

MISSOURI PROFESSIONALS MUTUAL

MEDICAL PROFESSIONAL LIABILITY POLICY

NOTICE: THE COVERAGE PROVIDED IN THIS POLICY IS GENERALLY LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE COMPANY DURING THE POLICY PERIOD AND PURSUANT TO THE TERMS CONTAINED HEREIN. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE PROVIDED BY IT WITH YOUR INSURANCE AGENT OR BROKER.

I. INSURANCE COVERAGE AGREEMENT

In consideration of the payment of the assessments stated on the **Policy Declaration** and any other assessments provided for in the Articles of Association of the **Company** and the Bylaws of the **Company**, and in reliance upon the statements and representations in the applications for insurance, and, subject to the applicable limit of liability, the exclusions, and all other terms as set forth in this **Policy**, the **Company** agrees to provide the coverages specified below:

(a) COVERAGE A – INSURED INDIVIDUAL

To pay on behalf of each **Insured Individual** all **Loss** which such **Insured Individual** becomes legally obligated to pay on account of any **Claim** first made against the **Insured Individual** and first **Reported** to the **Company** during the **Policy Period**, provided that the **Medical Incident** (i) arose out of an act or omission by an **Insured Individual** or by any person for whose acts or omissions the **Insured Individual** is legally responsible; (ii) occurred while providing, or legally obligated to provide, **Professional Services** for which such persons hold the required licenses; (iii) occurred after the **Retroactive Date** applicable to such **Insured Individual**; and (iv) occurred while such **Insured Individual** was acting as sole proprietor or was acting on behalf of or employed by an **Insured Organization** and acting within the scope of such employment.

(b) COVERAGE B – INSURED ORGANIZATION

To pay on behalf of each **Insured Organization** all **Loss** which such **Insured Organization** becomes legally obligated to pay on account of any **Claim** first made against the **Insured Organization** and first **Reported** to the **Company** during the **Policy Period**, provided that the **Medical Incident** (i) arose out of an act or omission by an **Insured Individual** or by any person for whose acts or omissions the **Insured Individual** is legally responsible and which is covered by the **Policy**; (ii) occurred after the later of the **Retroactive Date** applicable to such **Insured Individual** or the **Retroactive Date** applicable to such **Insured Organization**; and (iii) occurred while such **Insured Individual** was acting on behalf of or was employed by that **Insured Organization** and acting within the course and scope of such employment.

All terms and conditions for coverage under this **Policy** with respect to the **Insured Individual** shall apply in each instance to the **Insured Organization**.

(c) Timely **Reporting** to the **Company** during the **Policy Period** of any **Claim**, or any **Medical Incident**, is a condition precedent to coverage under this **Policy**. There will be no coverage under this **Policy** for any **Claim** not first made against an **Insured** and first **Reported** to the **Company** during the **Policy Period**, except where, during the **Policy Period**, an **Insured Reports a Medical Incident**, and a **Claim** arising out of that **Medical Incident** is first made against that **Insured** after the **Policy Period** is ended and while the **Insured** is not insured by the **Company**, then the **Claim** shall be considered as first made and reported during this **Policy Period**, and coverage shall be afforded pursuant to the **Policy** terms.

(d) Subject to the **Policy** terms, to provide a defense to a covered **Claim** at the **Company's** expense by counsel of **Company's** choice.

This insurance applies only to **Medical Incidents** that occur in the State of Missouri, United States of America, and **Medical Incidents** that occur elsewhere that arise out of spontaneous dire medical emergencies posing substantial, immediate and dire threats to life or limb of the person requiring emergent medical care. Except for such **Medical Incidents** arising from such spontaneous dire medical emergencies, the coverage provided under the **Policy** does not apply to any legal proceeding in any court located outside the State of Missouri.

Note: No coverage is afforded under this **Policy** for any **Claim** arising from any **Medical Incident** arising out of **Professional Services** other than those described in the application for this **Policy**, or in an endorsement to this **Policy**. It is a condition precedent to coverage under this **Policy** that any change in the practice of an **Insured** must be approved by the **Company** and an endorsement issued, and that there be complete compliance with all terms of Section VII. DUTIES OF INSURED.

II. DEFINITIONS

As used in the **Policy**, the following terms, when written in **bold face print** with the first letter of each word in the term capitalized as shown below, shall be defined as set forth below, and these definitions apply to the singular, plural, or possessive forms of these words, a different verb tense, the masculine, feminine or neuter gender, if used herein:

Claim means the receipt by any **Insured** of a demand or demands (including but not limited to, the commencement of a lawsuit or request for binding arbitration or mediation, against any **Insured** or receipt of an attorney lien letter) for money or services arising from an alleged **Medical Incident**.

Company means Missouri Professionals Mutual.

Defense Expenses means all costs and expenses incurred by the **Company** in defense of the **Claim**, including but not limited to attorneys' and experts' fees; reasonable expenses any **Insured** incurs at the **Company's** request; costs taxed against the **Insured** in a suit the **Company** defends; prejudgment interest, when owed by law, on that part of the judgment covered by this **Policy**; and interest on that amount of the judgment covered by this **Policy** which accrues after entry of the judgment but only until the **Company** tenders, deposits in court, or pays the amount due under the **Policy**. **Defense Expenses** do not include, and this **Policy** will not pay, any expenses or fees incurred by any attorney not hired by the **Company**.

Insured Organization means any partnership, professional corporation, professional association, limited liability company or other entity designated as an **Insured Organization** on the **Policy Declaration** of this **Policy**.

Insured means any **Insured Individual** and/or **Insured Organization**.

Insured Individual means:

1. A healthcare provider duly licensed and in good standing in Missouri and designated as an **Insured Individual** on the **Policy Declaration**.
2. A healthcare provider licensed in Missouri who, during the **Policy Period**, first becomes associated with the **Insured** either as a partner, member, officer, director, stockholder, associate, or employee, but only for a period of not longer than 60 days from the date the association begins and solely for acts or omissions while providing **Professional Services** on behalf of or in association with the **Insured**, all on the condition that the **Insured** notify the **Company** and submit a complete application to the **Company** for such medical service provider within 30 days of the date of association.
3. The heirs, executors, administrators, beneficiaries, assigns, appointed legal representatives, guardians and conservators of an **Insured** who would otherwise qualify under 1 through 2 above, but who is deceased, disabled or incapacitated, and the trustee or estate of said **Insured** in bankruptcy, but solely with respect to such liability of the **Insured** as is otherwise covered by this **Policy**.

Loss means a monetary judgment, arbitration award, or settlement and **Defense Expenses**. **Loss** does not include: sanctions, fines, punitive or exemplary damages, costs or fees imposed by state or federal law, double or treble damages, fees for the **Insured's** own services or fees incurred by the **Insured** in collecting fees for the **Insured's** own services or the **Insured's** own legal counsel, restitution or relief not permitted under the laws of the State of Missouri.

Medical Incident means a single act or omission or a series of related acts or omissions arising out of the rendering of, or the failure to render, **Professional Services** to any one person, which result(s) in, or is likely to result in, damages. In determining the Limit of Liability in Section V. LIMIT OF LIABILITY AND DEDUCTIBLES of this **Policy**, a series of acts or omissions by an **Insured**, which result in damages, will be considered collectively to be a single **Medical Incident**. The furnishing of obstetrical treatment to a mother and fetus or fetuses from conception through postpartum care shall be considered to be a single **Medical Incident**. The furnishing of **Professional Services** that results in injury to a patient even though the furnishing of such services (i) begins in one policy period and extends into another policy period or policy periods, or (ii) results in multiple injuries to the patient, or (iii) involves multiple acts of negligence shall be considered a single **Medical Incident**.

Policy means this policy, the **Policy Declaration**, the forms and endorsements listed thereon, the **Policy** Application(s), the Articles of Association of the **Company**, the Bylaws of the **Company**, and any endorsements issued by the **Company** from time to time, all of which are hereby incorporated into this **Policy**.

Policy Declaration means the Medical Professional Liability Claims Made Coverage Policy Declaration, or any renewal or modification thereof.

Policy Period means the policy period described on the **Policy Declaration**.

Professional Services means the provision of medical services in the **Insured's** area of specialty, including medical treatment, making medical diagnoses, and rendering medical opinions or medical advice, but does not include any medical services, medical diagnosis or medical opinions rendered as a consultant or expert witness regarding litigation or any planned litigation.

Reports, Reported, and Reporting mean the **Insured** providing written notice of a **Claim** or **Medical Incident** to the **Company** as soon as practicable, but in no event more than 10 days after the date of the **Claim** or of the **Insured** becoming aware of facts that could reasonably be expected to give rise to a **Claim**, and in compliance with Section VII. DUTIES OF INSURED (a).

Retroactive Date means the Retroactive Date for each **Insured** as specified in the **Policy Declaration**.

Retroactive Period means the period beginning on the **Retroactive Date** and ending at 12:01 a.m. CST the first day of the **Policy Period**.

Termination Date means (i) when used with respect to an **Insured Individual**, the date on which the **Insured Individual's** employment relationship with any **Insured Organization** shall have ended for any reason; (ii) when used with respect to the **Policy**, the date stated on the **Policy Declaration** as the last date of the **Policy Period**, or the date of cancellation as provided in Section XIII. CANCELLATION.

III. INVESTIGATION, DEFENSE AND SETTLEMENT

(a) The **Company** has the right to investigate any **Medical Incident**. Subject to the provisions of Section V. LIMIT OF LIABILITY AND DEDUCTIBLES and this paragraph (a), the **Company** has the right and duty to defend any **Claim** that, if awarded, would be covered by the **Policy**. The **Company** has the right to select defense counsel in any such **Claim** defended by the **Company**, regardless of whether or not the **Insured** is liable under this **Policy** for the cost of such defense counsel as a result of any deductible or otherwise. The **Company**, in its discretion, may elect to have all individuals and entities to which the **Company** provides insurance under this **Policy** or any other policy of insurance of the **Company** represented by the same counsel. The **Company** shall have no obligation to pay **Loss**, or to defend or continue to defend any **Claim**, with respect to a **Medical Incident** after the **Company** tenders, deposits in court, or pays the amount due under this **Policy**. The **Insured** shall have the right to separate counsel at its own cost and expense, and the **Insured** is encouraged to retain such separate counsel to represent the **Insured** with respect to any amounts which are in excess of the limit of liability afforded by this **Policy** or for **Claims** which are not covered under the **Policy**.

(b) The **Company** may not settle any covered **Claim** without the **Insured's** consent, so long as such consent is not "unreasonably withheld," as defined herein. Such consent shall conclusively be deemed to be "unreasonably withheld" if the **Company**, at any time after receipt by the **Company** of a **Claim**, obtains the opinion of at least two physicians (who may or may not be members of the **Company**), who are selected by the **Company** at its sole discretion (the "**Claim Panel**"), that settlement of such **Claim** is reasonable. The **Insured** may, at any time after receipt of the **Claim** by the **Company**, provide such **Insured's** written or verbal consent to settle any such **Claim**, such consent, once given, cannot be revoked. If the **Insured** provides such consent to settle to the **Company**, then the **Company** may settle such **Claim** and the **Insured** agrees to fully cooperate with the **Company** in order to settle or resolve the **Claim**. Such cooperation shall include, but is not limited to, the signing, at the **Company's** request, of any and all settlement agreements with the claimants. If the **Insured's** consent has been determined by the **Claim Panel** to be "unreasonably withheld," then the **Company** may settle such **Claim** on the terms and conditions provided by the **Claim Panel**, and the **Insured** agrees to fully cooperate with the **Company** to settle or resolve such **Claim**, including the signing, at the **Company's** request, of any and all settlement agreements with the claimants. The **Company** shall have no obligation to disclose the identities of the physicians on the **Claim Panel** or any written documentation of the **Claim Panel**. The determination of the **Claim Panel** shall be binding and conclusive on the **Insured**.

(c) The **Company** shall have no obligation to take an appeal from any judgment or arbitration award against an **Insured** but may do so if the **Company** so decides in its sole discretion.

IV. EXCLUSIONS

Unless specifically provided by endorsement to this **Policy**, the insurance afforded under this **Policy** shall not apply to any of the following, and the **Company** shall not be liable for any **Loss** nor obligated to provide a defense to any **Claim** alleging or arising out of any of the following:

(a) Liability of any **Insured** as a proprietor, director, medical director, hospital administrator, officer, stockholder, equity owner, or member of the Board of Directors, trustees, or governors of any hospital, long term care facility, dialysis center, outpatient care center, sanitarium, clinic with bed and board facilities, nursing home, laboratory or other business enterprise;

(b) Liability of an **Insured Individual** as a member, partner, officer, director, agent or shareholder of any partnership, professional corporation, professional association, limited liability company or other legal entity (other than the **Insured Organization**);

(c) In the case of an **Insured Organization**, to any vicarious liability of the **Insured Organization** arising out of the rendering, or failure to render **Professional Services** by any individual who is not an **Insured Individual**, unless (i) that individual is not a medical doctor, doctor of osteopathy, physician, surgeon, physician's assistant, nurse practitioner, advanced practice nurse, certified registered nurse anesthetist, certified nurse midwife, or midwife; (ii) the individual was, at the time of the **Medical Incident** giving rise to the **Claim**, an employee of the **Insured Organization** and acting within the course and scope of such employment; and (iii) the **Medical Incident** occurred after the **Retroactive Date** applicable to the **Insured Organization**;

(d) To any obligation for which the **Insured** or **Insured Organization** or any carrier acting as insurer for either may be held liable under any workers' compensation, employment practices, unemployment compensation or disability benefits or any similar law;

(e) Liability arising out of any contract or agreement whether oral, written or implied, between any **Insured** and any third party, other than a patient to whom the **Insured** has agreed to render professional services;

(f) Liability arising out of any willful, wanton, fraudulent, criminal, unlawful, or intentionally wrongful activity of any **Insured**, including but not limited to participation by any **Insured** in any conspiracy;

(g) Liability arising out of conduct of a sexual nature between any person and any **Insured**, with or without the consent of any such person, whether under the guise of treatment or not. This exclusion applies to **Loss** but does not affect our duty to defend an **Insured** or pay **Defense Expenses** against allegations of such conduct. Our duty to defend ends, however, when any **Insured** admits attempted or actual conduct of a sexual nature, has his or her license suspended or revoked, is found guilty in a criminal proceeding, or is found liable in a civil proceeding for such attempted or actual conduct of a sexual nature, whichever occurs first. This exclusion shall apply, regardless of the legal theory on which such **Claim** is brought, to any **Claim** alleging that the **Insured** is liable, in whole or in part, for **Loss** caused by conduct of a sexual nature;

(h) Liability arising out of any act or omission of an **Insured** (i) for which such **Insured** does not hold any required license to perform; (ii) which occurs during any time such **Insured's** license to practice the **Insured's** profession has been suspended, revoked, or voluntarily surrendered; (iii) which results in the suspension, revocation, or voluntary surrender of such **Insured's** license to practice the **Insured's** profession; or (iv) which constitutes a violation of any restriction imposed upon such license;

(i) Liability arising out of any antitrust violation, unfair competition, unfair trade or business practice, misappropriation of trade secrets, interference with advantageous relationships, or discrimination;

(j) Liability arising out of any act or omission which violates any statute, ordinance or regulation imposing any fine, penalty, or other sanction including, but not limited to attorneys' fees;

(k) Liability arising out of any billing statements for **Professional Services** rendered to a patient of any **Insured**;

(l) Liability arising out of (i) any **Medical Incident** which has been reported, or should have been reported, to another insurance carrier prior to the first date of the **Policy Period** shown on the **Policy Declaration** of this **Policy** or any **Medical Incident** which occurred prior to the first date of the **Policy Period** shown on the **Policy Declaration** of this **Policy**, if on such date, the **Insured** knew or believed, or had reason to know or believe, that such **Medical Incident** had occurred; or (ii) any **Medical Incident** that occurred during a period in which the **Insured** was not covered under a policy of professional liability insurance;

(m) Liability arising out of any of the following: (i) administering general anesthesia; (ii) administering or injecting silicone fluid; (iii) use of chelation therapy; (iv) use of laetrile therapy; (v) any surgical procedure which will affect, or which is intended to affect, obesity or weight control; (vi) any use or administration of Human Chorionic Gonadotropin (HCG) in the treatment of obesity or weight control; (vii) use of any blood or blood by-product that has not been tested for HIV; (viii) any sex change operation; or (ix) performance or practice of obstetrics;

(n) Liability for any matter which arises from any **Insured's** guarantee or warranty of the results of **Professional Services** or products;

(o) Liability for any matters arising out of or relating to libel, slander, defamation, malicious prosecution, false arrest, improper detention, improper imprisonment, assault, battery, or abuse of process;

(p) Liability for any matters arising out of or related to wrongful discharge, discrimination, and/or for any claims arising out of the employer/employee relationship;

(q) Liability for any **Claim** resulting from the rendering or failure to render **Professional Services** while any **Insured** is legally intoxicated or under the influence of alcohol, drugs, or intoxicants of any nature, or is mentally impaired;

(r) Liability for any **Claim** arising from a **Medical Incident** regarding which the **Insured** has failed to create or maintain medical records in original condition, or has improperly created, added to, altered, modified or disposed of any medical, hospital or other records.

(s) Liability related to: (i) defamatory or disparaging material; (ii) publication or utterance in violation of an individual's right to privacy; and/or (iii) any utterance, materials or matters released in the course of or related to advertising, broadcasting, publishing, or telecasting;

(t) Liability related to any service on peer review committees of hospitals or other committees associated with a health maintenance organization or similar medical care groups, health cost insurers, or government agencies providing health cost benefits;

(u) Liability for any acts, conduct or omission arising out of or relating to providing **Professional Services** (i) on behalf of the United States Government or any military service of the United States Government, except Medicare or Medicaid; (ii) under any contract with the State of Missouri or other State, except those relating to Medicare, Medicaid, or other state equivalent; and/or (iii) for any governmental agency which is providing coverage through the State Legal Expense Fund;

(v) To liability that relates to any **Professional Services** performed by an **Insured** which are outside the specialty or sub-specialty appearing on such **Insured's** application for insurance;

(w) Liability related to the prescription of or use of any drug or device not yet approved by the FDA for treatment on human beings;

(x) Liability for any **Claim** arising out of allegations of transmission or failure to utilize proper precautions to prevent the transmission of fatally contagious diseases, where the **Insured** knew or had reason to know of infection and failed to notify the **Company** and the patient in advance of rendering treatment;

(y) Liability to any employee or family member of any **Insured**, except when such employee is a patient, and then only in that capacity, and only for a **Medical Incident**;

(z) Liability arising out of the rendering, or failure to render, any services by any medical doctor, doctor of osteopathy, physician, surgeon, physician's assistant, nurse practitioner, advanced practice nurse, certified registered nurse anesthetist, certified nurse midwife, or midwife unless such individual is named on the **Policy Declaration** as an **Insured Individual**;

(aa) Liability arising out of or relating to any **Insured's** participation in any collaborative practice arrangement, regardless of whether the **Insured** would have any liability in the absence of his or her participation in such arrangement;

(bb) Liability arising out of or relating to any breach or violation of any patient privacy rights, including, but not limited to, those provided by the Health Insurance Portability and Accountability Act (HIPAA), the Gramm-Leach-Bliley Act of 1999, and at common law;

(cc) Liability arising from or relating to any **Insured Individual's** participation in any clinical studies and/or clinical trials.

V. LIMIT OF LIABILITY AND DEDUCTIBLES

(a) Subject to paragraphs (b), (d) and (f) of this Section V, the Limit of Liability specified in the **Policy Declaration** as applicable to each **Insured Organization** shall apply to all **Claims** made or brought against (i) all **Insured Organizations** and (ii) any **Insured Individual**, provided that such **Claim** or suit arises out of the rendering of, or failure to render, **Professional Services** by any person other than an **Insured Individual** for whose acts or omissions such **Insured Individual** is liable solely by reason of his status as a member, partner, officer, director or shareholder of an **Insured Organization**. Subject to paragraphs (b), (d) and (f) of this Section V, in the event there shall be more than one **Insured Organization** specified on the **Policy Declaration**, all such **Insured Organizations** shall share any remaining limit of liability, provided on the **Policy Declaration** for any such **Insured Organization** so that all **Claims** against any **Insured Organization** will apply against the Limit of Liability, if any, of all of the **Insured Organizations** so that there is only one limit.

(b) In the event that (i) the word "Shared", "***", or a similar word or phrase appears in the Schedule of Insureds on the **Policy Declaration** with respect to **Insured Organization(s)** and (ii) the **Claim** arose out of an act or omission by an **Insured Individual**, the Limit of Liability provided on the **Policy Declaration** for such **Insured Individual** and the **Insured Organization(s)** is shared and only the **Insured Individual's** Limit of Liability is applicable to **Claims** against an **Insured Individual** and/or

Insured Organization(s) so that there is only one limit for the **Insured Individual** and the **Insured Organization(s)**. In the event of such shared limit, all **Claims** against either the **Insured Individual** and/or the **Insured Organization(s)** will apply against the Limit of Liability of the **Insured Individual**.

In the event that (i) the word "Shared", "***", or a similar word or phrase appears in the Schedule of Insureds on the **Policy Declaration** with respect to **Insured Organization(s)**; (ii) the **Claim** is covered under the terms of this **Policy**; (iii) the **Claim** arose out of an act or omission by an individual (other than an **Insured Individual**); and (iii) did not arise in any way out of an act or omission of an **Insured Individual**, then the Company shall have discretion to apply any Limit of Liability specified on the **Policy Declaration**, including the lowest Limit of Liability specified on the **Policy Declaration**.

(c) Subject to paragraph (b) of this Section V, and regardless of the number of **Claims**, the Limit of Liability specified in the **Policy Declaration** as the "Primary Limit of Liability" "Each Medical Incident" for each **Insured** is the total of the **Company's** liability to such **Insured** resulting from any **Medical Incident** occurring after the **Retroactive Date** specified on the **Policy Declaration** and before the end of the **Policy Period** which results in **Claims** first made against the **Insured** and first **Reported** to the **Company** during the **Policy Period**, unless Retroactive Limits of Liability are specified on the **Policy Declaration**, in which case, the Limit of Liability specified in the **Policy Declaration** as the "Retroactive Limit of Liability" "Each Medical Incident" for each **Insured** is the total of the **Company's** liability to such **Insured** resulting from any **Medical Incident** occurring at any time during the **Retroactive Period** which results in **Claims** first made against the **Insured** and first **Reported** during the **Policy Period**.

(d) Subject to paragraph (b) of this Section V, the Limit of Liability specified in the **Policy Declaration** as the "Primary Limit of Liability" "Annual Aggregate" for each **Insured** is the total of the **Company's** liability to such **Insured** resulting from any and all **Medical Incidents** occurring at any time on or after the **Retroactive Date** which result in **Claims** first made against the **Insured** and first **Reported** to the **Company** during the **Policy Period**, provided however, that with respect to **Medical Incidents** occurring at any time during the **Retroactive Period**, the **Company's** liability to such **Insured** resulting from any and all **Medical Incidents** occurring at any time during the **Retroactive Period** which result in **Claims** first made against the **Insured** and first **Reported** to the **Company** during the **Policy Period** shall be further limited to the "Retroactive Limit of Liability" "Annual Aggregate" for such **Insured**.

(e) With respect to **Claims** covered under paragraph (c) of Section I. INSURANCE COVERAGE AGREEMENT, the following shall apply: (i) in the event Retroactive Limits of Liability are specified on the **Policy Declaration**, the remainder of the Retroactive Limits of Liability is the total of the **Company's** liability to an **Insured** for any such **Claims**; or, if there are no Retroactive Limits of Liability specified on the **Policy Declaration**, then the **Company** has the discretion to apply the remainder of any Limit of Liability specified on the **Policy Declaration** including the lowest Limit of Liability specified on the **Policy Declaration**.

(f) Any one limit of liability shall apply regardless of: (i) the number of persons or entities claiming **Loss** covered by this **Policy**, (ii) the number of **Claims** brought on account of a **Medical Incident**, (iii) the number of **Insureds** under the **Policy**, or (iv) the inclusion of an additional insured. If Retroactive Limits of Liability are provided on the **Policy Declarations**, any **Loss** paid by the **Company** for any covered **Claim** subject to those Retroactive Limits of Liability shall also reduce the Primary Limits of Liability for the **Medical Incident**, as well as the Annual Aggregate.

(g) The **Company** shall have the exclusive right to allocate **Loss** among claimants, **Insureds** and policies as the **Company** deems appropriate.

(h) If a "Deductible" amount is shown for any **Insured** on the **Policy Declaration** or is otherwise applicable to an **Insured**, such **Insured**, with respect to each covered **Claim**, shall be liable for **Loss** up to the Deductible amount shown on the **Policy Declaration**, and the **Company's** limit of liability will be reduced by the amount of the Deductible. In the event the **Company** pays on behalf of an **Insured** all or part of the Deductible as **Loss**, such **Insured** shall reimburse the **Company** for the amount of any such payment. (If any **Insured** fails to make such reimbursement within 30 days after written demand, the **Company** may exercise its rights under Section VII. DUTIES OF INSURED (g).) Each **Insured** agrees to pay all expenses incurred by the **Company**, including attorneys' fees and court costs, incurred by the **Company** in collecting any reimbursement. For all purposes hereunder, the term "Deductible" shall include any self-insured retention. With respect to any **Insured Organization**, the "Deductible" provided on the **Policy Declaration** with respect to the **Insured Individual** shall apply to both the **Insured Individual** and the **Insured Organization** so that there shall only be one "Deductible" for the **Insured Individual** and the **Insured Organization** applicable to any one **Claim**, provided however with respect to **Claims** arising out of acts or omission of individuals (other than **Insured Individuals**), the largest "Deductible" provided on the **Policy Declaration** with respect to all **Insured Individuals** listed on the **Policy Declaration** shall apply to the **Insured Organization**.

VI. ASSESSMENTS

Each **Insured** agrees to pay any and all assessments described on the **Policy Declaration**, including but not limited to any regular assessment applicable to the **Insured Organization** and **Insured Individual**, and all assessments which may be assessed pursuant to the Articles of Association of the **Company** and/or the Bylaws of the **Company** and the terms of such Articles of Association and Bylaws, as the same may be amended from time to time, are fully incorporated herein by this reference. Failure to pay assessments when due may result in actions for enforcement against delinquent parties and will result in termination of

coverage under this **Policy**. Each **Insured** agrees to pay all expenses incurred by the **Company**, including attorneys' fees and court costs, in collecting any assessment.

VII. DUTIES OF INSURED

The **Insured** shall comply with the following duties:

(a) If there is a **Medical Incident** or **Claim** involving any **Insured**, the **Insured** must comply with the **Policy Reporting** provisions stated in Section I. INSURANCE COVERAGE AGREEMENT at (c) or the **Company** will have no duty or obligation to pay **Loss** or defend that **Claim** or any **Claim** arising out of that **Medical Incident**. For either a **Claim** or a **Medical Incident**, the report must provide the **Company** with full disclosure and include all information pertaining thereto, including, but not limited to: (i) the date, time, and place of the event or **Medical Incident**; (ii) the person(s) involved; (iii) the specific nature of the event or **Medical Incident**; (iv) the services that were provided; (v) the type of claim that may result; (vi) the names and addresses of the injured and of available witnesses; (vii) the **Insured's** files and other documentation requested by the **Company**; and (viii) all other information which the **Insured** or the **Company** believe could be of assistance in evaluating or defending a **Claim**. If a **Claim** is made or suit is brought against any **Insured**, such **Insured** shall immediately forward to the **Company** every demand, notice, summons or other process received by such **Insured** or such **Insured's** representative. The **Company** will have no duty or obligation to pay **Loss** or defend any **Claim** where the **Insured** shall fail to forward a demand, notice, summons or other process as provided by this **Policy** and such failure operates to prejudice the rights of the **Company**. The **Insured** also agrees to be available by telephone, and to meet with representatives of the **Company**, at reasonable times in order to assist the **Company** in defending a **Claim**.

(b) In the event that a "Deductible" shall be shown on the **Policy Declaration** and if a **Claim** is made against any **Insured**, such **Insured** shall, within 30 days of receipt of written notice from the **Company**, post a cash bond or letter of credit acceptable to the **Company**, in its sole discretion, in the full amount of the Deductible naming the **Company** as the payee.

(c) The **Insured** and each of the **Insured's** employees and agents shall use diligence to prevent or minimize potential **Claims** made under this **Policy**. It is the duty of the **Insured** to implement reasonable loss control methods. Discovery of willful or grossly negligent acts, omissions, events or any violation of state or federal laws or regulations establishing safety, health, and occupational standards will be grounds for cancellation of the **Policy**.

(d) The **Insured** and each of the **Insured's** employees and agents shall cooperate with the **Company** and, upon the **Company's** request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the **Insured** because of injury or damage with respect to which insurance is afforded under this **Policy**; and the **Insured** and any of its members, partners, officers, directors, stockholders, and employees that the **Company** deems necessary shall attend hearings, mediations, trials and other proceedings and assist in securing and giving evidence and obtaining the attendance of witnesses. The **Insured** shall not, without the written consent of the **Company** and at the **Insured's** own cost, voluntarily make any payment, admit any liability, or assume any obligation or incur any expense. In the event any such **Insured** makes any payment, admits any liability, assumes any obligation, or incurs any expense without the **Company's** consent, the **Insured** forfeits the rights under this **Policy**, and the **Company** shall have no obligation to make any payment for **Loss** or provide any defense for such **Insured**.

(e) Upon receipt of any **Claim**, the **Insured** shall maintain all patient records without alteration and shall immediately transmit an exact copy of the same to the **Company**. No **Insured** shall alter or destroy patient records or take any action to misrepresent or conceal facts pertinent to any **Medical Incident** or **Claim**, whether in representations to the **Company** or in any legal proceedings or otherwise. The **Company** shall have no duty to defend or indemnify any **Claim** if, at any point, the **Company** learns that any medical record related to any person involved has been modified, altered, corrected, changed, substituted, replaced, revised, or otherwise arranged by or at the direction of any **Insured** so as to reveal information in a fashion other than the original medical record content, without clear identification on the record of the change, replacement or revision and the reason for such. Even if properly noted, the **Company** shall have no duty to defend or indemnify unless such changes, replacements, or revisions are medically legitimate and generally allowed within the medical standard of practice.

(f) If the location, nature or scope of any of the **Insured's** practice has changed from that which such **Insured** stated on its original application or renewal application, including but not limited to the changes described below, the **Insured** must immediately inform the **Company** in writing of such changes. No coverage is afforded under this **Policy** for any **Claim** arising from any **Medical Incident** arising out of or related to a change in the practice of any **Insured** unless, before the **Medical Incident** (or the first in a series of related acts comprising a single **Medical Incident**) this **Policy** is endorsed to reflect such change. For illustration purposes only, and without limiting the foregoing provision, the **Insured** must notify the **Company** of: (i) any change in the **Insured's** practice; (ii) any change in the **Insured's** specialty; (iii) any change in services provided; (iv) any change in the location of the **Insured's** practice; (v) any change in employees providing health care services; (vi) any change which will increase risk in activities or services provided; and (vii) the entry by any **Insured** into a collaborative practice agreement or arrangement.

(g) If the **Insured** fails to comply with any obligation under this **Policy**, interferes with the **Company's** exercise of its rights and obligations under the **Policy**, or fails to cooperate with the **Company**, then the **Company's** obligations to the **Insured** under

this **Policy** shall terminate, and the **Company** shall have no obligation to make any payment for **Loss** or provide any defense to any **Insured**.

VIII. REPRESENTATIONS OF INSURED

(a) By acceptance of this **Policy**, all **Insureds** agree: (i) that the statements in the **Policy Declaration** and in their respective applications or renewal applications for insurance are their agreements and representations; (ii) that said statements are true and complete to the best knowledge of all **Insureds**; (iii) that the **Policy** is issued in reliance upon the truth of such representations; and (iv) that the **Policy** embodies all agreements existing between themselves and the **Company** or any of the **Company's** agents relating to this insurance.

(b) Complete and truthful responses in any application or renewal application for insurance are conditions precedent to coverage under this **Policy**. Any fraudulent, or material misrepresentation or omission by any **Insured** in any application or renewal application for insurance shall void the **Policy** as to any party committing such fraud, or material misrepresentation or omission, and no coverage is afforded to such party hereby.

IX. CLAIMS AGAINST COMPANY

(a) No claim shall lie against the **Company** unless, as a condition precedent thereto, there shall have been full compliance with all of the terms and conditions of this **Policy**, nor until the amount of any **Insured's** obligation to pay shall have been finally determined either by judgment against an **Insured** after actual trial or by written agreement of the claimant and the **Company**. Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this **Policy** to the extent of the insurance afforded by the **Policy**. No person or organization shall have any right under the **Policy** to join the **Company** as a party to any action against an **Insured** to determine the **Insured's** liability, nor shall an **Insured** or their legal representative implead the **Company**.

(b) None of the provisions contained in this **Policy** shall be for the benefit of or enforceable by any third parties, including any health maintenance organizations or similar entities. No liabilities are assumed hereby unless expressly set forth in this **Policy**.

X. OTHER INSURANCE

(a) When other valid and collectible insurance covers any **Loss** covered by this **Policy**, then the **Company** shall not be liable for any such **Loss** except as provided in paragraph (e) of this Section X.

(b) When both this insurance and other insurance apply to the **Loss** on the same basis, whether primary, excess or contingent, the **Company** shall not be liable under this **Policy** for a greater proportion of the **Loss** than that stated in the applicable contribution provision below:

(c) If all such other valid and collectible insurance provides for contribution by equal shares, the **Company** shall not be liable for a greater proportion of such **Loss** than would be payable if each insurer contributes an equal share until the share of each insurer equals the lowest applicable limit of liability under any one policy or the full amount of the **Loss** is paid, and with respect to any amount of **Loss** not so paid the remaining insurers then continue to contribute equal shares of the remaining amount of the **Loss** until each such insurer has paid its limit in full or the full amount of the **Loss** is paid.

(d) If any such other insurance does not provide for contribution by equal shares, the **Company** shall not be liable for a greater proportion of such **Loss** than the applicable limit of liability under this **Policy** for such **Loss** bears to the applicable limit of liability of all valid and collectible insurance against such **Loss**.

(e) If any **Loss** covered by this **Policy** arises from the vicarious liability of an **Insured** and is also covered under any other insurance, then this **Policy** shall cover such **Loss** only to the extent that the amount of such **Loss** is in excess of the applicable retention and/or deductible and limit of liability in such other insurance, whether primary, excess, or contingent.

XI. SUBROGATION

In the event of any payment under this **Policy**, the **Company** shall be subrogated to any **Insured's** rights of recovery therefore against any person or organization, and any such **Insured** shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. No **Insured** shall do anything to prejudice such rights.

The **Company** without the consent of the **Insured Organization** or any **Insured Individual** may proceed to take whatever legal action is necessary, including but not limited to the filing of claims for indemnity or contribution against the individual (other than an **Insured Individual**) who was an agent or employee of the **Insured Organization** at the time of the occurrence of the **Medical Incident** which resulted in the **Claim** and who committed the act or omission that gave rise to the **Medical Incident** and the

Insured Organization and its employees and agents hereby agree to cooperate and assist with all efforts to prosecute said claims.

XII. RENEWAL/NON-RENEWAL

Renewal is subject to the **Company's** receipt of a completed and signed application and upon the **Company's** approval of insurability. The **Company** has the right not to renew the **Policy** for any reason. If the **Company** elects not to renew a **Policy** or any **Insured's** coverage under the **Policy**, notice of the non-renewal will be sent, via certified mail, to the **Insured** whose coverage will not be renewed 60 days prior to the effective date of such non-renewal.

XIII. CANCELLATION

(a) The **Insured** may cancel such **Insured's** coverage under the **Policy** at any time upon 60 days prior written notice to the **Company**.

(b) The **Company** may cancel the **Policy** or any **Insured's** coverage under the **Policy** for any reason upon 60 days prior written notice to the **Insured** whose coverage under the **Policy** is to be cancelled (except in the case of a cancellation for reasons described in Subsection (d) below), and shall have the unlimited and absolute right to cancel all or part of any insurance coverage, endorsement, or **Policy** at the **Company's** sole discretion, without cause, or a showing of good faith. By applying for and continuing its membership, each member acknowledges that there is no restriction of any kind on this discretion of the **Company**.

(c) Notwithstanding anything herein to the contrary, the **Insured Individual** and the **Insured Organization** shall not have the option to purchase an extended reporting endorsement, as addressed in Section XIV. TAIL COVERAGE, below, in the event this **Policy** is terminated due to (i) nonpayment of assessments, (ii) loss of the **Insured Individual's** medical license, (iii) the **Insured Individual** supplying false information to the **Company** or giving false testimony or altering physical evidence or medical records or documents regarding a **Claim** or a **Medical Incident** or causing another to do the same, or (iv) the **Insured Individual** or the **Insured Organization** failing to comply with any of the **Insured Individual's** or **Insured Organization's** obligations and duties under the **Policy**.

(d) The **Company** may cancel this **Policy** and/or any **Insured's** coverage under the **Policy** upon ten days prior written notice to the **Insured** if any **Insured** fails to make a full, timely payment of an assessment due hereunder. In the event of cancellation for failure to make a full, timely payment of assessments due hereunder, the **Policy** will be cancelled effective on the date the paid assessment was exhausted, calculated on an earned basis. The **Company** may also cancel this **Policy** upon ten days' prior written notice to the **Insured** in the event of (i) fraud or material misrepresentation affecting the **Policy** or in the presentation of a claim thereunder, (ii) a violation of any of the terms or conditions of the **Policy**, except those stated in Section VII. DUTIES OF INSURED at (e), or (iii) changes in conditions after the effective date of the **Policy** that have materially increased the hazards originally insured. In addition, the **Company** may cancel the **Policy** without notice to the **Insured** if cancellation is requested by a premium finance company and the premium finance company has provided notice to the **Insured** in compliance with Missouri law regarding cancellation for the **Insured's** failure to make a full, timely installment payment under a premium finance plan. Such cancellation shall be effective as of the date requested by the premium finance company.

(e) Failure to create or to maintain medical records in original condition as provided in Section VII. DUTIES OF INSURED at (e) is a material breach of the terms of this **Policy**, and is grounds for immediate cancellation of this **Policy** without notice to the **Insured**.

(f) In the event an **Insured Individual** shall have his or her license to practice medicine revoked and/or suspended and/or surrendered arising out of or related to any investigation, complaint, and/or disciplinary action involving the **Insured Individual**, this **Policy** is automatically cancelled with respect to coverage for the **Insured Individual** and the **Insured Organization** (with respect to the acts and omissions of such **Insured Individual**) upon the first to occur of the date such license shall have been (i) revoked, (ii) suspended, or (iii) surrendered.

(g) Except when there shall be an extended reporting endorsement issued by the **Company** as a part of this **Policy**, in the event an **Insured Individual's** employment relationship with any **Insured Organization** shall have been terminated for any reason, coverage under this **Policy** is automatically terminated with respect to coverage for such **Insured Individual** as of the **Termination Date**.

(h) In the event the **Insured** cancels such **Insured's** coverage under the **Policy**, such **Insured** shall continue to be liable for all assessments, other than the regular assessments, that the **Insured** is required to pay under this **Policy**. Any unused portion of a paid regular assessment will be calculated on an unearned basis, subject to a short rate penalty, and returned. In the event the **Company** cancels the **Policy**, the earned regular assessment shall be calculated on a pro rata basis, and any unused portion of a paid assessment will be returned as soon as practicable. However, the **Insured** shall continue to be liable for all assessments, other than regular assessments, that the **Insured** is required to pay under this **Policy**. Tendering unearned assessments shall not be a condition of cancellation.

XIV. TAIL COVERAGE

(a) Except for termination due to a reason listed in Section XIII. CANCELLATION, an **Insured Individual** shall have the option to purchase an extended reporting endorsement, also known as "tail coverage," upon termination of this **Policy**. To exercise this option, the **Insured Individual** (or such **Insured Individual's** estate) must provide written notice to the **Company** of his or her desire to obtain such coverage and pay the applicable assessment in full (if any such assessment is required) within 25 days of the **Termination Date** of the **Policy**. The **Company** shall specify assessments and deductibles for any extended reporting endorsements for **Insured Individuals**.

(b) If upon termination of this **Policy**, the **Insured Individual** (i) retires, is at least 55 years of age, and stops rendering, directly or indirectly, all medical services, and (ii) has been insured for the last three consecutive claims made years with the **Company**, an extended reporting endorsement will be provided upon prior notice of retirement at no additional charge.

(c) In the event of the death of the **Insured Individual** during the **Policy Period** an extended reporting endorsement, will be issued at no additional charge upon the notice to the **Company** within a reasonable period of time, provided that written proof of the date of death is provided to the **Company**.

(d) In the event the **Insured Individual** becomes totally and permanently disabled during the **Policy Period** for a period of at least six consecutive months and stops rendering, directly or indirectly, all medical services, an extended reporting endorsement, will be issued at no additional charge upon notice to the **Company** within a reasonable period of time, provided that written medical proof of total and permanent disability, including the date such disability occurred, certified by a physician acceptable to the **Company**, is provided to the **Company**.

(e) Notwithstanding anything herein to the contrary all extended reporting endorsements to this **Policy** shall apply only with respect to the **Insured Individual** and not with respect to any **Insured Organization** unless endorsed onto the **Policy** at the sole discretion of the **Company**. To be considered for this coverage, the **Insured Organization** must provide written notice to the **Company** of its desire to obtain such coverage and must pay the applicable assessment in full within 25 days of the **Termination Date** of the **Policy**. The **Company** shall specify assessments and deductibles for any extended reporting endorsements for **Insured Organizations**.

XV. MISCELLANEOUS

(a) The interest hereunder of any **Insured** is not assignable. If, however, an **Insured Individual** shall die or shall be adjudged incompetent by a court of competent jurisdiction, this insurance shall thereupon terminate for such person except as provided by endorsement issued by the **Company**.

(b) Notice to or knowledge possessed by any agent of the **Company** or by any other person shall not effect a waiver or a change in any part of this **Policy** or estop the **Company** from asserting any right under the terms of this **Policy**; nor shall the terms of this **Policy** be waived or changed, except by endorsement issued by the **Company**.

(c) This **Policy**, including the application forms, declarations, endorsements and Articles of Association and Bylaws of the **Company**, as the same may be amended from time to time and which will be furnished to the **Insured** upon request, embodies all agreements existing between the **Insured** and the **Company** or any of its agents relating to this insurance.

(d) This **Policy** may be executed in one or more identical counterparts, each of which shall be deemed an original but all of which together will constitute one and the same instrument.

(e) Each **Insured**, by acceptance hereof, acknowledges that the **Insured** has read and understood all of the provisions of this **Policy**, the Articles of Association of the **Company**, and the Bylaws of the **Company**.

(f) For the purpose of any suit, action or proceeding arising out of or relating to this **Policy**, the **Insured** hereby irrevocably consents and submits to the jurisdiction and venue in the courts of St. Louis County, State of Missouri. The **Insured** irrevocably waives any objection which it may now or hereafter have to the venue of any such suit, action or proceeding brought in such court and any claim that such suit, action or proceeding brought in such court has been brought in an inconvenient forum. The provisions of this section will not limit or otherwise affect the right of **Company** to institute and conduct an action in any other appropriate manner, jurisdiction or court.

(g) In the event any one or more of the provisions contained in this **Policy** shall be declared invalid, illegal or unenforceable by any Court of competent jurisdiction, as applied to any part or any circumstances, the validity, legality or enforceability of the remaining provisions of this **Policy** shall not be impaired thereby, and this **Policy** shall be construed as if such invalid, illegal or unenforceable provisions were not contained herein, unless otherwise stated herein. **Company** and the **Insured** intend this **Policy** to be enforceable as written.

(h) This **Policy** shall be construed and interpreted in accordance with the laws of the State of Missouri without reference to conflicts of law principles.

(i) All notices, requests, demands and other communications hereunder shall be deemed to have been duly given on the date of such mailing or personal delivery as the case may be if the same shall be in writing and shall be delivered in person or sent by first class mail, postage prepaid, and addressed to the address as provided on the **Policy Declaration**.

(j) By acceptance of this **Policy**, the **Insured Individual** becomes a member of the **Company** and shall be entitled to vote at all meetings of the members as provided in the Articles of Association and Bylaws of the **Company** and, upon termination of this **Policy**, shall participate in the distributions, if any, of dividends as fixed and determined by the directors in accordance with the Articles of Association and the Bylaws of the **Company**. This **Policy** is assessable under the provisions of Section 383.010 to 383.040, RSMo. As an **Insured** and a member of the **Company**, you may be required to make additional contributions to help meet excessive losses. The regular annual meeting of the members of the **Company** shall be held at 9:00 am on the fourth Thursday in April at the principal office of the **Company** as provided on the **Policy Declaration**, or such other time, date and place notice of which has been provided in accordance with the Articles of Association and the Bylaws of the **Company**.

For so long as the **Insured Individual** is a member of the **Company** (regardless of whether this **Policy** remains in effect), the **Company** may charge assessments as provided in its Articles of Association and Bylaws and the **Insured Individual** shall be obligated to pay such assessments. Failure to pay such assessments shall constitute a breach of contract by the **Insured Individual** and the **Company** may seek all available recourse. The **Insured Individual** shall be liable to any costs and expenses (including attorneys' fees) incurred by the **Company** in enforcing this obligation.

MISSOURI PROFESSIONALS MUTUAL



By _____

Authorized Signatory