	1,812	17,252	2,070	***020***
022	34,532	4,144	15,637	1,876	19,483	2,338	25,557	3,067	27,986	3,358	20,799	2,496	23,481	2,818	***022***
025	37,519	4,502	16,951	2,034	21,138	2,537	27,749	3,330	28,893	3,467	22,570	2,708	24,468	2,936	***025***
030	34,109	4,093	15,450	1,854	19,249	2,310	25,246	3,030	27,645	3,317	20,548	2,466	23,938	2,873	***030***
035	51,478	6,177	23,093	2,771	28,871	3,465	37,995	4,559	41,265	4,952	30,848	3,702	34,246	4,110	***035***
050	44,678	5,361	20,101	2,412	25,104	3,012	33,004	3,960	36,164	4,340	26,816	3,218	32,523	3,903	***050***
060	52,092	6,251	23,363	2,804	29,211	3,505	38,446	4,614	42,139	5,057	31,212	3,745	38,267	4,592	***060***
070	82,509	9,901	36,746	4,410	46,062	5,527	60,772	7,293	66,655	7,999	49,249	5,910	58,428	7,011	***070***
080	102,525	12,303	45,554	5,466	57,151	6,858	75,464	9,056	82,789	9,935	61,119	7,334	69,988	8,399	***080***
090	55,121	6,615	24,696	2,964	30,889	3,707	40,669	4,880	44,581	5,350	33,008	3,961	40,669	4,880	***090***
100	158,466	19,016	70,168	8,420	88,143	10,577	116,524	13,983	127,877	15,345	94,292	11,315	111,901	13,428	***100***
120	4,984	598	2,635	316	3,114	374	3,868	464	4,170	500	3,277	393	3,868	464	***120***
130	36,058	4,327	16,308	1,957	20,328	2,439	26,676	3,201	27,683	3,322	21,704	2,604	23,024	2,763	***130***
900	33,071	3,969	14,994	1,799	18,674	2,241	24,484	2,938	26,434	3,172	19,933	2,392	21,993	2,639	***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, 05, 06, 08, 10-12, 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), Beaver (04), Carbon (13), Clearfield (17), Dauphin (22), Jefferson (33), Washington (63)
Territory 4= Delaware (23), Fayette (26), Luzerne (40), Mercer (43)
Territory 5= Lackawanna (35)
Territory 6= Bucks (09), Chester (15), Columbia (19), Crawford (20), Erie (25), Lawrence (37), Lehigh (39), Monroe (45), Montgomery (46), Northampton (48), Schuylkill (54), Westmoreland (65)
Territory 7= Blair (07)

EXHIBIT 2

Year 2015 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)	7,600.44	3,374.58	4,225.83	6,756.80
Per Occ Bed	Mental Health/Mental Rehabilitation	3,803.48	1 ,688.75	2, 114.73	3,381.28
Per Occ Bed	Extended Care	338.37	150.23	188.13	300.80
Per Occ Bed	Outpatient Surgical	7,600.44	3,374.58	4,225.83	6,756.80
Per Occ Bed	Health Institution	1,522.70	676.07	846.62	1,353.66
Per 100 Visits	Emergency	759.73	337.33	422.41	675.40
Per 100 Visits	Other	303.89	134.93	168.97	270.16
Per 100 Visits	Mental Health/Mental Rehabilitation	189.95	84.32	105.58	168.84
Per 100 Visits	Extended Care	16.86	7.50	9.36	15.01
Per 100 Visits	Outpatient Surgical	759.73	337.33	422.41	675.40
Per 100 Visits	Health Institution	113.94	50.60	63.36	101.30
Per 100 Visits	Home Health Care	189.95	84.32	105.58	168.84
	NURSING HOMES				
Per Occupied Bed	Convalescent	516.81	229.49	287.37	459.46
Per Occupied Bed	Skilled Nursing	425.63	188.99	236.65	378.39
	PRIMARY HEALTH CENTERS				
Per 100 Visits	Emergency	747.59	331.91	415.67	664.60
Per 100 Visits	Other	299.04	132.76	166.27	265.85
Per 100 Visits	Mental Health/Mental Rehabilitation	186.92	83.00	103.93	166.18
Per 100 Visits	Outpatient Surgical	747.59	331.91	415.67	664.60
Per 100 Visits	Home Health Care	186.92	83.00	103.93	166.18

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
00674	Geriatrics – 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
00737	Endocrinology – No Surgery
00758	Hematology/Oncology – No Surgery
00786	Neoplastic Diseases – No Surgery
00741	Nephrology – 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
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 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
01545	Pulmonary Medicine – 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
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
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
02206	Gastroenterology – Excluding Major Surgery
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
07025	Thoracic Surgery
07084	Trauma – Major Surgery
07054	Vascular and Thoracic 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
09085	Peripheral Vascular Surgery
09026	Vascular 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

Mcare CODES	SPECIALTY DESCRIPTION
80402	Birth Centers
80999	Corporate/Association/Partnership Liability
80612	Hospitals
80924	Nursing Homes
80614	Primary Health Centers

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)

2015 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2015 only

216 Date: Completion Date

Please Select Primary Carrier

Related Lic. #:

Contact Person's Name and Address

Entity Name

Contact Person's Telephone #

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

Contact Person's Fax #

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

Contact Person's Email

If Correcting, Enter

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

Correcting: Previous 216 Date

Email subject line should be

Carrier Code		Receipt Date	
Check/EFT #		Transaction Count	0
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	$0.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$0.00		

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 Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License #
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		
															$ -	$ -	$ -		

EXHIBIT 4A
NONPARTICIPATING TRANSMITTAL (FORM e-316)

2015 Nonparticipating Transmittal Form (FORM e-316)

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

Insurance Company Name
Contact Person's Name
Insurance Company Address
Contact Person's Telephone #
Contact Person's Fax #
Contact Person's Email

Email completed e-316 to: **ra-in-remittance@pa.gov**

Date: Enter Today's Date

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

For Fund's Use Only
DO NOT CREATE HEADER
Receipt Date
Carrier Code
Count 0

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

2015 Exhibit 5
Worksheet for Partnerships, Professional Associations and Professional Corporations

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

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 Assessmen	Other Rating Factors

2015 Exhibit 6

Worksheet for **Hospitals**

(Specialty Code 80612)

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

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)		7,600.44	3,374.58	4,225.83	6,756.80	$ -
Mental Health/Mental Rehab.		3,803.48	1,688.75	2,114.73	3,381.28	$ -
Extended Care		338.37	150.23	188.13	300.80	$ -
Out-Patient Surgical		7,600.44	3,374.58	4,225.83	6,756.80	$ -
Health Institution		1,522.70	676.07	846.62	1,353.66	$ -

List of Annual Visit Counts

Exposure Type:	Total Visit Count*	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Emergency		$ 759.73	$ 337.33	$ 422.41	$ 675.40	$ -
Other		$ 303.89	$ 134.93	$ 168.97	$ 270.16	$ -
Mental Health/Mental Rehab.		$ 189.95	$ 84.32	$ 105.58	$ 168.84	$ -
Extended Care		$ 16.86	$ 7.50	$ 9.36	$ 15.01	$ -
Out-Patient Surgical		$ 759.73	$ 337.33	$ 422.41	$ 675.40	$ -
Health Institution		$ 113.94	$ 50.60	$ 63.36	$ 101.30	$ -
Home Health Care		$ 189.95	$ 84.32	$ 105.58	$ 168.84	$ -

* 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
2015 Mcare Assessment %	12%
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	

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		$ 516.81	$229.49	$287.37	$459.46	$ -
or						
Skilled Nursing		$ 425.63	$188.99	$236.65	$378.39	$ -

Prevailing Primary Premium	$ -
Mcare Assessment	$0.00

2015 Exhibit 8

Worksheet for **Primary Health Centers**

(Specialty Code 80614)

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

New Worksheet

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		$747.59	$331.91	$415.67	$664.60	$0.00
Other		$299.04	$132.76	$166.27	$265.85	$0.00
Mental Health/Mental Rehab.		$186.92	$83.00	$103.93	$166.18	$0.00
Out-Patient Surgical		$747.59	$331.91	$415.67	$664.60	$0.00
Home Health Care		$186.92	$83.00	$103.93	$166.18	$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, 05, 06, 08, 10-12, 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), Beaver (04), Carbon (13), Clearfield (17), Dauphin (22), Jefferson (33), Washington (63)
Territory 4: Fayette (26), Delaware (23), Luzerne (40), Mercer (43)
Territory 5: Lackawanna (35)
Territory 6: Bucks (09), Chester (15), Columbia (19), Crawford (20), Erie (25), Lawrence (37), Lehigh (39), Monroe (45), Montgomery (46), Northampton (48), Schuylkill (54) , Westmoreland (65)
Territory 7: Blair (07)