MUTUAL INSURANCE COMPANY OF ARIZONA ®

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MEDICAL PROFESSIONAL LIABILITY REPORTING POLICY

NOTICE TO THE POLICYHOLDER

This is a non-assessable reporting form of claims-made insurance **policy**. An **insured** must make timely and proper reports of **occurrences** and **claims**, as required by this **policy**, or there will be no coverage for such **occurrences** and **claims**. The insurance is defined by the language of this **policy**. Each **insured** should read all of it. **MICA** will defend lawsuits covered under this **policy** even if the **policy limits** have been exhausted.

IMPORTANT FEATURES REGARDING REPORTING UNDER THIS POLICY

(Words appearing in bold are defined in Section XII of this **policy**.)

Reporting Triggers Coverage

To have coverage for any **occurrence** which may be covered under this **policy**, an **Insured** must properly report the **occurrence** to the **Company's** claim department. Unless an **Insured** has obtained an **extended reporting period** or has properly reported within a **grace period**, there is no coverage for any **occurrence** (nor for resulting **claims**) first reported after the end of the **policy period**. A **claim** is not necessary before an **occurrence** may be reported. If an **occurrence** is covered by the **policy** and it is properly reported, coverage for it (and resulting **claims** and lawsuits) continues forever, subject to the applicable **limit of liability**, unless an **Insured** delays in reporting a resulting lawsuit to the **Company**, or if an **Insured** fails to meet his, her, or its other obligations under the **policy**.

The **reporting date** shall be the first day the **Company** receives a report of an **occurrence** from an **Insured**. A report of an **occurrence** from a source other than an **Insured** under this **policy** does not trigger coverage. Each **occurrence** is governed by the **policy** in effect on its **reporting date**.

When to Report

Do not wait. Delay in reporting an **occurrence** or a **claim**, even when a report is made while the **policy** is still in effect, will breach the reporting requirements and thereby jeopardize coverage. If a default is entered in connection with a **claim**, or if the **Company's** or an **Insured's** defense is prejudiced due to delayed reporting, there will be no coverage.

Extended Reporting Period

An **extended reporting period** is available. See Section XIII of this **policy**.

Basic Policy Format

Coverages are stated in the Insuring Agreement. Exclusions, Definitions and Conditions appear in Sections XI, XII, and XIII. **Limits of liability** are stated in the **Declarations** or in an **endorsement** attached to this **policy** and are explained in Sections IX and X.

Policy Documents

This **policy** is the entire agreement between each **Insured** and the **Company**. The **policy** includes:

- The **Named Insured's** and each **Insured Health Care Professional's** completed applications for **MICA** insurance;
- the **Declarations**;
- the printed language of the **policy** form;
- any applicable **endorsements**, signed agreements or both, regarding this **MICA** insurance.

The **policy** cannot be changed, except by written agreement or **endorsement**.

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MEDICAL PROFESSIONAL LIABILITY REPORTING POLICY

I. INSURING AGREEMENT

In consideration of payment of the premium charged and in reliance upon the representations of all **Insureds**, the **Company** will pay on behalf of an **Insured**:

Part 1 – Liability for Diagnosis and Treatment of Patients

All **damages** resulting from **bodily injury(ies)** to a **patient** or caused by a **patient** arising out of an **occurrence** to which this **policy** applies.

Part 2 – Other Liability

(a) All **damages** resulting from **personal injury**, provided that such **personal injury** arises out of an **occurrence**.

(b) All **property damage** caused by a **patient(s)**, and arising out of an **occurrence**, provided that the property is not:

- (i) property owned by, rented to, leased by, occupied by or used by an **Insured**;
- (ii) property in the care, custody, or control of an **Insured**;
- (iii) property loaned to an **Insured**;
- (iv) premises an **Insured** sells, gives away, vacates, abandons, or alienates, if the damage to property arises out of any part of those premises.

In order to be covered under this **policy**, the **occurrence** described in Section I, Part 1 or Part 2 must have taken place on or after the **retroactive date**.

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II. PERSONS INSURED

Subject to the terms and Conditions of this **policy**, each of the following is an **Insured**:

(a) The entity or person named in Item 1 of the **Declarations** or in an **endorsement** attached to this **policy** as the **Named Insured**;

(b) Any individual named in the Schedule of Insured Health Care Professional(s) as an **Insured Health Care Professional**;

(c) Any partner, officer, director, shareholder, owner or member of a **business enterprise** named in the **Declarations** or in an **endorsement** attached to this **policy**, but only to the extent that liability arising from **professional services** furnished on behalf of such **business enterprise** is imputed by operation of law to such partner, officer, director, shareholder, owner, or member, by virtue of his or her capacity as such. Such partner, officer, director, shareholder, owner or member is not an **Insured** under this Section **II** (c) for any of such person's own acts or omissions;

(d) Any person, other than a **Health Care Professional**, employed by, volunteering for, or acting under the direction and control of, an **Insured**, but only while acting within the scope of his or her duties on behalf of the **Insured**;

(e) A trustee; assignee; or legal representative of an **Insured**, in the event of bankruptcy, incapacity, or death.

III. LOCUM TENENS FOR INSURED HEALTH CARE PROFESSIONAL(S)

This **policy** provides up to 90 days of coverage to **locum tenens Health Care Professionals**; however, no **locum tenens** who is covered by any other available insurance, an insurance or self-insurance plan, self-insured trust, fronting self-insurance plan and/or retrospective premium policy, or any similar source of payment or indemnification shall qualify for this coverage. **Locum tenens** coverage in excess of 90 days in a single **policy period** shall require payment of an additional premium. Such coverage only applies to **locum tenens** holding unrestricted licenses to practice in the **Insured's** state while working on the **Insured's** behalf. The **locum tenens** must be practicing in the same specialty for

which the **Insured** has secured coverage under this **policy**.

The **locum tenens** is covered only while acting in the course and scope of his or her employment by, or contract with, an **Insured**. The **Insured** must maintain accurate records of all **locum tenens** and the dates each **locum tenens** works in place of the **Insured**. During times the **locum tenens** is covered, coverage is excluded for **professional services** provided by that **Insured**.

The **Insured's locum tenens** and that **Insured** shall have **shared limits**. Coverage afforded under this Section does not increase the **limit of liability** stated in the **Declarations** or in an **endorsement** attached to this **policy**.

Coverage under this Section will continue for the **locum tenens' occurrences** only if they happened on or after the **retroactive date** and are properly reported in accordance with the terms and Conditions of the **Insured's MICA** coverage. The **Locum tenens** is subject to the same duties as the **Insured** in the event of an **occurrence** or **claim**.

IV. ADDITIONAL INSUREDS

An **Additional Insured's** rights under this **policy** are completely derivative and dependent upon the rights of the **Named Insured**. An **Additional Insured** will have coverage for **occurrences** that take place on or after the **Additional Insured's retroactive date** and while the **Additional Insured** is properly endorsed on this **policy**. Coverage for such **occurrences** continues so long as the **Named Insured** maintains continuous **related MICA policies** or has an applicable **extended reporting period**. If the **Named Insured's** coverage ends or has been cancelled, the **Additional Insured's** coverage will be treated in the same way as the **Named Insured's** coverage. An **Additional Insured** has no right to obtain an **extended reporting period**.

The listing of an **Additional Insured** on this **policy** does not alter the duties of an **Insured** under this **policy**, nor does it increase the **limit of liability** available under any **policy** issued by the **Company**. An **Additional Insured** must cooperate with the **Company** and with defense counsel appointed by the **Company** in the same manner as an **Insured**.

If an **Additional Insured** is a **Health Care Professional**, that **Additional Insured's** coverage is limited to **occurrences** within the course and scope of his or her duties while providing health care **professional services** for an **Insured**. If an **Additional Insured** is an entity, that **Additional Insured's** coverage is limited to liability arising from health care **professional services** furnished on behalf of that **Additional Insured** by an **Insured** or any other **Additional Insured** listed on this **policy**. All limitations and Exclusions that apply to the **Named Insured** also apply to the **Additional Insured**.

Any settlements and judgments paid as a result of an **Additional Insured's occurrences** will apply against the applicable **limit of liability** of the **Named Insured**.

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V. DEFENSE

The **Company** will defend any lawsuit against an **Insured** seeking **damages** to which this insurance applies even if the allegations of the lawsuit are groundless, false or fraudulent.

The **Company** has the right to select an **Insured's** defense counsel and has the right to control an **Insured's** defense. The **Company** may, in its discretion, retain counsel before a **claim** is made or a lawsuit is filed against an **Insured**.

The **Company** will defend covered lawsuits even after the **limit of liability** has been exhausted. The **Company** will pay all reasonable defense costs. Such costs will not be deducted from the **limit of liability**.

An **Insured** may retain his, her or its own counsel, but the **Company** has no obligation to pay attorney fees or costs of such counsel.

In cases involving reservation of rights, the **Company**-appointed defense counsel will represent an **Insured's** interests only. The **Company** may obtain separate counsel to represent its interests. An **Insured** may engage personal counsel, solely at his, her or its own expense.

VI. SETTLEMENTS

The **Company** shall not settle any **claim** under Section I, Part 1, without the **Named Insured's** written consent. Upon consent, the **Company** may negotiate and, in its sole discretion, settle the **Claim**. The **Named Insured** may revoke his, her or its consent to settle provided that such revocation is in writing. However, any settlement offer of a defined duration which was made by the **Company** while the consent was effective will remain open until the offer expires, is rejected, or is

accepted, regardless of any intervening revocation of consent.

Consent is not required and the **Company** may settle in its sole discretion (a) after a judgment, verdict or an arbitration award has been rendered against any **Insured**, **Additional Insured**, or the **Company**; (b) in the event of the **Named Insured's** bankruptcy, incompetency or death; (c) if the **Named Insured** is a **business enterprise** that has been dissolved; or (d) if, after reasonable efforts, the **Company** has been unable to make contact with the **Named Insured**.

In all circumstances, the **Company** will decide the amount of any settlement.

VII. SUPPLEMENTARY PAYMENTS

In addition to the **occurrence limit of liability** stated in the **Declarations** or in an **endorsement** attached to this **policy,** the **Company** will make supplementary payments as provided below:

(a) all expenses incurred by the **Company**;
(b) all applicable costs of the lawsuit;
(c) reasonable travel and lodging expenses incurred by an **Insured** or an **Additional Insured** at the **Company's** request in assisting the **Company** in investigating or defending any **claim** or suit, including the following amounts due to attendance at trial or arbitration:
  (i) $1,500 per day and $750 per half day to physician **Insureds** and physician **Additional Insureds**; and
  (ii) documented loss of earnings by all other **Insureds** and **Additional Insureds**, not to exceed $1,500 per day and $750 per half day.

The **Company** will also make the following supplementary payments, but only with respect to that portion of any judgment that is within the **limit of liability** and based upon an **occurrence** covered by this **policy**:

(a) prejudgment interest on the portion of a judgment that is within the **limits of liability**;
(b) post-judgment interest on the portion of a judgment that is within the **limit of liability** that accrues after entry of the judgment and before the **Company** has paid, offered to pay, or deposited in court that part of the judgment that is within the **limit of liability**; and
(c) premiums on appeal bonds and bonds necessary to release attachments. However, where the defense of a lawsuit is provided under a reservation of rights, the **Company** may, at its option, elect not to pay such bonds.

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VIII. DISCRETIONARY MEDICAL PAYMENTS

In addition to the **occurrence limit of liability** stated in the **Declarations** or in an **endorsement** attached to this **policy**, the **Company** may pay medical expenses of persons injured by an **Insured's** or **Additional Insured's treatment** covered under Section I, Part 1, if the **Named Insured** consents. The **Named Insured's** consent is not required for payment of medical expenses made under Section I, Part 2a.

Discretionary medical payments:

(a) will not exceed $10,000 per **occurrence**;
(b) may be paid regardless of fault; and
(c) do not include charges for goods or services which an **Insured** provides.

IX. LIMITS OF LIABILITY

Each Occurrence Limit

The **Company's** duty to pay on behalf of an **Insured** for any **occurrence** covered by this **policy** shall not exceed the **occurrence limit of liability** for an **Insured** stated in the **Declarations** or in an **endorsement** attached to this **policy**. This **limit** applies regardless of the number of:

(a) persons who sustain **bodily injury**, **personal injury** or **property damage**;
(b) claimants;
(c) **claims** or potential **claims**;
(d) **related MICA policies**;
(e) **Insureds** or **Additional Insureds**;
(f) participants giving rise to the **occurrence**.

Aggregate Limit

The **Company's** duty to pay on behalf of an **Insured** for all **occurrences** covered by this **policy** shall not exceed the aggregate **limit of liability** for an **Insured** stated in the **Declarations** or in an **endorsement** attached to this **policy**. This **limit** applies regardless of the number of:

(a) **occurrences**;
(b) persons who sustain **bodily injury**; **personal injury** or **property damage**;
(c) claimants;
(d) **claims** or potential **claims**;
(e) **related MICA policies**;
(f) **Insureds** or **Additional Insureds**;
(g) participants giving rise to the **occurrences**.

Application of Limits

The **Company** will not pay more than a single **limit of liability** on behalf of an **Insured** for all losses arising from any one **occurrence**. The **limits of liability** of **related MICA policies** for the same **Insured** for **claims** arising from the same **occurrence** shall not be cumulative.

An **Insured** shares the **limit** of the **Named Insured** where liability for acts or omissions of others is imputed to such **Insured** by operation of law. In that circumstance, if the **Named Insured** is an individual, either or both Exclusion (d) and Exclusion (e) may apply.

Any person who qualifies as an **Insured** pursuant to Section II (d) has **shared limits** with the **Named Insured**.

When **claims** involve more than one claimant, **Insured, Additional Insured** or **policy**, the **Company** will allocate its payment among the available **limits** in its sole discretion.

Limit for Occurrences Prior to October 1, 1980

In no case will a **limit of liability** greater than $100,000 per **occurrence** and $300,000 aggregate apply to any **occurrence(s)** that took place before October 1, 1980.

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X. INCREASES IN LIMITS OF LIABILITY

For a **limit** to be increased, the following conditions apply:

(a) A new **policy** or **endorsement** must have been issued by the **Company**, stating the new **limit** and establishing the effective date of the increase.
(b) Increased **limits** never apply to **claims** arising from **occurrences** which have been, or could have been, reported before the effective date of the increase.

XI. EXCLUSIONS

This insurance does not apply to:

(a) any **occurrence** that took place before the **retroactive date**;
(b) any **occurrence** an **Insured** has reported, or could have reported, under any other available insurance, an insurance or self-insurance plan, self-insured trust, fronting self-insurance plan and/or retrospective premium policy, or any similar source of payment or indemnification;
(c) any **occurrence** that takes place after coverage under this **policy** ends, or that is first reported to the **Company** after the cancellation date, nonrenewal date, or expiration of any **grace period** or applicable **extended reporting period**;
(d) any **claim** made by, against, or in connection with, any **business enterprise** not named in the **Declarations** or in an **endorsement** attached to this **policy**, that is directly, indirectly or beneficially owned by an **Insured** or in which an **Insured** is a trustee, partner, officer, shareholder, director, member or employee, or which is controlled, owned, operated or managed by the **Insured**;
(e) any **claim** brought against an **Insured** solely due to his or her capacity as an officer, director, partner, shareholder, member, manager, joint venturer or owner of a **business enterprise** not named in the **Declarations** or an **endorsement** attached to this **policy;**
(f) any **claim** arising out of **treatment** rendered by any **Insured** who was not authorized to provide such services due to the suspension, revocation, surrender, or restriction of, or failure to obtain, the proper professional license in the state or locality in which the **treatment** was provided;

(g) any **claim** against an **Insured** arising from conduct outside the course and scope of his or her duties as a **health care professional**;

(h) any **claim** against any person employed by, volunteering for, or acting under the direction and control of an **Insured**, where such **claim** arises out of acts or omissions outside the scope of his or her duties as such on behalf of the **Insured**;

(i) any **claim** based upon, arising out of, or in any way involving, any action or proceeding brought by or on behalf of any federal, state, or local governmental, regulatory, licensing or administrative agency, whether that action or proceeding is brought in the name of such agency, or by or on behalf of such agency in the name of any other person or entity;

(j) any **claim** arising out of an actual or alleged antitrust violation, conspiracy, fraud, unfair competition, or criminal act or omission by or on behalf of any **Insured** or any person for whose acts an **Insured** is legally responsible;

(k) any **claim** brought against an **Insured** arising from a contract or agreement, except to the extent an **Insured** would be liable in the absence of such contract or agreement. However, this Exclusion does not apply to liability the **Named Insured** or an **Insured Health Care Professional** assumes in a contract with a Health Maintenance Organization, Preferred Provider Organization, Independent Practice Association, or any other similar organization, but only as respects liability arising from the rendering of or failure to render **treatment** by an **Insured**;

(l) any **claim** arising from any employment-related action, practice, policy or omission, including, but not limited to, that of refusal to employ; hiring or firing; promotion or demotion; coercion; performance; evaluation; compensation; disciplinary action; reassignment; defamation; harassment; humiliation; discrimination; retirement; lay off; or transfer. However, this Exclusion shall not apply to **claims** arising out of **peer review misconduct**.

(m) any **claim** alleging any welcome or unwelcome conduct, physical acts, gestures, or spoken or written words of a sexual nature, including, without limitation, sexual intimacy (even if consensual); sexual molestation; sexual assault; sexual battery; sexual abuse; sexual harassment; sexual exploitation; and any sexual act; whether made under guise of **treatment** or not or in the course of **treatment** or not. However, the **Company** will defend an **Insured** in properly reported lawsuits alleging **damages** for **occurrences** taking place on or after the **retroactive date** that are otherwise subject to this exclusion. The **Company** will not settle and will not pay a judgment, verdict or an arbitration award rendered against an **Insured**. An **Insured** may settle a **claim**, at his or her own expense, after reporting the proposed settlement to the **Company**;

(n) **bodily injury** or **personal injury** to, or sickness, disease or death of any employee of an **Insured**, unless arising from the employee's **treatment** as an **Insured's patient**;

(o) any employment obligation under any workers compensation; occupational health or safety; unemployment compensation; or disability benefits law or similar law;

(p) liability of an **Insured** resulting from radioactive, toxic, explosive or other hazardous properties of nuclear materials. However, this Exclusion does not apply to liability for **bodily injury** to an **Insured's patients** arising from such **Insured's** practice of nuclear medicine. Such liability is limited to **claims** covered under Section I, Part 1 and is subject to all terms and Conditions of this **policy**;

(q) any **claim** arising from the design, manufacture or marketing of an allegedly defective or dangerous product. However, this Exclusion does not exclude **claims** arising from an **Insured's** alleged negligence in prescribing or implanting products;

(r) Any **claim** arising out of the violation of any statute, code, ordinance, rule, or regulation governing the handling, disposal, reuse, recycling, reconditioning, or reclamation of medical, infectious, or hazardous waste, materials, or equipment.

XII. DEFINITIONS

Additional Insured means each person or entity listed as an **Additional Insured** on the **Declarations** or on an **endorsement** attached to this **policy**. An **Additional Insured** is not an **Insured**, and has no rights except as stated in Section IV of this **policy**.

Bodily injury (**bodily injuries**) means physical injury, sickness, disease, or mental or emotional distress sustained by a person, or death resulting therefrom.

Business enterprise means a firm, corporation, partnership or other legal entity that wholly or partly owns, operates, manages or otherwise controls an **Insured**, either directly or indirectly, or that is wholly or partly owned, operated, managed, or otherwise controlled by an **Insured**, either directly or indirectly.

Claim means either of the following:

(a) a demand received by an **Insured** for **damages**; or

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(b) a complaint, lawsuit, demand for arbitration or other legal process claiming **damages** served on an **Insured.**

Company means Mutual Insurance Company of Arizona (**MICA**).

Current means in force or in effect at the relevant time of reporting, voting, or declaration of dividend. **Current** excludes:

(a) **policies** under suspension of coverage;
(b) expired or cancelled **policies**; and
(c) **extended reporting periods**, as described in Section XIII of this **policy**.

Damages means any monetary amount that an **Insured** is legally obligated to pay as a result of a **claim** covered by this **policy**, but does not include fines or penalties, sanctions, the return of fees or other consideration paid to an **Insured**, or the portion of any award or judgment caused by the multiplication of actual damages under federal or state law.

Declarations means the part of this **policy** entitled “Declarations Page”.

Extended reporting period means a period available by **endorsement**, only as provided in Section XIII, for reporting **claims** or **occurrences** that took place prior to the end of the **policy period**.

Endorsement means a written change of **policy** provisions.

Grace period means a thirty (30) day period, available only as provided in Section XIII, for reporting **occurrences** that took place prior to the end of the **policy period**.

Health Care Professional means a physician, acupuncturist, certified registered nurse anesthetist; chiropractor; dentist; homeopath, neonatology nurse, nurse midwife; nurse practitioner; optometrist; perfusionist; physician assistant; podiatrist; psychologist; surgical assistant; or therapist (behavioral, occupational, physical or respiratory).

Insured (Insureds) means each **business enterprise** or **Health Care Professional** listed as an **Insured** in the **Declarations** or in an **endorsement** attached to this **policy**, or any other person qualifying as an **Insured** pursuant to Section II of this **policy**. An **Additional Insured** is not an **Insured**.

Limit(s) of liability (**limit, limits**) means the dollar amount setting forth the maximum amount payable for a type of coverage. The **limit(s) of liability** is (are) stated in the **Declarations** or in an **endorsement** attached to this **policy**.

Locum tenens means a temporary substitute **Health Care Professional** who works in place of the **Named Insured** or an **Insured Health Care Professional** on a temporary basis, due to such **Insured’s** vacation, illness or other absence.

Managed care business activities means services and activities performed in the administration or management of health care plans; **Utilization Review**; advertising, marketing or selling health care plans or health care products; handling, investigating or adjusting claims for benefits or coverages under health care plans; establishing health care provider networks; or acting as a member of any committee, panel or board that provides underwriting or claims advice or recommendations.

MICA means Mutual Insurance Company of Arizona.

Named Insured means the person or entity named in Item 1 of the **Declarations** or in an **endorsement** attached to this **policy**.

Notice means information reported to another. Written **notice** requires mailing or delivering the **notice** to the person’s or entity’s last known address.

Occurrence means with respect to the furnishing of or failure to furnish **professional services**, an actual or alleged event, incident, act, omission, or accident or a series of actual or alleged events, incidents, acts, omissions, or accidents, or repeated exposures to substantially the same general conditions, resulting in **bodily injury** (as to Section I, Part 1)), **personal injury** (as to Section I, Part 2 (a)), or **property damage** (as to Section I, Part 2 (b)), neither intended nor expected from the standpoint of an **Insured**, which may give rise to a **claim**. All actual or alleged events, incidents, acts, omissions, or accidents arising in connection with a continuing course of **treatment** shall constitute a single **occurrence** regardless of the number of participants in such events, incidents, acts, omissions, accidents or course of **treatment**. All actual or alleged events, incidents, acts, omissions, or accidents in the course of obstetrical **treatment** of mother and fetus or fetuses, from conception through postpartum care, constitute a single **occurrence**. The date of the first event, incident, act, omission, or accident involved in a potential **claim** shall be the date of the **occurrence**. All injuries and/or

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damages (including **bodily injury**, **personal injury** or **property damage**) arising from a continuing course of **treatment**, a series of events, incidents, acts, omissions, or accidents, or repeated exposure to substantially the same general conditions shall be deemed to arise from a single **occurrence**.

Patient(s) means a person to whom an **Insured** provides diagnostic or **treatment** services.

Peer review means a review of professional practices that is required or authorized by applicable state law.

Peer review misconduct means an **Insured's** violation of a **Health Care Professional's** legal rights in the course of **peer review** activities.

Personal injury means injury resulting from false arrest or imprisonment; malicious prosecution; libel; slander; defamation; discrimination; invasion of privacy; or **peer review misconduct**.

Policy (policies) means a **current** insurance agreement accepted by the **Company** and the **Named Insured**.

Policy period means the period beginning with the inception date stated in the **Declarations**, at 12:01 a.m. standard time at the **Named Insured's** address stated in the **Declarations** or in an **endorsement** attached to this **policy**, and ending at 12:01 a.m. standard time on the expiration date stated in the **Declarations**, or its earlier cancellation date or non-renewal date.

Professional services means **treatment** and **peer review**.

Property Damage means physical injury to tangible property, including all resulting loss of use or, loss of use of tangible property that is not physically injured.

Related MICA policy (policies) means other **MICA** Medical Professional Liability Reporting **policies** issued to the same **Insured** providing continuous coverage.

Renew (renewal) means the issuance of a new **MICA policy** for the next consecutive **policy period**.

Reporting date means the first day the **Company** receives a report of an **occurrence** from an **Insured**.

Retroactive date is stated in the **Declarations** or in an **endorsement** attached to this **policy** and means the first date of coverage for **occurrences**.

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Shared limit(s) means that the **limit of liability** shall not be cumulative regardless of the number of **Insureds, Additional Insureds,** persons involved in the **occurrence**, claimants, persons who sustain **bodily injury**, **personal injury** or **property damage**, or **claims** or potential **claims**.

Solo corporation means a legal entity which is listed as a “solo corporation” of the **Named Insured** or of an **Insured Health Care Professional** on the **Declarations** or in an **endorsement** attached to this **policy**. A **solo corporation** shares the coverage and **limit of liability** applicable to the **Insured**.

Treatment means health care services rendered to a **patient**. These services include:

(a) medical, surgical, dental or nursing services, including the furnishing of any related:
   i. counseling and social services;
   ii. food and beverages;
   iii. medical, surgical or dental supplies, appliances or drugs; or
(b) performing postmortem examinations on human bodies.

However, **treatment** does not include **managed care business activities**.

Utilization review means the process of evaluating the appropriateness, necessity, or cost of **treatment** for purposes of determining whether such **treatment** or costs will be authorized or paid for under any health care plan. **Utilization review** shall include prospective review of proposed **treatment** or costs, concurrent review or ongoing **treatment** or costs, and retrospective review of already rendered **treatment** or already incurred costs.

XIII. CONDITIONS

Consideration; Declarations; Applications

This **policy** is issued in exchange for and is conditioned upon:

(a) payment of the premium and all other charges; and
(b) the completeness and honesty of each **Insured's** statement in applications for this **policy** and any **related MICA policies**. All statements and descriptions in any application for this **policy** or in negotiations therefor, by or on behalf of each **Insured** shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and/or incorrect statements shall not prevent a recovery under the **policy** unless they are fraudulent, material either to the acceptance of risk, or the hazard assumed by the **Company**, or the **Company** in good faith would either not have issued the **policy**, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the **Company** as required by the application for the **policy** or otherwise. The **Insured** agrees that this **policy**, including the Application, **Declarations**, and any **endorsements**, constitutes the entire agreement between him, her, or it and the **Company** or any of the **Company's** agents relating to this insurance.

The **Named Insured** shall make available to the **Company**, upon request, copies of records designated by the **Company** for its use in computing premiums. All charges for this **policy** shall be computed under the **Company's** rules, rates, rating plans and premium schedules.

Policy Territory

This **policy** applies to **occurrences** taking place in the United States of America, its territories or possessions, Puerto Rico or Canada. Likewise, this **policy** applies only to lawsuits asserted against an **Insured** in the United States of America, including its territories or possessions, Puerto Rico or Canada.

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Inspection and Audit

The **Company** may inspect an **Insured's** property and operations at any time. The **Company** never warrants safety of property or operations. The **Company** may examine or audit an **Insured's** books and records, including **patient** care records, related to this **policy**.

Rights and Duties as the Named Insured

The **Named Insured** stated in Item 1 of the **Declarations** or in an **endorsement** attached to this **policy** shall be:

(a) authorized to make changes in the terms of this **policy** with the consent of the **Company**;
(b) the payee of any premiums refunded by the **Company**;
(c) responsible for the payment of all premiums due, keeping records of the information needed by the **Company** for premium computation, providing copies to the **Company** upon request, and notifying the **Company** should cancellation be desired.

For the purposes connected with giving and receiving **notice** under this **policy**, the **Named Insured** may act on behalf of any other **Insured**.

Insured's Duties in Event of Occurrence or Claim; Reporting an Occurrence or Claim

This **policy** is a reporting **policy**. Subject to its terms and Conditions, it applies only to covered **occurrences** and **claims** which an **Insured** properly reports to the **Company's** claim department before the end of the **policy period,** or during the **grace period** or any applicable **extended reporting period**. **Occurrences** or **claims** are not covered if they were reported, or could have been reported, under other **policies** or on the application for this **policy**, or if an **Insured's** first report of an **occurrence** is made after the end of the **policy period** or after the end of any **grace period** or **extended reporting period**. Each **occurrence** is governed by the **policy** in effect on its **reporting date**.

An **Insured** must report all **occurrences** and **claims** to the **Company** as soon as an **Insured** becomes aware of them. An **Insured** should not wait for a **claim** to be asserted before reporting an **occurrence**. Failure of an **Insured** to report any **occurrence** or **claim,** or to forward lawsuit papers, as required by this **policy** may jeopardize coverage provided by this **policy** for such **occurrence.** An **Insured** should not delay reporting a lawsuit or forwarding lawsuit papers to the **Company**.

Even if an **Insured** reports an **occurrence** or **claim** before the end of the **policy period**, **grace period** or **extended reporting period**, there will be no coverage if delay in reporting results in prejudice to the **Company** or to an **Insured's**

defense.

A report of an **occurrence** from a source other than an **Insured** under this **Policy** does not trigger coverage.

To report an **occurrence** or **claim** an **Insured** must:

(a) telephone the **Company's** claim department. The **Company** will confirm the report in writing; and
(b) provide all requested information to the **Company**, including, without limitation, the **patient's** name, dates of **treatment**, **treatment** rendered and results. Additionally, in reporting an **occurrence,** an **Insured** must identify the manner in which the **Insured** first became aware of the **occurrence** and the reasons the **Insured** believes the **occurrence** may give rise to a **claim**.

An **Insured** must cooperate with the **Company** and defense counsel appointed by the **Company**. This cooperation includes, but is not limited to, investigating, responding to and defending **claims** brought under this **policy**.

At the **Company's** request, an **Insured** is required, without limitation, to:

(a) attend hearings, testify and assist in settlements;
(b) assist in securing evidence;
(c) assist in obtaining the attendance of witnesses.

In connection with **occurrences** covered under this **policy**, an **Insured** shall not:

(a) voluntarily make any payment;
(b) assume any obligation;
(c) incur any expense, except to obtain first aid for others.

Failure to cooperate with the **Company** or defense counsel may jeopardize coverage under the **policy**.

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Other Sources of Indemnification

This insurance shall not apply unless and until the **limits** of all other sources of indemnification available to an **Insured** have been used up. Such sources shall include:

(a) other insurance;
(b) an insurance or self-insurance plan, self-insured trust, fronting self-insurance plan and/or retrospective premium policy;
(c) any similar source of payment or indemnification.

Cancellation

Either the **Company** or the **Named Insured** can cancel this **policy.**

The **Named Insured** can cancel this **policy** at any time by:

(a) returning the **policy** to the **Company** or its authorized representative; or
(b) mailing a written **notice** to the **Company**, stating when the cancellation is to be effective.

The **Company** must receive the **policy** or written **notice** before the cancellation date.

The **Company** can cancel this **policy** by giving written **notice** of cancellation to the **Named Insured**, at the **Named Insured's** last known address, at least:

(a) ten (10) days, if cancelling for nonpayment of premium; or
(b) thirty (30) days, if cancelling for any other reason, including without limitation any billed and past due deductible;

before the effective date of cancellation. **Notice** of cancellation will state the effective date of cancellation. If **notice** is mailed, proof of mailing will be sufficient proof of notice.

If this **policy** is cancelled, the refund, if any, will be prorated. The cancellation will be effective even if the **Company** has not made or offered a refund.

Nonrenewal

The **Company** will **renew** this **policy** unless written **notice** of the **Company's** intent not to **renew** is mailed to the **Named Insured** not less than thirty (30) days before the **policy** expires.

Neither an **Insured** nor the **Company** is required to **renew**. However, if a **renewal policy** is granted to an **Insured**, as long as there is no gap in the **Insured's MICA** coverage, the **Insured's retroactive date** will remain the same. The terms and Conditions of each new **policy** govern **occurrences** which an **Insured** first reports to the **Compan**y during each new **policy period**. The terms and Conditions of the new **policy** may be different from this **policy**.

Grace Period

If this **policy** is cancelled or nonrenewed, a **grace period** will be provided by the **Company** at no additional cost. This **grace period** expires at 12:01 a.m. standard time at the **Named Insured's** address stated in the **Declarations** or in an **endorsement** attached to this **policy** on the 31st day after the end of the **policy period** and is available only if:

(a) an **Insured** has not obtained, and will not obtain, an **extended reporting period**. If an **Insured** obtains an **extended reporting period**, all reports after the end of the **policy period** will be governed by the **extended reporting period endorsement**; and
(b) the **occurrence** is not covered by any other insurance or source of indemnification; and,
(c) an **Insured** has not obtained and will not obtain a **renewal policy** with the **Company** for the next year.

The **limits** available during this **grace period** are part of, and not in addition to, the **limits** available under the expiring **policy period**. This **grace period** shall not be available if the **policy** is cancelled retroactive to inception for nonpayment of premium.

Extended Reporting Period

If this **policy** is cancelled or nonrenewed (other than cancellation by the **Company** retroactive to inception for nonpayment of premium), the **Named Insured** and each **Insured Health Care Professional** shall have the right to extend the time for reporting **claims** or **occurrences** that took place prior to the end of the **policy period**. This extension will be available only if an **Insured** (or his or her legal representative in the case of bankruptcy, incompetency or death):

(a) within sixty (60) days after the end of the **policy period**, delivers to the **Company** written notice of election to purchase an **extended reporting period** and pay all amounts due to the **Company**. **MICA**, in its sole discretion, will determine whether it will accept late elections; and
(b) within ninety (90) days after the end of the **policy period**, pay an additional premium for the **extended reporting period** in accordance with the rates in effect on the effective date of the **extended reporting period**.

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If coverage for an **Insured Health Care Professional** ends during the **policy period**, such **Insured** shall have the right to purchase an **extended reporting period**.

The **extended reporting period**, if obtained, shall be granted by an **extended reporting period endorsement** issued by the **Company**. The **extended reporting period endorsement** will extend the period for reporting **occurrences** that took place on or after an **Insured's retroactive date** and before the end of the **policy period**. The length of the **extended reporting period** will be stated in the **endorsement**. If the full **extended reporting period** premium is paid, the **extended reporting period** shall last forever. Both the **Company's** and an **Insured's** duties under the **extended reporting period** are the same as set forth in the terms and Conditions of this **policy**.

The **extended reporting period endorsement** will provide one new set of **limits of liability** for all covered **occurrences** (and resulting **claims**) first reported during the **extended reporting period**. Unless otherwise specified on the **extended reporting period endorsement**, such **limits** will be in the same amounts as those applicable to this **policy** on the last day of the **policy period**.

Under the circumstances stated below, an **Insured** or his or her legal representative may obtain an **extended reporting period** without additional premium. A written application for an **extended reporting period** must be delivered to the **Company** within sixty (60) days after the end of an **Insured's policy period**. Such application will be granted only if the **Named Insured** has paid all amounts due to the **Company** and if an **Insured** qualifies under one of the following:

(a) an **Insured's** death;
(b) an **Insured's** permanent total physical or mental disability which causes permanent total retirement from the practice of medicine; or
(c) an **Insured's** permanent retirement from the practice of medicine but only if:

i. an **Insured's** retirement was after his or her 55th birthday;
ii. an **Insured** has purchased a **policy** with the **Company** providing continuous coverage for at least one full year (12 months) ending on the date of an **Insured's** retirement (and beginning no earlier than the inception date of the first **related MICA policy**); and
iii. during an **Insured's** retirement, he or she will not provide **professional services** for which he or she will be paid, directly or indirectly.

Coverage periods subject to suspension of coverage **endorsements** will not be included in determining years of full coverage. The **Company** may, in its sole discretion, determine whether an **Insured's** work after retirement, if any, involves **professional services** which disqualify him or her under this section. The **Company** also has the right to verify any claim of retirement or disability by examining an **Insured** and his or her records.

Action Against The Company

No action may be brought against the **Company** unless:

(a) the **Insured** has fully complied with all terms of this **policy**; and
(b) the amount of an **Insured's** obligation to pay has been fully determined either:
  i. by final judgment against an **Insured** after trial and appeal rights have expired or been exhausted; or
  ii. by written agreement among an **Insured**, the claimant and the **Company**.

A holder of such judgment or agreement may thereafter recover under the terms of this **policy**. No one shall have any right to join the **Company** as a party to any action against an **Insured**. An **Insured** may not sue the **Company** in an action involving other parties.

The **Company** will not pay an **Insured's** legal expenses incurred in any declaratory judgment action involving the **Company**.

Subrogation

The **Company** shall be subrogated to the rights of an **Insured**. An **Insured** shall do nothing to prejudice those rights. At the **Company's** request, an **Insured** shall bring lawsuit or transfer those rights to the **Company**. The **Insured** shall also assist the **Company** in enforcing its rights.

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Assignment; Termination on Death or Incompetence

An **Insured's** interest under this **policy** may not be assigned to another party. If an **Insured** dies or is declared mentally incompetent by a court, an **Insured's policy period** and any coverage under this **policy** automatically ends. An **extended reporting period** may be available, in accordance with Section XIII of this **policy**. Reports may be made on an **Insured's** behalf, during a declared period of mental incompetence and for thirty (30) days afterwards, for unreported **occurrences** that happened before the end of an **Insured's policy period**.

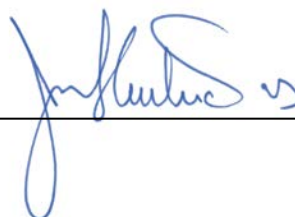
Changes

Terms of this **policy** cannot be changed or waived except by written **endorsement** issued by the **Company** or by written agreement signed by the **Company** and the **Named Insured**. The **Company** shall not be bound by any agreement concerning the handling of **claims** unless it has agreed in writing.

Membership

The **Named Insured** is a member of **MICA** with all rights and obligations of such membership, including, without limitation, the rights to attend membership meetings and vote.

Attest Mutual Insurance Company of Arizona



President