PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP
A MUTUAL INSURANCE COMPANY
11880 COLLEGE BOULEVARD, SUITE 300, OVERLAND PARK, KANSAS 66210-2141
T 913.262.2585 • 800.562.5589 F 913.262.3633

Physicians Professional Liability Insurance Policy

This is a non-assessable Policy

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IMPORTANT NOTICES

This policy does not become effective unless a Declarations Page is issued to form a part of it.

This is a claims-made policy. Please review this policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance advisor, agent or broker.

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

For information, or
to make a complaint, call:
1-800-562-5589

(Attach Declarations Page Here)

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TO REPORT AN ADVERSE OUTCOME OR CLAIM

In the event you directly or indirectly become involved in or learn of any situation which you believe may result in a claim which is covered by this policy, please report the details to the Company as soon as possible at:

Mailing Address	Preferred Physicians Medical Risk Retention Group Attention: Claims Department 11880 College Boulevard, Suite 300 Overland Park, Kansas 66210-2141
Telephone Number (24 Hours/Day)	913-262-2585 or Toll Free 1-800-562-5589
Fax Number	913-262-3633

Please provide the following initial information:

1. The date of treatment;
2. The name and age of the patient;
3. The nature of the medical treatment;
4. A description of the events related to the situation; and
5. The names of any witnesses including other health care providers.

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THIS CLAIMS-MADE POLICY IS ISSUED BY
PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP
A MUTUAL INSURANCE COMPANY
(Referred to in the Policy as "the Company")

In consideration of payment of the premium and issuance of a Declarations Page, the Company agrees to provide the following coverage:

Part 1. Professional Liability Coverage

1-1. Scope of Coverage

The Company will pay on behalf of the Policyholder all sums the Policyholder shall become legally obligated to pay as damages, subject to the following requirements:

(a) The claim must involve injuries arising out of professional services involving the practice of medicine;

(b) The injury must result from professional services provided or which should have been provided by the Policyholder;

(c) The professional services giving rise to the injury must have occurred on or after the Retroactive Date shown on the policy Declarations Page and before the policy is canceled or not renewed;

Prior Acts Coverage (also known as "Nose Coverage") is provided if the Retroactive Date shown on the Declarations Page is prior to (earlier than) the Date First Insured;

(d) The Policyholder must report the incident or claim to the Company on or after the Date First Insured shown on the Declarations Page but before the date the policy is canceled, terminated or not renewed, unless an Extended Reporting Coverage Endorsement is issued by the Company; and

(e) Coverage is subject to the policy terms, conditions, limits, exclusions and any endorsements issued.

1-2. Who is Covered

In the case of an individual physician, the term "Policyholder" means the individual named in Part I of the Declarations Page or the individual's estate.

In the case of an Entity (for example, a professional association or corporation), "Policyholder" refers to the Entity named in Part I of the Declarations Page.

Coverage for claims against the Policyholder arising out of professional services provided by persons or entities for whom the Policyholder is responsible may be available by endorsement with prior approval by the Company.

Coverage for an Additional Insured or Added Named Insured (persons or entities not covered by this policy) may be available by endorsement with prior approval by the Company.

1-3. Invoking Coverage

Coverage under this claims-made policy is initiated by the Policyholder reporting to the Company:

(a) an adverse outcome;

(b) a patient complaint that includes either a demand for compensation or an allegation of medical negligence;

(c) the receipt of information, correspondence or formal notice of the patient's intent to take legal action; or

(d) the receipt of a summons and complaint, petition or lawsuit.

The following initial information must be provided:

(a) The date of treatment;

(b) The name and age of the patient;

(c) The nature of the medical treatment;

(d) A description of the events surrounding the medical treatment; and

(e) The names of any witnesses including other health care providers.

Upon receipt of the Policyholder's report, the Company will provide written confirmation regarding the availability of coverage. Coverage is invoked upon the written confirmation of coverage to the Policyholder.

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Part 2. Limits of Liability

Two limits apply to the maximum amount of damages the Company will pay under the policy. The Limits of Liability shown on the Declarations Page – Part II may be amended by endorsement, subject to approval by the Company. The two limits are:

2-1. Each Claim Limit

This limit is the maximum amount of damages the Company will pay for each claim regardless of the number of claimants or the nature of claims alleged. For example, this limit applies to a single pregnancy regardless of the number of maternal and fetal injuries claimed, multiple injuries sustained from a course of treatment, or claims asserted by persons other than the patient. This limit is also subject to the Aggregate Per Year Limit.

2-2. Aggregate Per Year Limit

This limit is the total amount of damages the Company will pay for all claims made in any twelve (12) month period commencing with the Date First Insured and each twelve (12) month period thereafter.

Part 3. Additional Benefits

The following additional benefits are provided and do not reduce the Limits of Liability stated in the policy. If the Aggregate Per Year Limit is exhausted, these additional benefits are no longer provided.

3-1. Defense

The Company will defend and pay all costs of defending each covered claim. The Company has the exclusive right to investigate, negotiate, defend and appoint defense counsel.

The Company's duty to defend ends, however, when the Limits of Liability have been exhausted by the payment of judgments and/or settlement.

3-2. Interest

The Company will pay all interest on the amount of any judgment that accrues after the entry of judgment and before the Company has paid, offered to pay, or deposited with the court the part of the judgment that is within the Limits of Liability available under the policy.

The Company will pay pre-judgment interest only on that part of the judgment covered under the policy. If the Company makes an offer to pay the Limits of Liability available, the Company will not pay any pre-judgment interest that accrues thereafter.

3-3. Appeal Bonds

If the Company decides to appeal a judgment against you, it will pay the portion of the premium on any appeal bonds relating to that portion of the judgment covered under the policy. The decision to appeal is solely at the discretion of the Company.

3-4. Investigation and Trial Expenses

The Company will pay reasonable costs which the Policyholder incurs at the Company's request during the investigation and defense of a claim. The Company will also reimburse the Policyholder for actual loss of earnings while attending trial, not to exceed a total of $500 per day.

Part 4. Exclusions – No Defense or Payment of Damages

In addition to the limitations contained within the Scope of Coverage, the policy excludes coverage for the following:

(a) Claims or incidents including adverse outcomes known to the Policyholder and not disclosed at the time of applying for insurance.

(b) Claims arising from events on or after the Retroactive Date and prior to the Date First Insured if the incident or claim was reported to the Policyholder's previous malpractice insurance company.

(c) Claims arising from events or actions during any period of time when the Policyholder failed to maintain continuous Professional Liability Coverage.

(d) The ownership or participation in any business enterprise unless otherwise endorsed onto the policy.

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(e) The performance of administrative duties as a medical director on behalf of a hospital, health care facility or insurance entity.

(f) Disputes involving fees or insurance reimbursement for direct patient treatment.

(g) Disciplinary or administrative proceedings before a licensing board, governmental agency or health insurance entity.

(h) Any event for which the Policyholder is entitled to indemnity or coverage under any other insurance policy or for which the Policyholder is entitled to coverage under a contractual agreement.

(i) Liability assumed under a written or an oral contract or agreement, except the Company will cover liability assumed under a hospital or managed care contract for physicians services, but only to the extent that the liability would have been covered by the policy in the absence of the contract or agreement.

(j) Violation of anti-trust laws, interference with contractual or employment relationships, violations of employment laws or civil rights.

(k) The use of any drug or pharmaceutical disapproved, suspended or restricted by the United States Food and Drug Administration for the treatment of human beings.

(l) The design, development, manufacture, assembly, sale or distribution of any goods or products.

(m) Any actual or attempted sexual acts, sexual misconduct or sexual harassment.

(n) Any intentional, willful, wanton, fraudulent, criminal or malicious acts or omissions.

(o) Any punitive or exemplary damages, criminal or civil fines or penalties.

(p) Liability arising from the use of alcohol or drugs, or liability which results from substance abuse.

(q) Liability arising from the alteration, falsification or destruction of medical records with fraudulent intent.

Part 5. General Conditions, Rules and Duties

5-1. Application

The statements made in the Application or Recertification Questionnaire are a part of the policy. The Policyholder is responsible for information provided by individuals acting on the Policyholder's behalf.

Coverage may be voided from the date the Policyholder either misstates or fails to disclose requested information during the Application or Recertification process.

5-2. Premium

The premium for the initial Policy Period and all subsequent renewal Policy Periods is payable in advance.

Unless the premium for renewal of the policy is paid prior to the Expiration Date of the current Policy Period, the policy will automatically terminate on the Expiration Date of the current Policy Period.

Renewal premium payments received after the Expiration Date of the current Policy Period will be returned to the Policyholder, unless the Company agrees to accept the premium payment and reinstate coverage.

The renewal premium will be billed prior to the Expiration Date of the policy, at rates applicable to the new Policy Period.

5-3. Duties in the Event of an Adverse Outcome or Claim

(a) The Policyholder must notify the Company as soon as practical upon becoming aware of facts which one could reasonably expect to give rise to a claim under the policy. The reporting requirements are stated in Part 1-3, Invoking Coverage of the policy.

(b) The Policyholder must cooperate with the Company in the investigation and management of each reported adverse outcome or claim, including the following:

(1) Immediately send the Company any demand, notice, summons, petition, complaints or other legal paper;

(2) Authorize or provide the Company with access to medical records or other information; and

(3) Assist the Company, upon its request, with the investigation, defense, settlement or trial of an adverse outcome or claim, and in the enforcement of any rights against others who may be held responsible.

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(c) The Policyholder agrees not to voluntarily make any payment, assume any obligation or incur any expense without the written consent of the Company.

5-4. Consent to Settle

The Company will obtain the Policyholder's consent to settle, unless:

(a) Consent is prohibited by law or regulation, or

(b) Consent is obtained through the following procedure:

A recommendation by the Company for settlement of a claim will be based on careful consideration of all circumstances surrounding the Policyholder's potential liability. The Policyholder agrees to give careful consideration to the recommendation.

If the Policyholder does not agree with the recommendation by the Company for settlement of a claim, then the Company may refer the matter to a peer review panel selected by the Company. The panel will consist of three board certified physicians in the Policyholder's practice specialty from Preferred Physicians Medical's Board of Directors.

The decision of the peer review panel will be binding on the Company and the Policyholder.

The selection and decision of the peer review panel will be accomplished within a procedure and time frame established by the Company.

5-5. Practice Changes

The Policyholder agrees to notify the Company in writing of any change in the Policyholder's practice which is materially different from the information provided during the Application or Recertification process. Material change includes a change in partners or associates, practice locations, procedures, administrative responsibilities, privileges at health care facilities or restrictions on any medical license.

5-6. Practice Standards

The Policyholder specifically agrees:

(a) To practice in accordance with all current ASA Standards For Basic Anesthetic Monitoring in all practice locations;

(b) To practice only while properly licensed, certified and/or registered; and

(c) To conform to all regulatory or statutory requirements regarding the practice of medicine including the dispensing of controlled substances.

5-7. Policy Changes

No changes requested by the Policyholder will be effective until approved by the Company. Endorsements issued to modify coverage or other terms and conditions become part of the policy. If the terms of any endorsement are inconsistent with the terms of the policy, then the terms of the endorsement supersede the policy.

The Policyholder is entitled to the benefit of any change the Company makes which broadens or extends coverage without requiring the payment of additional premium. Any such change will be effective on the date authorized by the Company.

5-8. Assignment and Transfer

The policy cannot be assigned or transferred. Upon the death of the Policyholder, the terms and conditions of Part 6-2, Automatic Extended Reporting Coverage Endorsement are applicable.

5-9. Cancellation and Non-renewal

Either the Policyholder or the Company may cancel the policy at any time.

(a) If the Policyholder cancels, a written request or a release furnished by the Company and signed by the Policyholder must be mailed to the Company stating the cancellation date desired. The cancellation date cannot be backdated for more than thirty (30) days from receipt by the Company of the written request.

(b) If the Company cancels or non-renews the policy, the Company will send a written notice to the current address. The Company will provide notice sixty (60) days prior to the effective date of cancellation. If cancellation is for nonpayment of premium other than renewal premium, notice will be given ten (10) days prior to the effective date of cancellation.

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5-10. Premium Refunds to Policyholder

The Company will issue to the Policyholder prorated refunds of any unearned premium within a reasonable time following cancellation, unless the Policyholder has agreed to premium refunds being transferred to a third party.

5-11. Recovery from Third Parties

The Policyholder agrees to preserve and transfer any rights of recovery, legal or contractual, that may allow the Company to recover all or part of a covered loss.

5-12. Other Insurance

Coverage provided by the policy is primary except when stated to apply on an excess or contingent basis with other insurance. When this insurance is primary and the Policyholder has other insurance which applies on an excess or contingent basis, liability under the policy shall not be reduced by the existence of other insurance.

If it is determined the policy and other insurance apply to a loss on the same basis, whether primary, excess or contingent, the policy provides:

(a) Contribution by equal shares if all other insurance permits contribution by equal shares. Under this method each policy of insurance contributes equal amounts until the policy has paid its limits or the loss is satisfied.

(b) Contribution by limits if any insurance does not permit contribution by equal shares. Under this method each insurer's share is based on the ratio of its applicable limit to the total applicable limits of all insurance policies.

5-13. Actions Against the Company

No one can sue the Company unless there has been compliance with all the terms of the policy and the amount of the obligation to pay has been finally determined either by judgment or written agreement between the Policyholder, the claimant and the Company.

Any person or organization who has secured a judgment or written agreement shall be entitled to recover under the policy in the same manner and to the same extent coverage is provided the Policyholder.

No person or organization has any right under this policy to include the Company in any legal proceeding against the Policyholder to determine the Policyholder's liability, nor can the Company be joined as a co-defendant in any such legal proceeding, nor can the rights under the policy be assigned or transferred to any other person.

5-14. Expert Witness

The Policyholder agrees to not serve as an expert witness in a claim against any policyholder of the Company without the prior written consent of the Company.

5-15. Time Limit

Any action against the Company must be commenced within two years of the date the Company notifies the Policyholder of a denial of coverage, or within two years of the date the Company fails to pay any final judgment or settlement.

5-16. Bankruptcy

Bankruptcy or insolvency of the Policyholder shall not relieve the Company of its obligations under the policy.

5-17. Terms Conformed to Statute

Any terms of the policy that conflict with the statutes applicable to risk retention groups in the State where the policy is issued are amended to conform to the statutes.

Part 6. Extended Reporting Coverage (also known as "Tail Coverage")

IMPORTANT NOTICE: If the Policy is canceled, terminated or not renewed and the Policyholder does not purchase Extended Reporting Coverage, or does not qualify for Automatic Extended Reporting Coverage (described in Part 6-2 of the Policy), there will be no coverage for claims which are first reported to the Company after the cancellation, termination or non-renewal of the policy.

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6-1. Right to Purchase Extended Reporting Coverage Endorsement

If the policy is canceled, terminated or not renewed, the Policyholder has the right, upon payment of additional premium, to purchase Extended Reporting Coverage, which extends indefinitely the period of time in which the Policyholder may report claims to the Company.

The Policyholder must exercise the right by paying the additional premium and providing written notice to the Company no later than thirty (30) days after the cancellation, termination or non-renewal date of the policy.

Extended Reporting Coverage is subject to all policy provisions, including additional benefits, exclusions, general conditions, duties, endorsements, and Limits of Liability unless other Limits of Liability are mutually agreed upon in writing.

The coverage is not effective unless the additional premium is paid and the Extended Reporting Coverage Endorsement is issued.

If the policyholder is an entity that purchases Extended Reporting Coverage Endorsement for its liability arising from acts or omissions of a departing physician and the physician at the time of a claim made against the entity does not have valid insurance in effect to cover this claim, the entity will pay the balance of the individual physician's tail premium in order to have coverage for itself for the claim.

The additional premium shall be computed in accordance with the Company's rules, rates, rating plans, and premiums applicable on the effective date of the Extended Reporting Coverage Endorsement.

6-2. Automatic Extended Reporting Coverage Endorsement

An Extended Reporting Coverage Endorsement will be provided automatically without payment of any additional premium if the policy is canceled, terminated or not renewed due to the occurrence of one of the following events:

(a) The Policyholder's total and permanent retirement from the practice of anesthesiology, regardless of age, after being continuously insured with the Company under a claims-made policy for four (4) years immediately preceding retirement; or, insured a combination of a minimum of one (1) year with the Company at mature rates and three (3) continuous years on a claims-made policy of another carrier;

(b) The Policyholder's total and permanent disability from the current practice of medicine, but only after a period of permanent and total disability of not less than six (6) months. Disability claims must be supported by a qualified medical opinion and approved by the Company; or

(c) The Policyholder's death.

IN WITNESS WHEREOF: Preferred Physicians Medical Risk Retention Group, a Mutual Insurance Company, has caused the policy to be signed by its Chief Operating Officer at Overland Park, Kansas, but the policy is not effective unless Preferred Physicians Medical Risk Retention Group, a Mutual Insurance Company, has issued a DECLARATIONS PAGE as part of the policy.

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Chief Operating Officer

Notes

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