Supreme Court No. S209836
2nd Civil No. B235409
Los Angeles County Superior Court No. VC058225

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

CATHERINE FLORES,

Plaintiff/Appellant,

vs.

PRESBYTERIAN INTERCOMMUNITY HOSPITAL,

Defendant/Respondent

After a Decision by the Court of Appeal, Second Appellate District
Case No. B235409

MOTION REQUESTING COURT TO TAKE JUDICIAL NOTICE; MEMORANDUM OF POINTS AND AUTHORITIES; DECLARATION OF EDWARD W. LLOYD; PROPOSED ORDER

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Pursuant to Evidence Code sec. 459, Plaintiff/Appellant, Catherine Flores hereby requests this Court on review of the above-captioned matter to judicially notice the following matters:

1. Assembly Bill AB1 as originally enacted into law September 23, 1975, a copy of which is attached hereto as exhibit "1";

2. The website of the NORCAL Mutual Insurance Company at www.norcalmutual.com, including but not limited to the exemplar "Professional Liability Insurance Hospital Policy" and "Professional Liability Insurance Policy" displayed on that website, copies of which policies are attached hereto as exhibit "2";

3. The website of The DoctorsCompany at www.the doctors.com including but not limited to the cover page thereon entitled "Medical Practice Coverages Insuring the Business of Medicine", a copy of which is attached hereto as exhibit "3";

4. The website of the American Academy of Orthopaedic Surgeons at www.aaos.org/news/aaosnow/jan08/managing6.asp including the article thereon entitled "Protecting your assets: Why medical liability insurance isn't enough", a copy of which is attached hereto as exhibit "4";

5. The annual report of the California Department of Insurance outlining the market share of insurers writing medical malpractice insurance in California as reported on the website of Presidio Insurance at www.presidioinsurance.com/news//california-medical-

malpractice., a copy of which is attached hereto as exhibit "5".

This Motion is made upon the grounds that such materials are relevant to review of the matter presently before this Court; constitute matters of which this Court must or may take judicial notice, i.e. official laws of the State of California and/or facts that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy; and serve to assist the Court in its resolution of the issues before it.

The matters sought to be judicially noticed are relevant to the subject matter of this review. Issues presented by review include a definition of professional negligence. Although PIH seeks a definition all inclusive of everything that occurs within a hospital, neither the medical industry nor the insurance industry acts in accordance with the definition sought. For example, the medical insurer websites and medical malpractice insurance policies sought to be judicially noticed differentiate negligent acts within a hospital between those arising from medical incidents involving the physician-patient relationship and those arising from general negigence-premises liability.

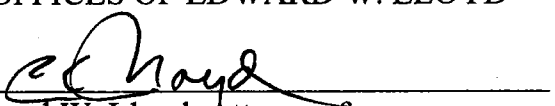
The matters here sought were not presented to the Trial Court, which decided the matter on demurrer before any discovery or investigation into insurance could be conducted.

The matters sought to be judicially noticed concern matters occurring both before and after the judgment in this case. They involve ongoing and continuing practices in the medical and insurance industry which existed both before and after the judgment.

This Motion is based upon this Motion, the Memorandum of Points and Authorities and Declaration of Edward W. Lloyd filed concurrently herewith, and the records and files herein.

Dated: January 10, 2014

LAW OFFICES OF EDWARD W. LLOYD



by Edward W. Lloyd, Attorney for
Plaintiff/Appellant

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTORY STATEMENT OF FACTS:

The review requested of this Court involves an interpretation of the term "professional negligence" as contained in several provisions of MICRA as enacted by the Legislature in 1975. Defendant/Respondent PIH urges a definition of professional negligence that encompasses any and every act of negligence occurring within the confines of a hospital, from a botched surgery to a fall occasioned by a janitor's negligence in leaving a wet-mopped floor in a dangerous condition. Plaintiff/Appellant on the other hand asserts that the Legislature intended a much narrower interpretation of "professional negligence" limited to negligent acts or omissions directly related to medical incidents involving the specialized care and skill of a medical health care provider.

As Flores will demonstrate in her Answer Brief on the Merits, the issue before this court is one of statutory interpretation. To construe a statute, rules of law have developed to be followed. One of those rules is to look to the intent of the legislative body that enacted the statute. Here, the prime legislative intent, as stated by the Legislature, was to lower the cost of medical malpractice insurance. The intent was not to lower the cost of general liability insurance, but again, only to lower the cost of medical malpractice insurance.

Although PIH argues that every negligent act or omission occurring in a hospital constitutes professional negligence, the insurance industry has not adopted that view. The very insurance industry involved in this review does not treat each and every negligent act or omission occurring in a hospital as professional negligence. To the contrary, the insurance industry segregates negligent acts and omissions occurring within a hospital into acts constituting medical malpractice, i.e related to medical procedures, and acts constituting ordinary negligence, i.e. premises liability.

It is disingenuous for PIH and/or its insurers to argue to this Court that every act of negligence occurring within its walls is professional negligence when it carries both medical malpractice insurance and general liability/premises liability insurance.

Further, the very fact that hospitals carry both medical malpractice insurance **and** general liability insurance goes directly to the issue of legislative intent. As it now exists, the burden of the slip and fall incident is not placed upon the medical malpractice policy. It is instead the burden of the general liability/premises liability policy. Under a definition urged by PIH, the burden of the slip and fall would be transferred to the medical malpractice policy as it would then constitute "professional negligence".

By way of this Request for Judicial Notice, Flores seeks to have this

review conducted in "the real world". If Hospital is to argue to the Court that all negligent acts and omissions within its confines are professional in nature, this Court should know that PIH and its insurance carriers are acting differently in the in the real world. They insure and handle medical malpractice claims under a professional negligence coverage and they insure and handle premises liability claims under a general liability coverage.

In conducting its review, this Court should know that an interpretation to the effect that all negligence within the confines of a hospital is "professional negligence" will not serve to lower malpractice premiums. To the contrary, premises liability claims are reported to the general liability coverage and not to the medical malpractice coverage. Such an interpretation would do nothing to lower medical malpractice premiums. To the contrary, it may well drive-up medical malpractice premiums. A definition that all negligence within a hospital is professional negligence could well shift the burden of premises liability claims to the medical malpractice carrier.

To this extent, Flores has asked this Court to take judicial of the current state of hospital and physician insurance coverage. Norcal Mutual Insurance Company is one of the largest medical malpractice insurance carriers in this State. It provides medical malpractice insurance for a separate premium in which it defines "professional liability" for an injury caused by a "Medical

Incident". It also provides general liability insurance covering, among other matters, premises liability. Its general liability coverage expressly excludes liability arising as a result of a "medical incident".

Flores suggests that in reviewing this matter, the court should be aware of the distinction that the medical and medical insurance industry draws between ordinary and professional liability coverage in the real world. They do not treat and they do not insure everything that goes wrong in a hospital as "professional negligence". To this extent:

1. Flores asks this Court to take judicial notice of the NorCal Mutual Insurance Companies website and the exemplar Hospital Policy and Physicians Policy (exh. "2" hereto). Said policies clearly show the industry treatment of classification, reporting and handling of liability claims, differentiating between claims arising from "medical incidents" and those arising from "premises liability";

2. Flores asks this Court to take judicial notice of the website of the American Academy of Orthopaedic Surgeons' article entitled "Protecting your assets: Why medical liability insurance isn't enough". This article also demonstrates the distinction drawn by the medical industry and insurance industry between professional and ordinary liability. This article explains that "...medical liability insurance does

not cover liability arising from activities inherent in running a medical practice not directly related to the physician-patient relationship. These potential liabilities include employment lawsuits and tort claims for injuries sustained on the office premises." This article is relevant to demonstrate that the American Academy of Orthopaedic Surgeons does not consider a premises liability claim to be covered by medical malpractice insurance. A copy of this article is attached as exh. "4";

3. Flores asks this Court to take judicial notice of The Doctors Company website and its article entitled "Medical Practice Coverages: Insuring the Business of Medicine". This is a major medical malpractice carrier in California, the successor to SCIPIE. This material also notes that it offers separate coverage for property and general liability claims. A copy of this website/article is attached hereto as exh. "3"; and

4. Flores asks this Court to take judicial notice of the website of Presidio Insurance reporting on the California Department of Insurance's annual report on market shares of California med mal carriers, listing The Doctors company and Norcal Mutua l as the predominant carriers in California. A copy of this website/article is attached hereto as exh. "5"

Flores will also demonstrate in her Answer Brief on the Merits that MICRA constituted a constellation of numerous additions and amendments to the Business and Professions Code, Civil Code, Code of Civil Procedure, and Insurance Code. Rules of interpretation mandate that a statute be interpreted to give general effect and order within the entire scheme of legislation of which any single statute is a part. As initially enacted, and as largely stands today, the interpretation of "professional negligence" as urged by PIH would have created and would create chaos within MICRA.

It is thus important for this Court to have before it the initial MICRA legislation as enacted as AB 1. Several sections have since been amended or deleted. To pass on the legislative intent, however, it is important for this Court to see MICRA in its original form.

To this extent, Flores asks this Court to take judicial notice of Assembly Bill AB 1. A copy of same is attached hereto as exh. "1".

II. THIS COURT IS AUTHORIZED TO TAKE JUDICIAL NOTICE UPON ITS REVIEW:

Pursuant to Evidence Code sec. 459, a reviewing court shall take judicial notice of matters noticeable under Evidence Code sec. 451 and 453. It may also take judicial notice of any matter specified in sc. 452.

III. ASSEMBLY BILL AB 1 IS JUDICIALLY NOTICEABLE UNDER EVIDENCE CODE SECTION 451:

Per Evidence Code sec. 451(a)(1), a court of this State must take judicial notice of "the decisional, constitutional, and public statutory law" of California. This Court is specifically authorized to take mandatory judicial notice of AB 1, a public statutory law of Califonia.

IV. THE MEDICAL MALPRACTICE INSURANCE WEBSITES AND POLICIES ARE JUDICIALLY NOTICEABLE UNDER EVIDENCE CODE SECTION 452:

Evidence Code sec. 452(h) authorizes this Court to take judicial notice of "facts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." Flores' request to notice the websites and policies of the major malpractice carriers in California falls within this category.

In the case of Ampex Corporation v. Cargle (2005) 128 Cal. App. 4th 1569, at 1573, the Court held that it was proper to judicially notice a company's records posted on its website.

V. FLORES' FAILURE TO ASK THE TRIAL COURT TO JUDICIALLY NOTICE THESE DOCUMENTS IS EXCUSABLE:

A reviewing court can take judicial notice of matters that were not before the trial court. (Haworth v. Superior Court (2010) 50 Cal. 4th 372, at 379) It is true that it is better practice when the request for judicial notice is also made in the courts below, but this failure is excusable in the case at bar.

The Judgment against Flores in the trial court was entered following the sustaining of demurrer without leave to amend and subsequent dismissal. As such, Flores had neither opportunity nor sufficient time to conduct discovery on the issue of insurance nor to fully develop the issue as it has now been developed for presentation to our highest tribunal. It would have been nice had Flores been able to conduct discovery as to what insurance PIH had and what coverages it had and even what coverage had been invoked in this case, but that opportunity was not present. Judgement was entered following demurrer.

Dated: January 10, 2014

LAW OFFICES OF EDWARD W. LLOYD

by Edward W. Lloyd, Attorney for Plaintiff/Appellant

DECLARATION OF EDWARD W. LLOYD

I, Edward W. Lloyd, declare:

1. That I, Edward W. Lloyd, am an attorney at law, duly authorized to practice law in all courts of the State of California. I am attorney of record for Plaintiff/appellant herein, Catherine Flores. Except as may otherwise be stated herein, I have personally knowledge of all matters set forth herein and if called to testify, could and would testify competently thereto. My personal knowledge comes from the fact that I personally participated in all matters set forth herein.

2. The matters which I request the Court to judicially notice were not the subject of a request for judicial notice at the Trial Court in the proceedings below. The judgment below was entered after a demurrer was sustained to the Complaint without leave to amend. As such, I had neither sufficient opportunity nor time in which to conduct discovery as to insurance in effect, the type of insurance coverage and the policy to which Flores' claim had been reported. Further, I had not then sufficiently researched the complex issues involved in this case which have only come to light after appellate review to fully understand the need for this Court to be informed about the practices of the insurance and medical industries in drawing their own distinctions between

professional and general negligence for insurance coverage purposes.

3. I opine that all matters requested are highly relevant to this appeal. PIH contends that negligent acts and omissions occurring in a hospital constitute "professional negligence". At the same time, both the medical industry and the insurance industry continue to draw important distinctions between professional negligence and general negligence/premises liability and offer separate coverages for each. As a result, neither the medical nor insurance industry acts in accordance with the position taken by PIH in this review. The insurance websites and policies asked to be noticed point out what appears to this author to be a highly disingenuous position take by PIH. Further, the insurance policies asked to be noticed provide separate coverage for general liability/premises liability. As such, although Hospital would argue that a slip and fall occurring in a hospital is pro fessional negligence, the policies themselves show how they would continue to be reported under premises liability coverage, thereby having no effect upon medical malpractice rates, or potentially reported as professional negligence greatly increasing the burden of the malpractice carrier and raising premiums, the exact opposite of the legislative intent of MICRA.

4. Also, AB 1 in its initial format is relevant to demonstrate the legislative intent as formulated in 1975. As MICRA has been amended since, it is necessary for the Court to have before it a concise and easy to find version of the original MICRA legislation.

5. The matters sought to be judicially noticed arguably represent the state of the medical insurance industry both before and after judgment in this case.

6. Attached hereto as exhibit "1" is a true and correct copy of Assembly Bill AB 1, the MICRA statutes, as originally enacted in 1975. I personally copied this document form the official records of the Legislature of the State of California located at the Orange County Law Library in Santa Ana, California.

7. Attached hereto as exhibit "2" is a true and correct copy of an exemplar Norcal Mutual Insurance Company hospital and physician policy of insurance. This document was and is located upon the website of Norcal located at www.norcalmutual.com.

8. Attached hereto as exhibit "3" are true and correct copies of the website of TheDoctorsCompany insurance company located at www.thedoctors.com.

The article appearing thereon is entitled "Medical Malpractice Coverages Insuring the Business of Medicine".

9. Attached hereto as exhibit "4" is a true and correct copy of the website of the American Academy of Orthopaedic Surgeons located at www.aaos.org/news/aaosnow/jan08/managing6.asp. The article appearing thereon is entitled "Protecting your assets: Why medical liability insurance isn't enough".

10. Attached hereto as exhibit "5" is a true and correct copy of the website of Presidio Insurance reporting on the annual report of the California Department of Insurance outlining market shares of California medical malpractice insurers. It is located at www.presidioinsurance.com/news/california-medical-malprctice.

I declare under penalty of perjury of the laws of the State of California the foregoing to be true and correct. Executed this 10th day of January, 2014, at Santa Ana, California.

Edward W. Lloyd

FOR YOU CONVENIENCE AND TO AVOID CONFUSION, THE FOLLOWING IS A COMPOSITE OF THE MEDICAL MALPRACTICE REFORM LEGISLATION (AB 1XX AND SB 24XX) AND THE JOINT UNDERWRITING ASSOCIATION LAW (SB 491 AND SB 24XX).

MEDICAL INJURY COMPENSATION REFORM ACT

Assembly Bill No. 1xx

CHAPTER 1xx

An act to amend Sections 125.5, 2100, 2101, 2116, 2119, 2361, 2361.5, 2362, 2364, 2372.5, 2436, 2454, 2456, and 2458 of, to add Sections 2100.2, 2100.5, 2100.6, 2100.7, 2100.8, 2101.5, 2101.6, 2122, 2372, and 2372.1 to, to add Article 11 (commencing with Section 800) to Chapter 1 of Division 2 of, to add Article 2.3 (commencing with Section 2123) and Article 2.4 (commencing with Section 2124.5) to Chapter 5 of Division 2 of, to add Article 8.5 (commencing with Section 6146) to Chapter 4 of Division 3 of, to repeal Section 2372 of, to repeal Article 11 (commencing with Section 800) of Chapter 1 of Division 2 of, and to repeal Article 2.3 (commencing with Section 2123) of Chapter 5 of Division 2 of, the Business and Professions Code; to amend Section 43.8 of, and to add Sections 3333.1 and 3333.2 to the Civil Code; to amend Sections 340.5 and 1094.5 of, to add Sections 667.7 and 674.7 to, and to add Chapter 5 (commencing with Section 364) to Title 2 of Part 2 of, and to add Title 9.1 (commencing with Section 1295) to Part 3 of, the Code of Civil Procedure; and to add Sections 11587 and 11588 to, the Insurance Code, relating to health, and making an appropriation therefor.

[Approved by Governor September 23, 1975. Filed with Secretary of State September 23, 1975.]

AB 1xx, Keene. Injury of patients: compensation.

AND

Senate Bill No. 24xx

CHAPTER 2xx

An act to amend Sections 160, 800, 804, 2100.6, 2101, 2116, 2123.1, 2123.2, 2123.3, 2123.9, 2123.10, 2124, 2124.2, 2124.45, 2124.7, 2372, 2372.5, 2454, 2456, 2458, and 6146 of, and to add Sections 2101.7 and 2601.5 to, the Business and Professions Code, to amend Sections 3333.1 and 3333.2 of the Civil Code, to amend Sections 340.5, 364, 667.7, and 1295 of the Code of Civil Procedure, to amend Sections 4040, 11588, 11890, 11895, 11896, 11897, 11898, 11900, 11902, 11902.2, 11903, and 11904 of, and to add Sections 108.5, 1858.05, and 1858.15 to, the Insurance Code, and to amend Section 830.3 of the Penal Code, relating to medical malpractice, and to amend Assembly Bill 1 of the 1975-76 Second Extraordinary Session, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 24, 1975. Filed with Secretary of State September 24, 1975.]

SB 24xx, Behr. Insurance: medical malpractice.

The people of the State of California do enact as follows:

Section 1 of AB 1xx. (a) This act shall be known and may be cited as the Medical Injury Compensation Reform Act.

(b) The Legislature finds and declares that there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state. The Legislature, acting within the scope of its police powers, finds the statutory remedy herein provided is intended to provide an adequate and reasonable remedy within the limits of what the foregoing public health and safety considerations permit now and into the foreseeable future.

Section 125.5 of the Business and Professions Code is amended to read:

125.5 (a) The superior court for the county in which any person has engaged or is about to engage in any act which constitutes a violation of a chapter of this code administered or enforced by a board within the department may, upon a petition filed by the board with the approval of the director, issue an injunction

or other appropriate order restraining such conduct. The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that no undertaking shall be required. As used in this section, "board" includes commission, bureau, division, agency and a medical quality review committee.

(b) The superior court for the county in which any person has engaged in any act which constitutes a violation of a chapter of this code administered or enforced by a board within the department may, upon a petition filed by the board with the approval of the director, order such person to make restitution to persons injured as a result of such violation.

(c) The court may order a person subject to an injunction or restraining order, provided for in subdivision (a) of this section, or subject to an order requiring restitution pursuant to subdivision (b), to reimburse the petitioning board for expenses incurred by the board in its investigation related to its petition.

(d) The remedy provided for by this section shall be in addition to, and not a limitation on, the authority provided for in any other section of this code.

Section 160 of the Business and Professions Code is amended to read:

160. The Chief and all investigators of the Division of Investigation of the department and all investigators of the Board of Medical Quality Assurance have the authority of peace officers while engaged in exercising the powers granted or performing the duties imposed upon them or the division in investigating the laws administered by the various boards comprising the department or commencing directly or indirectly any criminal prosecution arising from any investigation conducted under these laws. All persons herein referred to shall be deemed to be acting within the scope of employment with respect to all acts and matters in this section set forth.

Article 11 (commencing with Section 800) of Chapter 1 of Division 2 of the Business and Professions Code is repealed.

Article 11 (commencing with Section 800) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 11. Professional Reporting

800. (a) The Board of Medical Quality Assurance, the Board of Dental Examiners, the Board of Osteopathic Examiners, the California Board of Registered Nursing, the Board of Vocational Nurse and Psychiatric Technician Examiners, the State Board of Optometry, the Board of Examiners in Veterinary Medicine, and the State Board of Pharmacy shall each separately create and maintain a central file of the names of all persons who hold a license, certificate or similar authority from such board. Each such central file shall be so created and maintained as to provide an individual historical record for each such person with respect to (1) any conviction of a crime in this or any other state which constitutes unprofessional conduct under Section 2383, pursuant to the reporting requirements of Section 803; (2) any judgment or settlement requiring him or his insurer to pay any amount of damages in excess of three thousand dollars ($3,000) with respect to any claim that injury or death was proximately caused by such person's negligence, error or omission in practice or rendering of unauthorized professional services, pursuant to the reporting requirements of Section 801 or 802; (3) any public complaints for which provision is hereinafter made by regulation, pursuant to subdivsion (b) of this section; (4) disciplinary information reported pursuant to Section 805.

(b) Each such board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in or connected with the performance of professional services by such person.

Each such complaint shall be immediately forwarded to the appropriate medical quality review committee for action, pursuant to Article 2.3 (commencing with Section 2123) of Chapter 5.

Upon a determination by the committee that the complaint is without merit, the central file shall be purged of information relating to the complaint.

(c) The contents of any central file shall be confidential except that it may be reviewed (1) by the licensee involved or his counsel or representative who may, but is not required to submit any additional exculpatory or explanatory statements or other information, which statements or other information must be included in the file, (2) by any district attorney or representative or investigator therefor who has been assigned to review the activities of a healing arts licentiate, (3) by any representative of the Attorney General's office or investigator thereof who has been assigned to review the activities of a healing arts licentiate, or (4) by any investigator of the Department of Consumer Affairs who has been assigned to review the activities of a healing arts licentiate. Such licensee may, but is not required to submit any additional exculpatory or explanatory statements or other information which statements or other information must be included in the file.

801. (a) Every insurer providing professional liability insurance to a person who holds a license, certificate or similar authority from or under any agency mentioned in Section 800(a) (except a person licensed pursuant to Chapter 3 (commencing with Sec-

tion 1200) of Division 2) shall send a complete report to that agency as to any settlement or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by such person's negligence, error or omission in practice or his rendering of unauthorized professional services. Such report shall be sent within 30 days after such written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of such arbitration award on the parties.

(b) Notwithstanding any other provision of law, no insurer shall enter into such a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without such written consent. The requirement of written consent can only be waived by both the insured and the insurer. The provisions of this section shall only apply to a settlement on a policy of insurance executed or renewed on or after January 1, 1971.

802. Every settlement or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by negligence, error or omission in practice, or the unauthorized rendering of professional services, by a person who holds a license, certificate or other similar authority from an agency mentioned in Section 800(a) (except a person licensed pursuant to Chapter 3 (commencing with Section 1200) of Division 2) who does not possess professional liability insurance as to such claim shall, within 30 days after any such written settlement agreement has been reduced to writing and signed by all the parties thereto or 30 days after service of such arbitration award on the parties, be reported to the agency which issued the license, certificate or similar authority. A complete report shall be made by appropriate means by such person or his counsel, with a copy of such communication to be sent to the claimant through his counsel if he is so represented, or directly if he is not. If, within 45 days of the conclusion of such written settlement agreement or service of such arbitration award on the parties, counsel for the claimant (or if he is not represented by counsel, the claimant himself) has not received a copy of the report, he shall himself make such a complete report. Failure of the physician or claimant (or, if represented by counsel, their counsel) to comply with the provisions of this section is a public offense punishable by a fine of not less than fifty dollars ($50) or more than five hundred dollars ($500). Knowing and intentional failure to comply with the provisions of this section, or conspiracy or collusion not to comply with the provisions of this section, or to hinder or impede any other person in such compliance is a public offense punishable by a fine of not less than five thousand dollars ($5,000) nor more than fifty thousand dollars ($50,000).

803. Within 10 days after a judgment by a court of this state that a person who holds a license, certificate or other similar authority from an agency mentioned in Section 800(a) (except a person licensed pursuant to Chapter 3 (commencing with Section 1200) of Division 2) has committed a crime or is liable for any death or personal injury caused by his negligence, error or omission in practice, or his rendering unauthorized professional services, the clerk of the court which rendered such judgment shall report the same to that agency which issued the license, certificate or other similar authority; provided that, where the judge who tried the matter finds that it does not relate to the defendant's professional competence or integrity he may, by order, dispense with the requirement that the report be sent.

804. (a) Any agency to whom reports are to be sent under Section 801, 802, or 803, may develop a prescribed form for the making of such reports, usage of which it may, but need not, by regulation require in all cases.

(b) A report required to be made by Sections 801 and 802 shall be deemed complete only if it includes the following information: (1) the name and last known business and residential addresses of every plaintiff or claimant involved in the matter, whether or not each such person recovered anything; (2) the name and last known business and residential addresses of every physician or provider of health care services who was claimed or alleged to have acted improperly, whether or not such person was a named defendant and whether or not any recovery or judgment was had against such persons; (3) the name, address and principal place of business of every insurer providing professional liability insurance as to any person named in (2) and the insured's policy number; (4) the name of the court in which the action or any part of the action was filed along with the date of filing and docket number of each such action; (5) a brief description or summary of the facts upon which each claim, charge or judgment rested including the date of occurrence; (6) the names and last known business and residential addresses of every person who acted as counsel for any party in the litigation or negotiations, along with an identification of the party whom said person represented; (7) the date and amount of final judgment or settlement; and (8) such other information as the agency to whom the reports are to be sent may, by regulation, require.

(c) Every person named in such report, who is notified by the board within 60 days of the filing of the report, shall maintain for the period of three years from the filing of such report any records he has as to the matter in question and shall make those available

upon request to the agency with which the report was filed.

805. The chief administrator or executive officer of any county hospital or county medical facility or any clinic, health facility, general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, or special hospital licensed pursuant to Division 2 of the Health and Safety Code (commencing with Section 1200), or any health care service plan or medical care foundation shall report to the agency which issued the license, certificate, or similar authority when any person who holds a license, certificate or similar authority under any agency mentioned in Section 800 is denied staff privileges, removed from the medical staff of such institution, or if his staff privileges are restricted for a cumulative total of 45 days in any calendar year, for any medical disciplinary cause or reason. Such report shall be made within 20 working days following such removal or restriction, shall be certified as true and correct by the chief administrator or other executive officer, and shall contain a statement detailing the nature of the action, its date and all of the reasons for, and circumstances surrounding, such action. If the removal or restriction is by resignation or by voluntary action, the report shall state whether the resignation was requested or bargained for.

The reporting required herein shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800.

806. Each agency in the department receiving reports pursuant to the preceding sections shall prepare a statistical report based upon such records for presentation to the Legislature not later than 30 days after the commencement of each regular session of the Legislature, including a summary of administrative and disciplinary action taken with respect to such reports and any recommendations for corrective legislation if the agency considers such legislation to be necessary.

807. Each agency in the department shall notify every person licensed, certified or holding similar authority issued by it, and the department shall notify every insurance company doing business in this state and every institution mentioned in Section 805 of the provisions of this article.

Section 2100 of the Business and Professions Code, as amended by Chapter 716 of the Statutes of 1971, is amended to read:

2100. There is in the Department of Consumer Affairs a Board of Medical Quality Assurance of the State of California which consists of 19 members who shall be appointed by the Governor, subject to confirmation by the Senate, seven of whom shall be public members.

Section 2100.2 is added to the Business and Professions Code, to read:

2100.2. Notwithstanding any other provision of law, the terms "board" or "Board of Medical Examiners" as used in this chapter shall mean the Board of Medical Quality Assurance.

Section 2100.5 is added to the Business and Professions Code, to read:

2100.5. The board shall consist of the following three divisions: a Division of Medical Quality, a Division of Licensing, and a Division of Allied Health Professions.

Section 2100.6 is added to the Business and Professions Code, to read:

2100.6 The Division of Medical Quality shall have responsibility for (a) reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board; (b) the administration and hearing of disciplinary actions; (c) carrying out disciplinary action appropriate to findings made by a medical quality review committee, a hearing officer, or the division.

Section 2100.7 is added to the Business and Professions Code, to read:

2100.7. The Division of Licensing shall have the responsibility for: (a) developing and administering the physicians and surgeons examination; (b) issuing licenses and certificates; (c) suspending, revoking or limiting licenses and certificates upon order of the Division of Medical Quality; (d) administering programs of continuing competence for certificate holders pursuant to Section 2101.6; (e) approving undergraduate and graduate medical education programs; (f) approving clinical clerkship and special programs; (g) administering student loan programs, grants and reciprocity certificates.

Section 2100.8 is added to the Business and Professions Code, to read:

2100.8. The Division of Allied Health Professions shall have responsibility for:

(a) The activities of examining committees and nonphysician certificate holders under the jurisdiction of the board.

(b) Discipline of nonphysician certificate holders to the extent such discipline is currently within the jurisdiction of the board.

(c) Acting as liaison with other healing arts boards concerning the activities of the licentiates of other boards.

(d) Reporting to the Legislature and the Governor by July 1, 1976, concerning the desirability of certifying currently noncertified categories providing health services of a technical nature.

Section 2101 of the Business and Professions Code is amended to read:

2101. Members of the board shall only be appointed from persons who have been citizens of this state for at least five years next preceding their appointment. Members of the board, except the public members, shall only be appointed from persons who hold licenses under this chapter or any preceding medical practice act of this state. Five of such licensee members shall be members of the faculty of a clinical department of an approved medical school in the state. The public members shall not be licentiates of the board. No person who in any manner owns any interest in any college, school, or institution engaged in medical instruction shall be appointed to the board. Not more than four members of the board may be full-time members of the faculties of medical schools.

Section 2101.5 is added to the Business and Professions Code, to read:

2101.5 The Division of Medical Quality shall consist of seven members of the board, three of whom shall be public members. The Division of Licensing shall consist of seven members, two of whom shall be public members. The Division of Allied Health Professions shall consist of five members, two of whom shall be public members.

Each member presently serving on the board shall be assigned by the Governor to sit in a specific division. Appointments made by the Governor subsequent to the effective date of this section shall be made to a specific division.

Section 2101.6 is added to the Business and Professions Code, to read:

2101.6. In order to insure the continuing competence of physicians and surgeons certificate holders under this chapter, the Division of Licensing shall by January 1, 1977, adopt and administer standards for continuing education of such certificate holders. The division shall require certificate holders to demonstrate satisfaction of the continuing education requirements at intervals of not less than four nor more than six years.

Section 2101.7 is added to the Business and Professions Code, to read:

2101.7 The Governor may remove any member of the board for neglect of duty required by this chapter, incompetency, or unprofessional conduct.

Section 2116 of the Business and Professions Code is amended to read:

2116. The board may prosecute all persons guilty of violating the provisions of this chapter.

It may employ investigators, legal counsel, medical consultants, and any such clerical assistance as it may deem necessary to carry into effect the provisions of this chapter. The board may fix the compensation to be paid for such service and may incur such other expenses as it may deem necessary.

The Attorney General shall act as the legal counsel for the board for any judicial proceedings and, at the board's discretion, for any administrative proceedings and his services shall be a charge against it.

Section 2119 of the Business and Professions Code is amended to read:

2119. A division of the board may, within its jurisdiction, adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act, such rules as may be reasonably necessary to enable it to carry into effect the provisions of this chapter.

Five members of the Division of Medical Quality, three members of the Division of Licensing, and three members of the Division of Allied Health Professions shall constitute a quorum for the transaction of business at any meeting.

It shall require the affirmative vote of a majority of the membership of a division to carry any motion or resolution, to adopt any rule, to pass any measure, or to authorize the issuance of any certificate under this chapter, except that a decision by the Division of Medical Quality to revoke the certificate of a physician and surgeon shall require an affirmative vote of five members of the division.

Section 2122 is added to the Business and Professions Code, to read:

2122. The Division of Medical Quality of the board shall report to the Legislature and the Governor by July 1, 1977, with a recommended program by which to insure the continuing competence of certificate holders under this chapter on the basis of individual performance evaluation.

The division shall seek advice and consultation in making its recommendation from medical quality review committees, professional medical societies, professional standards review organizations, and other appropriate persons.

The Division of Medical Quality shall report to the Legislature and the Governor by January 1, 1977, with a recommended program whereby the activities of medical quality review committees and professional standard review organizations can be integrated to assure the maintenance of high-quality medical practice, and the establishment of individual performance evaluation standards for certificate holders.

Article 2.3 (commencing with Section 2123) of Chapter 5 of Divsion 2 of the Business and Professions Code is repealed.

Article 2.3 (commencing with Section 2123) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 2.3. Medical Quality Review Committees

2123. The Legislature finds and declares that the public health requires the establishment of procedures to assure the maintenance of high-quality medical practice by holders of certificates under this chapter.

The Legislature intends by this article to establish a system of medical quality review committees under the jurisdiction of the Division of Medical Quality of the Board of Medical Quality Assurance to initiate a continuing review of the quality of medical practice by certificate holders and to undertake such remedial or disciplinary functions as are specified herein and appropriate for the protection of the public and the certificate holder.

2123.1. As used in this chapter:

(a) "Board" means the Board of Medical Quality Assurance of the State of California.

(b) "Committee" means a medical quality review committee created by this article.

(c) "District" means a district established by Section 2123.2.

(d) "Department" means the Department of Consumer Affairs.

2123.2 The state is divided, for the purposes of this article, into the following 14 districts:

(a) The first district consists of the Counties of Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen, Tehama, Plumas, Mendocino, Glenn, Butte, Lake, and Colusa.

(b) The second district consists of the Counties of Sierra, Yuba, Sutter, Yolo, Nevada, Placer, El Dorado, and Sacramento.

(c) The third district consists of the Counties of Sonoma, Napa, and Solano.

(d) The fourth district consists of the Counties of Marin, San Francisco, and San Mateo.

(e) The fifth district consists of the Counties of Contra Costa and Alameda.

(f) The sixth district consists of the Counties of Alpine, Amador, Calaveras, Tuolumne, San Joaquin, Stanislaus, and Merced.

(g) The seventh district consists of the County of Santa Clara.

(h) The eighth district consists of the Counties of Santa Cruz, San Benito, Monterey, and San Luis Obispo.

(i) The ninth district consists of the Counties of Mariposa, Madera, Fresno, Kings, Tulare, and Kern.

(j) The 10th district consists of the Counties of Santa Barbara and Ventura.

(k) The 11th district consists of the County of Los Angeles.

(l) The 12th district consists of the Counties of Mono, Inyo, San Bernardino, and Riverside.

(m) The 13th district consists of the County of Orange.

(n) The 14th district consists of the Counties of San Diego and Imperial.

2123.3. A medical quality review committee is hereby created for each of the districts established by Section 2123.2. Each committee shall be composed of persons appointed by the Governor from among residents of the district.

The medical quality review committees shall have the following composition:

(a) The first district shall be composed of 10 members, six of whom shall hold valid physician's and surgeon's certificates, two of whom shall be public members, and two of whom shall be nonphysician licentiates of a healing arts board.

(b) The second district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public members, and three of whom shall be nonphysician licentiates of a healing arts board.

(c) The third district shall be composed of 10 members, six of whom shall hold valid physician's and surgeon's certificates, two of whom shall be public members, and two of whom shall be nonphysician licentiates of a healing arts board.

(d) The fourth district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public members, and three of whom shall be nonphysician licentiates of a healing arts board.

(e) The fifth district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public members, and three of whom shall be nonphysician licentiates of a healing arts board.

(f) The sixth district shall be composed of 10 members, six of whom shall hold valid physician's and surgeon's certificates, two of whom shall be public members, and two of whom shall be nonphysician licentiates of a healing arts board.

(g) The seventh district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public members, and three of whom shall be nonphysician licentiates of a healing arts board.

(h) The eighth district shall be composed of 10 members, six of whom shall hold valid physician's and surgeon's certificates, two of whom shall be public members, and two of whom shall be nonphysician licentiates of a healing arts board.

(i) The ninth district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public

members, and three of whom shall be nonphysician licentiates of a healing arts board.

(j) The 10th district shall be composed of 10 members, six of whom shall hold valid physician's and surgeon's certificates, two of whom shall be public members, and two of whom shall be nonphysician licentiates of a healing arts board.

(k) The 11th district shall be composed of 20 members, 12 of whom shall hold valid physician's and surgeon's certificates, four of whom shall be public members, and four of whom shall be nonphysician licentiates of a healing arts board.

(l) The 12th district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public members, and three of whom shall be nonphysician licentiates of a healing arts board.

(m) The 13th district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public members, and three of whom shall be nonphysician licentiates of a healing arts board.

(n) The 14th district shall be composed of 15 members, nine of whom shall hold valid physician's and surgeon's certificates, three of whom shall be public members, and three of whom shall be nonphysician licentiates of a healing arts board.

A medical quality review committee may, pursuant to regulations adopted by the Division of Medical Quality, establish panels of five committee members consisting of three physician members, one public member, and one member who is a licentiate of a healing arts board other than the Board of Medical Quality Assurance for the purposes of hearing and deciding cases before a committee. Five members shall constitute a quorum in order for a panel of a committee to conduct business. It shall require an affirmative vote of a majority of those present at a meeting of a panel, such majority constituting at least a majority of a minimum quorum for a panel to decide any case, pass any measure, or make any recommendation. Where a medical quality review committee meets as a whole, a majority of the membership of the committee shall constitute a quorum to conduct business. It shall require an affirmative vote of a majority of those present at a meeting of a committee, such majority constituting at least a majority of a minimum quorum for a committee, to decide any case, pass any measure, or make any recommendation.

A finding or decision by a panel established under this section shall constitute a finding or decision by a committee.

2123.4. Each member of each committee, except the initial members, shall be appointed by the Governor for a term of four years.

Of those appointments of physicians and surgeons to be made by the Governor to medical quality review committees, for every three physicians to be so appointed, one shall be appointed from among not less than three persons to be nominated by professional medical societies, within the district, which represents the profession at large, one shall be appointed from the faculty of a clinical department of an approved medical school in the state. The faculty member need not reside in the district and shall be appointed from among not less than three nominations submitted to the Governor by the deans of the approved medical schools of the state. One member shall be appointed by the Governor from among not less than three nominations which are submitted to him by the Division of Medical Quality.

Each physician and surgeon appointee shall be licensed to practice in California.

Each member shall hold office until the appointment and qualification of his successor, or until six months have elapsed since the expiration of the term for which he was appointed, whichever first occurs.

Of those initial appointments of physicians and surgeons to medical quality review committees, for every three physicians so appointed, one shall serve a term which expires on September 1, 1978, one shall serve a term which expires on September 1, 1979, and one shall serve a term which expires on September 1, 1980.

Of those initial appointments of persons other than physicians and surgeons to medical quality review committees, for every two persons so appointed, one shall serve a term which expires on September 1, 1979, and one shall serve a term which expires on September 1, 1980.

2123.5. The Governor may remove any member of a committee for neglect of any duty required by this chapter, incompetency, or unprofessional conduct.

Vacancies in the membership of any committee shall be filled by the Governor by appointment from nominees submitted as provided in Section 2123.4 and with due regard for the proportional makeup of the committee as provided therein.

2123.6. Each member of a committee shall receive a per diem and expenses, as provided in Section 103.

2123.7. Each member of a committee is subject to the same rules and regulations as if he were a member of the board.

2123.9. Except as otherwise provided in this article, all hearings shall be conducted by a committee or panel of a committee in accordance with the provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2 of the Government Code.

If a contested case is heard by a committee or panel of a committee, the hearing officer who presided

at the hearing shall be present during the committee's consideration of the case and, shall advise the committee or panel on matters of law.

2123.10. Within 30 days of the conclusion of any hearing which is conducted by a committee or panel, the committee or panel shall render its decision. A decision by a committee or panel calling for the discipline of a licensee, or restricting or limiting the extent, scope, or type of practice of the certificate holder for a period of one year or less, or the suspension from practice of a licensee for 30 days or less, shall be final, except where the committee or panel orders reconsideration pursuant to Section 2124.1. Where a committee or panel renders a decision calling for suspension of a license for a period exceeding 30 days, or restriction or limitation on the extent, scope, or type of practice of the certificate holder for a period exceeding one year, or revocation of a license, the decision shall constitute a proposed decision to the Division of Medical Quality. The proposed decision shall be subject to the same procedure as the proposed decision of a hearing officer under subdivisions (b) and (c) of Section 11517 of the Government Code. A final decision of a committee shall constitute the decision of the Division of Medical Quality. No suspension for a period exceeding 30 days, or restriction or limitation on the extent, scope, or type of practice of the certificate holder for a period exceeding one year, or revocation of a license shall be carried out except upon order of the Division of Medical Quality.

The Division of Medical Quality shall act upon a proposed decision within 90 days of receiving such decision from a committee.

2123.11. Each medical quality review committee shall be staffed by at least one medical consultant and sufficient competent investigators from the board as are necessary to carry out the purposes of this article. The investigators so utilized shall be specially trained to investigate medical practice activities.

2124. A medical quality review committee shall have the following authority and duties:

(a) To initiate reviews of the quality of medical care practiced by certificate holders.

(b) To investigate all matters assigned to it by the Division of Medical Quality, and such other matters within the jurisdiction of a committee which it finds warrant action.

(c) To initiate investigations of complaints made by members of the public, and other certificate holders, a health care facility or a division of the board that a certificate holder has been guilty of unprofessional conduct and to report to the complainant within 90 days of the receipt of the complaint by the committee as to the committee's findings and decision. All investigations made pursuant to this section shall be commenced immediately and completed within 90 days, with 30-day progress reports submitted to the Division of Medical Quality.

(d) To investigate the circumstances of practice of any physician and surgeon certificate holder which have resulted in any judgments or settlements requiring the certificate holder or insurer of the certificate holder to pay any amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the certificate holder's error, negligence, or omission.

(e) Investigations conducted pursuant to this section shall be commenced within 15 days and completed within three months. Where applicable, a progress report shall be issued to the complainants within 30 days of the initiation of the investigation. Once an investigation has been completed and grounds for disciplinary action are found by the Attorney General to exist, the Attorney General shall file an accusation with a committee within 30 days. A hearing shall be held by a committee or a panel of a committee within 45 days of the filing of an accusation.

(f) Where a review or investigation carried out pursuant to subdivision (a), (b), (c), or (d) of this section results in a likelihood or a finding of unprofessional conduct, to hold a hearing pursuant to Section 2123.8 to determine whether unprofessional conduct has occurred.

(f) Upon a finding of unprofessional conduct to take appropriate remedial or disciplinary action in relation to the certificate holder pursuant to Sections 2372, 2372.1, and 2372.5.

(g) Seek injunctions or restraining orders pursuant to Section 2436.

(h) A committee or a panel of a committee which investigates a certificate holder pursuant to this section shall not be the committee or panel of a committee which hears any disciplinary matters resulting from that investigation.

2124.1. Any decision of the Division of Medical Quality or of a committee or panel within the authority granted it by this article is final, except that the Division of Medical Quality or a committee may, on its own motion or on petition of any party, within the time and in the manner prescribed in Chapter 5 (commencing with Section 11500) of Part 1, Division 3, Title 2 of the Government Code, order a reconsideration of all or any part of a decision.

2124.2. The Division of Medical Quality shall adopt, amend, or repeal, in accordance with the provisions of Chapter 4.5 (commencing with Section 11371), Part 1, Division 3, Title 2 of the Government Code, such regulations as may reasonably be necessary to en-

able medical quality review committees and panels to carry into effect the provisions of this article.

Failure to comply with the time limitations of Section 2123.10 or 2124 shall not invalidate any proceedings of the Division of Medical Quality, nor shall it affect the jurisdiction of the division to render a decision, but such a failure shall be reported by the division to the Speaker of the Assembly and the President pro Tempore of the Senate within three months.

2124.3. The Division of Licensing, subject to the State Civil Service Act, may employ investigators to evaluate the curricula of medical schools. Such persons shall meet such reasonable standards of experience and education, to be determined by the board, as will enable them to competently perform such duties.

2124.4. Upon receiving a report from any court of an unusually high number of claims for compensation filed against a certificate holder under this chapter, the Division of Medical Quality shall inform the appropriate medical quality review committee. The committee shall investigate the nature and cause of the injuries involved and shall, if appropriate, initiate disciplinary action.

2124.45. Any physician and surgeon may communicate to the committee or panel regarding any other physician and surgeon. Such communications shall remain confidential and shall not be admissible before any hearing or before any court except that the committee or panel may begin investigation on the basis of such communication and may use such communication to develop further information. Such communication shall be admissible in a defamation action where it is alleged that communication is false and made with malice.

Upon a determination by the committee or panel that the communication is without merit, the central file shall be purged of information relating to the communication.

Article 2.4 (commencing with Section 2124.5) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 2.4. Medical Statistics

2124.5. There is hereby created under the Board of Medical Quality Assurance the Bureau of Medical Statistics. The purpose of the bureau shall be to provide the board and its divisions with statistical information necessary to carry out their functions of licensing, medical education, medical quality and discipline.

2124.6. The bureau shall conduct such research including the gathering of appropriate statistics as deemed desirable by the board and its divisions and related to their functions. The bureau shall have access to all medical or other information pertaining to the provision of health care services not privileged under law. In the gathering of such information, the bureau shall initially draw upon existing sources of pooled health data and may purchase such information or contract for the development of such data. In the event that such sources are deemed inadequate by the board or a division the bureau may require any state agency or health care provider to transmit to the bureau statistical information not privileged under law, provided that no provider shall be required to incur unreasonable expenses in the provision of such information. The bureau shall not gather or maintain statistical or other information that identifies individual patients, physicians or other health care providers, except for reports required by Article 11 (commencing with Section 800) of Chapter 1 of Division 2.

2124.7. Each insurer shall, within 30 days of such termination, furnish the bureau with the names of all health care providers in this state whose malpractice liability insurance has been terminated. Any. health facility that limits or denies a health care provider's privileges shall report such information to the bureau pursuant to Section 805. The bureau, upon the receipt of information submited pursuant to this section, shall immediately transmit a copy of such information to the named health care provider and the appropriate committee.

2124.8. The bureau shall be the repository for all reports filed with the board pursuant to Article 11 (commencing with Section 800) of Chapter 1 of Division 2.

2124.85. The bureau shall report at least annually to the Legislature on the data it has collected pursuant to this article. Such reports and any data not privileged under the law shall also concurrently be made available to the public.

2124.9. It is the intent of this article that the bureau shall serve to provide the divisions of the board with statistical information necessary to carry out their functions.

Section 2361 of the Business and Professions Code is amended to read:

2361. The Division of Medical Quality shall take action against any holder of a certificate, who is guilty of unprofessional conduct which has been brought to its attention, or whose certificate has been procured by fraud or misrepresentation or issued by mistake.

Unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision or term of this chapter.

(b) Gross negligence.

(c) Incompetence.

(d) Gross immorality.

(e) The commission of any act involving moral turpitude, dishonesty, or corruption, whether the act is committed in the course of the individual's activities as a certificate holder, or otherwise, or whether the act is a felony or a misdemeanor.

(f) Any action or conduct which would have warranted the denial of the certificate.

Section 2361.5 of the Business and Professions Code is amended to read:

2361.5. Clearly excessive prescribing or administering of drugs or treatment, use of diagnostic procedures, or use of diagnostic or treatment facilities which are detrimental to the patient, as determined by the customary practice and standards of the local community of licensees, is unprofessional conduct within the meaning of this chapter in addition to other matters defined as unprofessional conduct in this chapter.

Section 2362 of the Business and Professions Code is amended to read:

2362. The Division of Licensing shall take action against any holder of any reciprocity certificate, whose certificate, upon which his reciprocity certificate was issued, was procured by fraud or misrepresentation or issued by mistake, or who is found to be practicing contrary to the provisions of this chapter.

Section 2364 of the Business and Professions Code is amended to read:

2364. No action shall be taken against the holder of any certificate except in compliance with the provisions of Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code.

Section 2372 of the Business and Professions Code is repealed.

Section 2372 is added to the Business and Professions Code to read:

2372. The holder of a certificate whose default has been entered or who has been heard by a committee, panel, or hearing officer thereof and found guilty may:

(a) Have his certificate revoked upon order of the Division of Medical Quality upon recommendation of the committee, panel, or hearing officer thereof;

(b) Have his right to practice suspended for a period not to exceed one year upon order of the Division of Medical Quality upon recommendation of the committee, panel, or hearing officer thereof;

(c) Be placed on probation by the committee;

(d) Have such other action taken in relation to discipline as the committee, panel, or hearing officer thereof may deem proper.

Section 2372.1 is added to the Business and Professions Code, to read:

2372.1. In exercising its disciplinary authority a committee shall wherever possible take such action as is calculated to aid in the rehabilitation of a certificate holder or where due to lack of continuing education or other reasons restriction on scope of practice is indicated to order such restrictions as are indicated by the evidence. It is the intent of the Legislature that committees shall seek out those certificate holders who have demonstrated deficiencies in competency and then take such actions as are indicated, with priority given to those measures, including further education, restrictions on practice, or other means that will remove such deficiencies as are found from the evidence.

Section 2372.5 of the Business and Professions Code is amended to read:

2372.5. The authority of the Division of Medical Quality, a committee, or a hearing officer thereof to discipline the holder of a certificate by placing him on probation includes, but is not limited to, the following:

(a) Requiring the certificate holder to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the Division of Medical Quality, a committee, or a hearing officer thereof.

(b) Requiring the certificate holder to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the Division of Medical Quality, a committee, or a hearing officer thereof. If the Division of Medical Quality, a committee, or a hearing officer thereof requires the certificate holders to submit to such an examination, the committee shall receive and consider any other report of a complete diagnostic examination given by one or more physicians of the certificate holder's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the certificate holder.

Section 2436 of the Business and Professions Code is amended to read:

2436. Whenever any person has engaged or is about to engage in any acts or practices which constitute or will constitute an offense against this chapter, the superior court of any county, on application of the board or of 10 or more persons holding physician's and surgeon's or podiatrist's certificates issued under this chapter, or on application of any division of the Board of Medical Quality Assurance may issue an injunction or other appropriate order restraining such conduct. Proceedings under this section shall be governed by Chapter 3 of Title 7, Part 2, of the Code of Civil Procedure, except that no undertaking shall be required in any action commenced by the board.

Section 2454 of the Business and Professions Code is amended to read:

2454. The receipts of the initial license fees and renewal fees collected by the Board of Medical Quality

Assurance from persons licensed under this chapter shall be paid into the Contingent Fund of the Board of Medical Examiners of California which is continued in existence as the Contingent Fund of the Board of Medical Quality Assurance, and shall be used to carry out the provisions of this chapter relating to the compilation, publication, and sale of a directory.

If there is any surplus in these receipts after the expenses of issuing the directories have been paid, such surplus shall be applied solely to expenses incurred under the provisions of this chapter. No surplus in these receipts shall be deposited in or transferred to the General Fund.

Section 2456 of the Business and Professions Code is amended to read:

2456. All fees earned by the board and all fines and forfeitures of bail to which the board is entitled shall be reported at the beginning of each month, for the month preceding, to the State Controller. At the same time the entire amount of these collections shall be paid into the State Treasury and shall be credited to the contingent fund of the Board of Medical Quality Assurance.

This contingent fund shall be for the uses of the board and out of it shall be paid all salaries and all other expenses necessarily incurred in carrying into effect the provisions of this chapter. Any surplus accumulating in such contingent fund shall remain in such fund and shall not be transferred to the General Fund.

Section 2458 of the Business and Professions Code is amended to read:

2458. The amount of fees and refunds prescribed by this chapter in connection with physicians and surgeons certificates, certificates to practice podiatry, certificates to practice midwifery, and certificates of drugless practitioners is that fixed by the following schedule:

(a) The fee for each applicant for a certificate by written examinaion, unless otherwise provided in this chapter, shall be fixed annually by the board at an amount not to exceed one hundred dollars ($100) nor less than fifteen dollars ($15). If the applicant's credentials are insufficient or if he does not desire to take the examination, the sum of ten dollars ($10) shall be retained and the remainder of the fee is returnable on application.

(b) Each applicant for a certificate based upon a national board diplomate certificate, and each applicant for a reciprocity certificate, shall pay an application fee in the sum of ten dollars ($10) at the time his application is filed. If the applicant qualifies for a certificate, he shall be notified and, in addition to the initial license fee, shall pay a fee which shall be fixed annually by the board at a sum not in excess of one hundred dollars ($100) nor less than five dollars ($5) for the issuance of the certificate.

(c) Each applicant for a certificate under Article 6 shall pay an application fee in the sum of ten dollars ($10) at the time his application is filed. If the applicant qualifies for a certificate, he shall be notified and, in addition to the initial license fee, shall pay a fee which shall be fixed annually by the board at a sum not in excess of forty dollars ($40) nor less than five dollars ($5) for the issuance of the certificate.

(d) The renewal fee shall be fixed by the board at a sum not in excess of one hundred fifty dollars ($150).

(e) The delinquency fee is ten dollars ($10).

(f) The duplicate certificate fee is two dollars ($2).

(g) The endorsement fee is five dollars ($5).

(h) The fee for issuance of a duplicate certificate upon a change of name authorized by law of a person holding a certificate under this chapter shall be two dollars ($2).

(i) The initial license fee is an amount equal to the renewal fee in effect on the last regular renewal date before the date on which the license is issued, except that if the license will expire less than one year after its issuance, then the initial license fee is an amount equal to fifty percent (50%) of the renewal fee in effect on the last regular renewal date before the date on which the license is issued.

Section 2601.5 is added to the Business and Professions Code, to read:

2601.5. Notwithstanding any other provision of law, the term "board" or "Board of Medical Examiners" as used in this chapter shall mean the Division of Allied Health Professions of the Board of Medical Quality Assurance.

Section 830.3 of the Penal Code is amended to read:

830.3. (a) The Deputy Director, Assistant Directors, chiefs, assistant chiefs, special agents, and narcotics agents of the Department of Justice, and such investigators who are so designated by the Attorney General, are peace officers.

The authority of any such peace officer extends to any place in the state as to a public offense committed or which there is probable cause to believe has been committed within the state.

(b) Any inspector or investigator regularly employed and paid as such in the office of a district attorney is a peace officer.

The authority of any such peace officer extends to any place in the state:

(1) As to any public offense committed, or which there is probable cause to believe has been committed, within the county which employs him; or

(2) Where he has the prior consent of the chief of police, or person authorized by him to give such consent, if the place is within a city or of the sheriff, or

person authorized by him to give such consent, if the place is within a county; or

(3) As to any public offense committed or which there is probable cause to believe has been committed in his presence, and with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of such offense.

(c) The Director of the Department of Alcoholic Beverage Control and persons employed by such department for the enforcement of the provisions of Division 9 (commencing with Section 23000) of the Business and Professions Code are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the laws relating to alcoholic beverages, as that duty is set forth in Section 25755 of the Business and Professions Code. Any such peace officer is further authorized to enforce any penal provision of law while, in the course of his employment, he is in, on, or about any premises licensed pursuant to the Alcoholic Beverage Control Act.

(d) The Chief and investigators of the Division of Investigation of the Department of Consumer Affairs, and investigators of the Board of Medical Quality Assurance, are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code.

(e) Members of the Wildlife Protection Branch of the Department of Fish and Game deputized pursuant to Section 856 of the Fish and Game Code, deputies appointed pursuant to Section 851 of such code, and county fish and game wardens appointed pursuant to Section 875 of such code are peace officers; provided, that the primary duty of deputized members of the Wildlife Protection Branch, and the exclusive duty, except as provided in Section 8597 of the Government Code, of any other peace officer listed in this subdivision, shall be the enforcement of the provisions of the Fish and Game Code, as such duties are set forth in Sections 856, 851 and 878, respectively, of such code.

(f) The State Forester and such employees or classes of employees of the Division of Forestry of the Department of Conservation and voluntary fire wardens as are designated by him pursuant to Section 4156 of the Public Resources Code are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the law as that duty is set forth in Section 4156 of such code.

(g) Officers and employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the law as that duty is set forth in Section 1655 of such code.

(h) The secretary, chief investigator, and racetrack investigators of the California Horse Racing Board are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the provisions of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of the Penal Code. Any such peace officer is further authorized to enforce any penal provision of law while, in the course of his employment, he is in, on, or about any horseracing enclosure licensed pursuant to the Horse Racing Law.

(i) Police officers of a regional park district, appointed or employed pursuant to Section 5561 of the Public Resources Code, and officers and employees of the Department of Parks and Recreation designated by the director pursuant to Section 5008 of such code are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the law as such duties are set forth in Sections 5561 and 5008, respectively, of such code.

(j) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the law as that duty is set forth in Section 13104 of such code.

(k) Members of an arson-investigating unit, regularly employed and paid as such, of a fire protection agency of the state, of a county, city, or district, and members of a fire department of a local agency regularly paid and employed as such, are peace officers; provided, that the primary duty of arson investigators shall be the detection and apprehension of persons who have violated or who are suspected of having violated any fire law, and the exclusive duty, except as provided in Section 8597 of the Government Code, of fire department members other than arson investigators when acting as peace officers shall be the enforcement of laws relating to fire prevention and fire suppression. Notwithstanding the provisions of Section 171c, 171d, 12027, or 12031, members of fire departments other than arson investigators are not peace officers for purposes of such sections except when designated as peace officers for such purposes by local ordinance or, if the local agency is not authorized to act by ordinance, by resolution.

(l) The Chief and such inspectors of the Bureau of Food and Drug as are designated by him pursuant to subdivision (a) of Section 216 of the Health and Safety Code are peace officers; provided, that the exclusive duty of any such peace officer shall be the enforcement of the law as that duty is set forth in Section 216 of such code.

(m) Persons designated by a local agency as park rangers, and regularly employed and paid as such, are

peace officers; provided, that the primary duty of any such peace officer shall be the protection of park property and preservation of the peace therein. Notwithstanding the provisions of Section 171c, 171d, 12027, or 12031, such park rangers are not peace officers for purposes of such sections except when designated as peace officers for such purposes by local ordinance or, if the local agency is not authorized to act by ordinance, by resolution.

(n) Members of a community college police department appointed pursuant to Section 25429 of the Education Code are peace officers; provided, that the primary duty of any such peace officer shall be the enforcement of the law as prescribed in Section 25429 of the Education Code.

(o) All investigators of the Division of Labor Law Enforcement, as designated by the Labor Commissioner, are peace officers; provided, that the primary duty of any such peace officer shall be enforcement of the law as prescribed in Section 95 of the Labor Code.

(p) The authority of any peace officer listed in subdivisions (c) through (o), inclusive, extends to any place in the state; provided, that except as otherwise provided in this section, Section 830.6 of this code, or Section 8597 of the Government Code, any such peace officer shall be deemed a peace officer only for purposes of his primary duty, and shall not act as a peace officer in enforcing any other law except:

(1) When in pursuit of any offender or suspected offender; or

(2) To make arrests for crimes committed, or which there is probable cause to believe have been committed, in his presence while he is in the course of his employment; or

(3) When, while in uniform, such officer is requested, as a peace officer, to render such assistance as is appropriate under the circumstances to the person making such request, or to act upon his complaint, in the event that no peace officer otherwise authorized to act in such circumstances is apparently and immediately available and capable of rendering such assistance or taking such action.

Article 8.5 (commencing with Section 6146) is added to Chapter 4 of Division 3 of the Business and Professions Code, to read:

Article 8.5. Contingency Fee Agreements: Medical Injury Tort Claims

6146. (a) An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person's alleged professional negligence in excess of the following limits:

(1) Forty percent of the first fifty thousand dollars ($50,000) recovered.

(2) Thirty-three and one-third percent of the next fifty thousand dollars ($50,000) recovered.

(3) Twenty-five percent of the next one hundred thousand dollars ($100,000) recovered.

(4) Ten percent of any amount on which the recovery exceeds two hundred thousand dollars ($200,000).

Such limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant, or a person of unsound mind.

(b) If periodic payments are awarded to the plaintiff pursuant to Section 667.7 of the Code of Civil Procedure, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which attorneys' fees are calculated under this section.

(c) The Board of Governors of the State Bar of California shall report and make recommendations to the Legislature by July 1, 1976, on an equitable method for regulating compensation of defense counsel consistent with the policies embodied in this article regarding regulation of plaintiff's attorney's fees.

(d) For purposes of this section:

(1) "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office-overhead costs or charges shall not be deductible disbursements or costs for such purpose;

(2) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(3) "Professional negligence" is a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 43.8 of the Civil Code is amended to read:

43.8. In addition to the privilege afforded by Section 47, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against any person on account of the communication of information in the possession of such person to any hospital, hospital medical staff, professional society, medical or dental school, professional licensing board or division, committee or panel of such licensing board when such communication is intended to aid in the evaluation of the qualifications, fitness or character of a practitioner of the healing arts and does not represent as true any matter not reasonably believed to be true. The immunities afforded by this section and by Section 43.7 shall not affect the availability of any absolute privilege which may be afforded by Section 47.

Section 3333.1 is added to the Civil Code, to read:

3333.1 (a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

(b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(c) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 3333.2 of the Civil Code is added to read:

3333.2 (a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

(b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000).

(c) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 340.5 of the Code of Civil Procedure is amended to read:

340.5. In an action for injury or death against a health care provider based upon such person's alleged professional negligence, the time for the commencement of action shall be three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of legal action exceed three years unless tolled for any of the following: (1) upon proof of fraud, (2) intentional concealment, or (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. Actions by a minor shall be commenced within three years from the date of the alleged wrongful act except that actions by a minor under the full age of six years shall be commenced within three years or prior to his eighth birthday whichever provides a longer period. Such time limitation shall be

tolled for minors for any period during which parent or guardian and defendant's insurer or health care provider have committed fraud or collusion in the failure to bring an action on behalf of the injured minor for professional negligence.

For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a Health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Chapter 5 (commencing with Section 364) is added to Title 2 of Part 2 of the Code of Civil Procedure, to read:

CHAPTER 5. THE COMMENCEMENT OF ACTION BASED UPON PROFESSIONAL NEGLIGENCE

364. (a) No action based upon the health care provider's professional negligence may be commenced unless the defendant has been given at least 90 days' prior notice of the intention to commence the action.

(b) No particular form of notice is required, but it shall notify the defendant of the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered.

(c) The notice may be served in the manner prescribed in Chapter 5 (commencing with Section 1010) of Title 14 of Part 2.

(d) If the notice is served within 90 days of the expiration of the applicable statute of limitations, the time for the commencement of the action shall be extended 90 days from the service of the notice.

(e) The provisions of this section shall not be applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name, as provided in Section 474.

(f) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

365. Failure to comply with this chapter shall not invalidate any proceedings of any court of this state, nor shall it affect the jurisdiction of the court to render a judgment therein. However, failure to comply with such provisions by any attorney at law shall be grounds for professional discipline and the State Bar of California shall investigate and take appropriate action in any such cases brought to its attention.

Section 667.7 of the Code of Civil Procedure is added to read:

667.7 (a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(b) (1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such pay-

ments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to subdivision (a) shall revert to the judgment debtor.

(e) As used in this section:

(1) "Future damages" includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(2) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(3) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

(4) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(f) It is the intent of the Legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the Legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment.

Section 674.7 is added to the Code of Civil Procedure, to read:

674.7. A certified copy of any judgment or order of the superior court of this state issued pursuant to Section 667.7, when recorded with the recorder of any county, shall from such recording become a lien upon all real property of the judgment debtor, not exempt from execution, in such county, owned by him at the time, or which he may afterwards and before the lien expires, acquire, for the respective amounts and installments as they mature (but shall not become a lien for any sum or sums prior to the date they severally become due and payable) which liens shall have, to the extent herein provided and for the period of 10 years from such recording, the same force, effect and priority as the lien created by recordation of an abstract of a money judgment pursuant to Section 674.

The certificate of the judgment debtor, certified by him under penalty of perjury, that all amounts and installments which have matured under said judgment prior to the date of such certificate have been fully paid and satisfied shall, when acknowledged and recorded, be prima facie evidence of such payment and satisfaction and conclusive in favor of any person dealing in good faith and for a valuable consideration with the judgment debtor or his successors in interest.

Whenever a certified copy of any judgment or order of the superior court issued pursuant to Section 667.7 has been recorded with the recorder of any county, the expiration or satisfaction thereof made in the manner of an acknowledgment of a conveyance of real property may be recorded.

Section 1094.5 of the Code of Civil Procedure is amended to read:

1094.5. (a) Where the writ is issued for the purpose of inquiring into the validity of any final administrative order or decision made as the result of a proceeding in which by law a hearing is required to be given, evidence is required to be taken and discretion in the determination of facts is vested in the inferior tribunal, corporation, board or officer, the case shall be heard by the court sitting without a jury. All or part of the record of the proceedings before the inferior tribunal, corporation, board or officer may be filed with the petition, may be filed with respondent's points and authorities or may be ordered to be filed by the court. If the expense of preparing all or any part of the record has been borne by the prevailing party, such expense shall be taxable as costs.

(b) The inquiry in such a case shall extend to the questions whether the respondent has proceeded without, or in excess of jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion. Abuse of discretion is established if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.

(c) Where it is claimed that the findings are not supported by the evidence, in cases in which the court is authorized by law to exercise its independent judgment on the evidence, abuse of discretion is established if the court determines that the findings are not supported by the weight of the evidence; and in all other cases abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record.

(d) Where the court finds that there is relevant evidence which, in the exercise of reasonable diligence, could not have been produced or which was improperly excluded at the hearing before respondent, it may enter judgment as provided in subdivision (e) of this section remanding the case to be reconsidered in the light of such evidence; or, in cases in which the court is authorized by law to exercise its independent judgment on the evidence, the court may admit such evidence at the hearing on the writ without remanding the case.

(e) The court shall enter judgment either commanding respondent to set aside the order or decision, or denying the writ. Where the judgment commands that the order or decision be set aside, it may order the reconsideration of the case in the light of the court's opinion and judgment and may order respondent to take such further action as is specially enjoined upon it by law but the judgment shall not limit or control in any way the discretion legally vested in the respondent.

(f) Except as provided in subdivision (g), the court in which proceedings under this section are instituted may stay the operation of the administrative order or decision pending the judgment of the court or until the filing of a notice of appeal from the judgment or until the expiration of the time for filing such notice, whichever occurs first; provided, that no such stay shall be imposed or continued if the court is satisfied that it is against the public interest; provided, that the application for the stay shall be accompanied by proof of service of a copy of the application on the respondent. Service shall be made in the manner provided by Title 5 (commencing with Section 405) of Part 2 or Chapter 5 (commencing with Section 1010) of Title 14 of Part 2. If an appeal is taken from a denial of the writ, the order or decision of the agency shall not be stayed except upon the order of the court to which such appeal is taken; provided, that in cases where a stay is in effect at the time of filing the notice of appeal, such stay shall be continued by operation of law for a period of twenty (20) days from the filing of such notice. If an appeal is taken from the granting of the writ, the order or decision of the agency is stayed pending the determination of the appeal unless the court to which such appeal is taken shall otherwise order. Where any final administrative order or decision is the subject of proceedings under this section, if the petition shall have been filed while the penalty imposed is in full force and effect, the determination shall not be considered to have become moot in cases where the penalty imposed by the administrative agency has been completed or complied with during the pendency of such proceedings.

(g) The court in which proceedings under this section are instituted may stay the operation of the administrative order or decision of any licensing board respecting any person licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, except Chapter 11 (commencing with Section 4800) thereof, or licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act pending the judgment of the court, or until the filing of a notice of appeal from the judgment or until the expiration of the time for filing such notice, whichever occurs first; provided, that such stay shall not be imposed or continued unless the court is satisfied that the public interest will not suffer and the licensing board is unlikely to prevail ultimately on the merits; and provided further that the application for the stay shall be accompanied by proof of service of a copy of the application on the respondent. Service shall be made in the manner provided by Title 5 (commencing with Section 405) of Part 2 or Chapter 5 (commencing with Section 1010) of Title 14 of Part 2. If an appeal is taken from a denial of the writ, the order or decision of the agency shall not be stayed except upon the order of the court to which such appeal is taken; provided, that in cases where a stay is in effect at the time of filing the notice of appeal, such stay shall be

continued by operation of law for a period of twenty (20) days from the filing of such notice. If an appeal is taken from the granting of the writ, the order or decision of the agency is stayed pending the determination of the appeal unless the court to which such appeal is taken shall otherwise order. Where any final administrative order or decision is the subject of proceedings under this section, if the petition shall have been filed while the penalty imposed is in full force and effect, the determination shall not be considered to have become moot in cases where the penalty imposed by the administrative agency has been completed or complied with during the pendency of such proceedings.

Title 9.1 (commencing with Section 1295) is added to Part 3 of the Code of Civil Procedure, to read:

TITLE 9.1. ARBITRATION OF MEDICAL MALPRACTICE

1295. (a) Any contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract and shall be expressed in the following language: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

(b) Immediately before the signature line provided for the individual contracting for the medical services must appear the following in at least 10-point bold red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT."

(c) Once signed, such a contract governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature. Written notice of such rescission may be given by a guardian or conservator of the patient if the patient is incapacitated or a minor.

(d) Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian.

(e) Such a contract is not a contract of adhesion, nor unconscionable nor otherwise improper, where it complies with subdivisions (a), (b) and (c) of this section.

(f) Subdivision (a) (b) and (c) shall not apply to any health care service plan contract offered by an organization registered pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, which has been negotiated to contain an arbitration agreement with subscribers and enrollees under such contract.

(g) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 108.5 is added to the Insurance Code, to read:

108.5. "Medical malpractice insurance" means insurance coverage against the legal liability of the insured, and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional services by any person who holds a certificate or license issued pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, a license issued pursuant to the Osteopathic Initiative Act, or a license as a health facility pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

Section 1858.05 is added to the Insurance Code, to read:

1858.05. Whenever a written complaint and request for hearing with the commissioner has been filed pursuant to Section 1858, and the complaint concerns medical malpractice insurance, the commissioner shall within 30 days either by order deny the hearing or proceed as provided in Sections 1858.1 or 1858.2. The

complainant may petition the court for an order to compel compliance with this section.

Section 1858.15 is added to the Insurance Code, to read:

1858.15. Once commenced, an examination pursuant to Section 1858.1 shall be promptly conducted and concluded within a reasonable time. If the examination is being conducted as the result of a written complaint and request for hearing filed pursuant to Section 1858, and the complaint concerns medical malpractice insurance, the complainant may petition the court for an order to compel compliance with this section.

Section 4040 of the Insurance Code is amended to read:

4040. A mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest not exceeding either 6 percent per annum, or the maximum interest rate permitted by the Federal Reserve Bank, whichever is the higher rate, on single maturity time deposits in the amount of one hundred thousand dollars ($100,000) and over, running one year or more, which interest shall or shall not constitute a liability of the insurer as to its funds other than as such excess as stipulated in the agreement. Except as provided herein, written agreements evidencing such borrowed money shall not be issued in units of less than ten thousand dollars ($10,000). A mutual insurer authorized to transact medical malpractice insurance, as defined by Section 108.5, may issue such written agreements in units of less than ten thousand dollars ($10,000) but only to issuees who are eligible to purchase medical malpractice insurance from the insurer. No commission or promotion expense shall be paid in connection with any such loan.

Section 11587 is added to the Insurance Code, to read:

11587. (a) Any insured person who holds a certificate or license issued pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, a license issued pursuant to the Osteopathic Initiative Act, or a license as a health facility pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, who alleges to be aggrieved by any medical malpractice insurance rate adopted by an insurer licensed pursuant to Part 2 (commencing with Section 680) of Division 1 may, in writing, request of such insurer an explanation of the composition of such rate and of its application to him. If such explanation is alleged to be inadequate, insufficient, or is not provided within 30 days after making the request therefor, such person may file a simple petition for hearing with the commissioner. The commissioner shall conduct public hearings within 15 days after a petition has been filed with him to determine whether such rate is justified, according to the provisions of Chapter 9 (commencing with Section 1850) of Part 2 of Division 1.

The public hearing shall be conducted pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that any affected person, or his legal representative, shall, upon application to the commissioner at least five days prior to the hearing, be allowed to reasonably participate in the examination of the insurer. The commissioner shall determine within 45 days after such petition has been filed whether such rate is so justified. In the event the commissioner finds such rate, or some part thereof, not to be so justified, he shall inform the insurer, in detail, of the facts upon which he bases his conclusion and of the specific provisions of law upon which he relies. In addition, the commissioner shall order the insurer to either reduce the rate to the level deemed by him to be justified or cancel the policy upon 60 days notice to the insured and tender to the insured all of the then unearned premium due such insured. Such order shall be effective 15 days from the date thereof, upon which date such insurer shall mail any cancellation notice required to be given an affected insured..

(b) For the purposes of this section, two or more petitions received by the commissioner alleging grievances concerning one rate adopted by an insurer shall be considered, heard, and determined simultaneously. If additional such petitions alleging substantially similar grievances are received by the commissioner after the issuance of a determination by him upon earlier filed petitions as herein provided, such additional petitions shall be automatically subject to such determination, which fact the commissioner shall communicate in writing to the petitioner and his insurer. The commissioner shall disregard and deny any petition alleging grievances based upon any rate increase not greater than 10 percent of the annualized rate previously charged the petitioner.

(c) Prior to such public hearing the insurer shall submit to the commissioner such information as the commissioner may require to justify the rate increase. Such information shall be a public record and shall be made available upon request to any person, provided that the requesting person shall pay the reasonable cost for the reproduction of such information.

(d) The commissioner shall have the authority to subpoena all books, records, data, and persons deemed necessary to make such a finding pursuant to subdivision (a).

(e) The provisions of this section shall remain in force and effect until December 31, 1977, and on that date, this section is repealed, except that they shall continue in effect from year to year upon a finding by the insurance commissioner 30 days prior to the beginning of each year that there still exists a malpractice insurance crisis.

Section 11588 is added to the Insurance Code, to read:

11588. No insurer authorized to do business in this state and to provide professional liability insurance to persons lawfully engaged in the practice of medicine or osteopathy, health plans, and to partnerships or corporations lawfully engaged in the operation of hospitals, sanitariums, clinics, or other health care facilities, shall refuse to issue or renew insurance at rates which are not excessive or unfairly discriminatory as defined in Section 1852 to such persons, partnerships or corporations, solely on the grounds that such persons, partnerships or corporations have entered, or intend to enter, into valid written agreements with patients or prospective patients for the arbitration of cases or controversies arising out of the professional or business relationships between such persons, partnerships or corporations and said patients.

SEC. 28 AB1xx. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

SEC. 29. No appropriation is made by this act, nor is any obligation created thereby under Section 2231 of the Revenue and Taxation Code, for the reimbursement of any local agency for any costs that may be incurred by it in carrying on any program or performing any service required to be carried on or performed by it by this act.

JOINT UNDERWRITING ASSOCIATION

Senate Bill No. 491
CHAPTER 93

An act to add Chapter 5 (commencing with Section 11890) of Part 3 of Division 2 of the Insurance Code, relating to insurance, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor May 23, 1975. Filed with Secretary of State May 23, 1975.]

SB 491, Behr. Insurance: medical malpractice.

AND

Senate Bill No. 24xx
CHAPTER 2xx

An act to amend Sections 160, 800, 804, 2100.6, 2101, 2116, 2123.1, 2123.2, 2123.3, 2123.9, 2123.10, 2124, 2124.2, 2124.45, 2124.7, 2372, 2372.5, 2454, 2456, 2458, and 6146 of, and to add Sections 2101.7 and 2601.5 to, the Business and Professions Code, to amend Sections 3333.1 and 3333.2 of the Civil Code, to amend Sections 340.5, 364, 667.7, and 1295 of the Code of Civil Procedure, to amend Sections 4040, 11588, 11890, 11895, 11896, 11897, 11898, 11900, 11902, 11902.2, 11903, and 11904 of, and to add Sections 108.5, 1858.05, and 1858.15 to, the Insurance Code, and to amend Section 830.3 of the Penal Code, relating to medical malpractice, and to amend Assembly Bill 1 of the 1975-76 Second Extraordinary Session, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 24, 1975. Filed with Secretary of State September 24, 1975.]

SB 24xx, Behr. Insurance: medical malpractice.

The people of the State of California do enact as follows:

SECTION 1 of SB 491. Legislative intent. The Legislature recognizes that the voluntary market for medical malpractice insurance is becoming substantially constricted in this state. The immediate cause of this potential constriction of the private insurance market for medical malpractice insurance is that traditional ratemaking methods are unable to predict accurately the ultimate costs of the claims which must be resolved, often in the far distant future. The causes, though complex, are partly attributable to the rapidly expanding concepts of tort liability as applied to medical malpractice litigation.

Despite the shortcomings in the present tort liability insurance reparations system, the unavailability of medical malpractice insurance would seriously affect the practice of medicine and therefore seriously affect the health and welfare of the citizens of this state.

To that end, the Legislature recognizes that significant changes of a procedural nature are necessary in the common law governing actions for professional negligence and declares its intent to enact such changes during the 1975-76 Regular Session. Therefore, the

purpose of this statute is to assure the availability of medical practice insurance.

Chapter 5 (commencing with Section 11890) is added to Part 3 of Division 2 of the Insurance Code, to read:

CHAPTER 5. CALIFORNIA MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION

Article 1. Definitions

11890. As used in this article:

(1) "Association" means the Joint Underwriting Association established pursuant to the provisions of this chapter.

(2) "Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any licensee.

(3) "Net direct premiums" mean gross direct premiums written on liability insurance in this state, including the liability portion of the multiperil policies and of automobile insurance policies, less return premiums and any surplus premium deposits. "Net direct premiums" shall not mean any reinsurance premiums or premiums for ocean marine insurance.

(4) "Commissioner" means the Insurance Commissioner.

(5) "Licensee" means any person licensed under the State Medical Practice Act, Dental Practice Act, Registered Nursing Practice Act as defined in Chapter 6 of the Business and Professions Code, or Chiropractic Initiative Act, and any health care facility as defined in Section 1250 of the Health and Safety Code.

(6) "Dividends" are excess policyholder funds which are not needed to pay losses or expenses and which are released to the policyholder.

Article 2. Joint Underwriting Association

11895. (a) A temporary Joint Underwriting Association is hereby created consisting of all those insurers authorized to write and engaged in writing within this state on a direct basis, liability insurance including the liability portion of multiperil policies and of automobile insurance policies but not of ocean marine insurance. Every such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact such kind of insurance in this state.

(b) The association shall be the exclusive agency through which medical malpractice insurance may be written on a primary basis for licensees in any region in this state, and shall operate on a nonprofit basis. The association may operate in any such region only upon a finding by the commissioner, after public hearing, that medical malpractice insurance is not substantially available to physicians through private insurers in any geographic region defined by him, or upon a finding by the commissioner that the premiums being charged for medical malpractice insurance in any such region are so high as to have caused or threatened to cause in the immediate future a significant unavailability of needed health care service to the residents of such region, or upon a finding by the commissioner that some insured licensees are unable to renew outstanding policies of medical malpractice insurance by virtue of an order prohibiting such renewal by an insurer and that said licensees are not reasonably able to obtain needed insurance coverage through normal channels. Thereafter, if the commissioner determines, upon application of any interested party and after public hearing, that medical malpractice insurance is available through private insurers in any such region with respect to which he has previously made such finding, the association shall thereupon cease its underwriting operations. Notwithstanding anything to the contrary contained in this code, any licensed health care facility may, but need not, include physicians as additional insureds on any liability insurance contracts held by the facility.

(c) Nothing contained in this chapter shall prohibit (1) any insurer from issuing or renewing any policy of medical malpractice insurance in this state; provided, however, that upon a determination by the commissioner, after public hearing, that substantial adverse selection within any geographical region designated by him against the association has, or will likely, result, the commissioner may issue an order to insurers operating in such region that no original policies shall thereafter be issued or that renewal policies shall be issued only if the insurer will offer such insurance to a representative sample of rating classifications, or both. Each insurer issuing or renewing policies within the region specified in such order shall submit to the commissioner, on a quarterly basis, the number of its insureds in each of its rating classifications in such region, together with such other information as the commissioner may require. Such data shall be provided in such manner and within such times as the commissioner shall establish. The commissioner shall, within 30 days after receipt thereof, make a determination as to the compliance with this subdivision by the filer. The commissioner shall be entitled to inspect at any time a list of each insurer's insureds, grouped according to their rating classifications; or (2) any insurer from issuing or renewing any policy of medical malpractice insurance to any physician and surgeon who specializes in psychiatric medicine.

(d) In order to insure compliance with subdivision

(c), the commissioner shall be entitled to inspect at any time a list of each insurer's insureds, grouped according to their rating classifications.

11896. The purpose of the association shall be to provide, for a period ending on March 1, 1978, a market for medical malpractice insurance on a self-supporting basis without subsidy from association members.

11897. The association shall, pursuant to provisions of this article and the plan of operations with respect to medical malpractice insurance, have the power on behalf of its members to do all the following, which powers may be exercised directly or by contractual delegation:

(a) Issue or cause to be issued policies of medical malpractice insurance to applicants, including incidental coverages and subject to limits as specified in the plan of operation, which shall be offered on the following basis: one hundred thousand dollars ($100,000) for each claimant under one policy, and three hundred thousand dollars ($300,000) for all claimants under one policy in any one year; or, two hundred fifty thousand dollars ($250,000) for each claimant under one policy, and seven hundred fifty thousand dollars ($750,000) for all claimants under one policy in any one year; or, five hundred thousand dollars ($500,000) for each claimant under one policy, and one million five hundred thousand dollars ($1,500,000) for all claimants under one policy in any one year; or, one million dollars ($1,000,000) for each claimant under one policy, and three million dollars ($3,000,000) for all claimants under one policy in any one year.

(b) Underwrite such insurance and adjust and pay losses with respect thereto, or appoint service companies to perform those functions.

(c) Assume reinsurance from its members.

(d) Cede reinsurance.

11898. The association shall be governed by a board of 11 directors elected annually. Seven of such directors shall be elected at a time and place designated by the commissioner from the members of the association, of which four shall be domestic insurers and three shall be foreign insurers. Four of such directors shall be licensed physicians appointed by the commissioner after consultation with the California Hospital Association, the California Medical Association, and any other representative of the health care system which the commissioner wishes to consult.

11899. Within 30 days after the effective date of this chapter, the directors of the association shall submit to the commissioner for his review a proposed plan of operation consistent with the provisions of this article. The plan of operation shall provide for economic, fair, and nondiscriminatory administration, and for the prompt and efficient provision, of medical malpractice insurance, and shall contain other provisions including, but not limited to, preliminary assessment of all members of initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers or other servicing arrangements, and procedures for determining amounts of insurance to be provided by the association.

11900. The plan of operation shall be subject to approval by the commissioner after consultation with the members of the association and other affected individuals and organizations. If the commissioner disapproves all or any part of the proposed plan of operation the directors shall, within 15 days, submit for review an appropriate revised plan of operation or a part thereof. If the directors fail to act, the commissioner shall promulgate a plan of operation or a part thereof, as the case may be. The plan of operation approved or promulgated by the commissioner shall become effective and operational upon order of the commissioner, who shall act not later than 60 days from the effective date of this chapter.

Any such plan of operation shall require the association to issue a claims-made policy covering the period from the effective date of this chapter to the date on which the association is in full operation to any person newly licensed under any of the acts specified in Section 11890, subsection (5) or any licensee who qualifies under this chapter. However, such coverage shall be subject to the underwriting standards and cancellation provisions set forth in Sections 11902.1 and 11906. Pending the approval of the operation, the association shall designate a service company or service companies to bind the association for such coverage. Such policies shall make provision for payment of dividends.

11901. Amendments to the plan of operation may be made by the directors of the association, subject to the approval of the commissioner, or shall be made at the direction of the commissioner.

11902. Except as otherwise provided in this chapter, no medical malpractice insurance policy issued by the association shall be on other than a claims-made basis, the policy form for which shall be filed with the commissioner.

11902.1. The policy may provide that the association may cancel any of its policies in the event of nonpayment of any premium assessment or other charge by mailing or delivering to the insured at the address shown in the policy written notice stating when, not less than 10 days thereafter, cancellation shall be effective.

11902.2. All policies written by the association

shall contain a provision that guarantees the insured that the association shall issue, on the written demand of any licensee to whom it has issued a claims-made policy, a rider to said policy, providing full liability coverage for any acts or omissions by said licensee which occurred during the same period covered by the association's claims-made policy, excluding liability for any claim of injury or loss made to the association during such period.

The premium for the occurrence rider shall not exceed the total amount that the insured would have paid for occurrence policies, if such occurrence policies had been issued to the insured by the association, less the total amount that the insured paid for claims-made policies issued to him by the association. However, if a majority of the board of directors concludes that the occurrence rider premium would be inadequate, the board may request the actuary panel (as provided for in Section 11903) to hold public hearing in order to determine if an assessment should be permitted. Based upon its findings, the actuary panel may recommend an assessment to the Insurance Commissioner not to exceed 10 percent of the initial net occurrence rider premium. Individual policyholders shall be able to pay for an occurrence rider on a quarterly basis for a period not to exceed two years. If the policyholder fails to make payment, the occurrence rider shall be void. Any policyholder electing to pay for the occurrence rider on a deferred payment basis may be assessed a finance charge of not to exceed 6 percent per annum on the unpaid balance. A private insurer issuing a medical malpractice insurance policy on an occurrence or claims-made basis, which replaces or commences coverage upon the expiration of a policy issued by the association, may provide liability coverage for acts or omissions by the insured which occurred during the period the association's policy was in effect, excluding liability for any claim of injury or loss made to the association during such period. The intent of this section is to permit a qualified licensee to purchase an occurrence rider from either the association, or from a private insurer.

11903. Except as provided to the contrary herein, and notwithstanding the provisions of Section 1860.2, the rates, rating plans, rating rules, rating classifications, and territories applicable to insurance written by the association, and the statistics relating thereto, shall be subject to the provisions of Chapter 9 (commencing with Section 1850) of Part 2 of Division 1, giving due consideration to the past and prospective loss and expense experience of medical malpractice insurers, trends in the frequency and severity of losses, the investment income of the association, and such other information as may be relevant. The premium rates for an occurrence policy and a claims-made policy for each year the association issues policies shall be established by the association. In determining whether the association's rates are in compliance with Chapter 9 (commencing with Section 1850) of Part 2 of Division 1, the commissioner shall consider recommendations made by a panel consisting of three actuaries. One actuary shall represent the general public, and he shall be appointed by the Insurance Commissioner. One actuary shall represent the medical profession, and he shall be appointed by the Governor from a list of names submitted by the state's professional medical societies. And one actuary shall be appointed by the association's board of directors. The panel shall conduct public rate hearings within 15 days after the submission of such rates by the association, and within 30 days after such hearings the panel shall file its rate recommendations with the commissioner. Thereafter, the panel shall conduct public hearings and make recommendations when requested by the commissioner. Any dissenting panel member may submit minority recommendations. A hearing officer shall be supplied by the Office of Administrative Hearings solely for the purpose of presiding over the hearings. All rates shall be on an actuarially sound basis, giving due consideration to the group retrospective rating plan, and shall be calculated to be self-supporting. Such rates shall be deemed not inadequate if they are so constituted that the expense and loss costs of the plan of operation are equal to or exceeded by the premium. Competition or lack thereof shall not be considered as a rating standard hereunder.

All policies issued by the association shall be subject to a nonprofit group retrospective rating plan under which the final premium for all policyholders of the association, as a group, shall be equal to administrative expenses, loss and loss adjustment expenses, and taxes, plus an allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses, and a reasonable management fee, on policyholder supplied funds. The maximum final premium for all policyholders of the association, as a group, shall be limited as provided in this chapter.

The commissioner shall make the examination provided for under Article 6 (commencing with Section 1857) of Chapter 9 of Part 2 of Division 1 as often as he deems appropriate to ensure that the group retrospective rating plan is being operated in a manner consistent with this section. If he finds that it is not being so operated, he shall issue an order to the association, specifying in what respect its operation is deficient and stating what corrective action shall be taken.

11904. The association shall certify to the commissioner the estimated amount of any deficit remaining after the termination of all underwriting activities of the association. Within 60 days after such certification the commissioner shall authorize the association to

commence recoupment of the deficit by making an equitable assessment against any persons who obtained insurance through the association. Any member of the association assessed by or contributing to it shall, upon termination of the association, recoup all such assessments from the association out of a reserve established by it for such purposes. Such reserve shall be funded by premium or assessment income derived from charges to policyholders of the association. Policyholder assessments shall be limited to the 10-percent provision as provided for in Section 11902.2.

11905. In the event that sufficient funds are not available for the sound financial operation of the association pending recoupment as provided herein all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner provided for in this chapter. Any such contributions shall not exceed 1 percent of each member's net direct premium attributable to the line of insurance the writing of which requires it to be a member of this association.

11906. Any licensee in or practicing in a county declared eligible by the commissioner under this chapter shall, on or after the effective date of the plan of operations, be entitled to apply to the association for medical malpractice insurance. Such application may be made on behalf of an applicant by a broker or agent authorized by the applicant.

If the association determines that the applicant meets the underwriting standards of the association, as prescribed in the plan of operation, the association upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical malpractice insurance.

11907. All members of the association shall participate in its writings, expenses, servicing allowances, management fees, and losses in the proportion that the net direct premium of each member (excluding that portion of a premium attributable to the operation of the association) written during the preceding calendar year bears to the aggregate net direct premium written in this state by all members of the association. Each member's participation in the association shall be determined annually on the basis of such net direct premium written during the preceding calendar year.

11908. Any applicant to the association, any person insured pursuant to this chapter, or their representatives, or any affected member, may appeal to the commissioner within 30 days after any ruling, action, or decision by or on behalf of the association, with respect to those items in the plan of operation defined by the board of directors as appealable matters. All orders of the commissioner made pursuant to this article shall be subject to judicial review.

11909. The association shall file in the office of the commissioner, annually on or before the first day of March, a statement which shall contain information with respect to its transactions, condition, operations and affairs during the preceding year. Such statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the commissioner. The commissioner may, at any time, require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the association.

11910. The commissioner shall make an examination into the affairs of the association at least annually. Such examination shall be conducted and the report thereon filed in the manner prescribed in Article 4 (commencing with Section 730) of Chapter 1 of Part 2 of Division 1.

11911. In addition to the provisions of Section 736, all reasonably necessary costs incurred by the commissioner pursuant to this chapter shall be charged to and promptly reimbursed by the association.

Article 3. Liability

11915. There shall be no liability on the part of, and no cause of action of any nature shall arise against the association or its members, the commissioner or his authorized representatives, or any other person or organization, for any statements made in good faith by them during any proceeding or concerning any matters within the scope of this chapter.

11916. The association shall not be a member of the California Insurance Guaranty Association, nor shall that association be otherwise responsible for losses sustained by the Joint Underwriting Association.

SEC. 11 SB 24xx. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting such necessity are:

There is a crisis in health care in California because of the inability of many physicians and surgeons to secure malpractice insurance which may cause many of them to leave the private practice of medicine. To help solve this problem, it is imperative that this act take effect immediately.

SEC. 14 SB 24xx. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Professional Liability Insurance

HOSPITAL POLICY

For hospitals and hospital systems

Important

This policy does not become effective unless a Declarations Page and applicable endorsements are issued to form a part of it.

The insurance provided by this policy is contained in multiple coverage sections. Some coverages are provided on a Claims Made basis. Other coverages are provided on an Occurrence basis. Where coverage is provided on a Claims Made basis, coverage is limited for only those claims resulting from medical incidents which happened on or after the applicable Retroactive Date specified on the Declarations Page and which are first reported to NORCAL while the policy is in effect.

This policy requires arbitration of disputes with NORCAL.

Please review this policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance adviser, agent or broker.

HPL - 0101 1/1/2006

WHAT TO DO IN CASE OF A CLAIM, ADMINISTRATIVE PROCEEDING OR EMPLOYMENT-RELATED CIVIL ACTION

In the event an Insured directly or indirectly becomes involved in any situation which an Insured believes may result in a Claim while covered under this policy, You should immediately report the details to the NORCAL Mutual Insurance Company Professional Claims Department.

CALIFORNIA
If You are located in Southern California

Telephone: (800) 356-5513 (toll free)
(626) 577-4300

Mailing Address: NORCAL Mutual Insurance Company
Two North Lake Avenue, Suite 500
Pasadena, CA 91101-1867

If You are located in Northern California

Telephone: (800) 416-0791 (toll free)
(415) 397-9700

Mailing Address: NORCAL Mutual Insurance Company
560 Davis Street, 2nd Floor
San Francisco, CA 94111-1902
Attn: Professional Claims Department

ALASKA
If You are located in Alaska:

Telephone: (800) 770-3414 (outside Anchorage)
(907) 563-3414 (in Anchorage)

Mailing Address: NORCAL Mutual Insurance Company
4000 Old Seward Hwy., Suite 203
Anchorage, AK 99503

RHODE ISLAND
If You are located in Rhode Island:

Telephone: (800) 230-1004 (toll free)
(401) 276-7500

Mailing Address: NORCAL Mutual Insurance Company
Fleet Center
50 Kennedy Plaza, 7th Floor
Providence, RI 02903

Please see Common Condition I., "Duties In The Event of Claim."

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NORCAL MUTUAL INSURANCE COMPANY
HOSPITAL SYSTEMS LIABILITY POLICY

THIS POLICY IS NON-ASSESSABLE

PART I POLICY INTRODUCTION

The insurance provided by this Policy is contained in multiple coverage sections. Some coverages are provided on a "claims made" basis. Other coverages are provided on an "occurrence" basis.

This Policy is provided based on the statements, representations and agreements made in an application, updated application or other written statement or communication an Insured supplies or is supplied on behalf of an Insured. In reliance upon the above information and subject to all the terms and conditions of this Policy, We agree to provide the insurance coverage described in this Policy.

Various provisions in this Policy restrict coverage. Read the entire Policy carefully to determine the rights and duties of an Insured, and what is covered and is not covered. We will not pay sums or perform acts or services unless explicitly provided for in this Policy.

The words We, Us and Our refer to NORCAL Mutual Insurance Company. Other words and phrases that are underlined have special meaning. Refer to the Definitions section for their meanings.

This Policy is not effective unless a Declarations Page and applicable endorsements are issued as part of the Policy.

IN WITNESS WHEREOF: NORCAL Mutual Insurance Company has caused this Policy to be signed by its President and Secretary at San Francisco, California.

T. Scott Diener
President & CEO

Katherine H. Crocker
Secretary

PART II COVERAGES

In consideration of the payment of premium, NORCAL Mutual Insurance Company agrees with You as follows:

COVERAGE A - Professional Liability Insurance - Claims Made

THIS INSURANCE IS PROVIDED ON A CLAIMS MADE BASIS.

A. INSURING AGREEMENTS

1. **Indemnity.** We will pay on behalf of an Insured all sums, up to the Limits of Liability shown on the Declarations Page or applicable endorsement, that an Insured shall become legally obligated to pay as Damages because of injury caused by a Medical Incident directly resulting from Professional Health Care Services or Professional Committee Activities:

   a. That takes place within the Coverage Territory; and

   b. That takes place on or after the applicable Retroactive Date and before the expiration or termination date of this Policy or applicable coverage; and

   c. That results in a Claim first made against an Insured during the Policy Period and is first reported to Us during the Policy Period.

2. **Defense.** We shall have the right and duty to defend an Insured against any Claim because of injury caused by a Medical Incident directly resulting from Professional Health Care Services or Professional Committee Activities:

   a. That takes place within the Coverage Territory; and

   b. That takes place on or after the applicable Retroactive Date and before the expiration or termination date of this Policy, and

   c. That results in a Claim first made against an Insured during the Policy Period and is first reported to Us during the Policy Period.

   We have the exclusive right, using counsel of Our choice, to investigate, negotiate and defend any Claim. Our duty to defend ends, however, when the Limits of Liability shown on the Declarations Page or applicable endorsement have been exhausted by payment of judgments and/or settlements.

   Defense Costs are payable in addition to the Limits of Liability shown on the Declarations Page or applicable endorsement for Professional Liability Insurance. We may investigate any Claim as We deem appropriate. We shall not be liable for the cost of legal services and other costs or fees incurred by an Insured without Our written consent. We shall not be liable for the cost of any legal services and other costs or fees incurred before Our written receipt of notice of Claim.

B. WHO IS INSURED

In addition to those persons or organizations included within the definition of Insured, each of the following is an Insured to the extent set forth below, subject to Common Condition Q., "Other Insurance":

1. Employees, Authorized Volunteer Workers and students while acting within the course and scope of their duties for You.

2. This Policy provides coverage for You or Your Health Care Extenders, interns, externs, residents, dentists, osteopathic or other medical doctors when such professionals are endorsed onto this Policy.

3. Any member of a duly authorized board or any committee of the Named Insured, any person communicating information to the Named Insured or its medical or professional staff for the purpose of aiding in the evaluation of Professional Health Care Services or the qualifications, professional competence, fitness or character of an applicant for membership or privileges on such medical or professional staff, but only while acting within the course and scope of their duties for You.

4. Any administrator or department head while acting within the course and scope of their administrative duties for You; however, coverage does not apply to the rendering of Professional Health Care Services.

C. EXCLUSIONS

1. **No Defense or Payment of Damages.** In addition to the Common Exclusions in PART VI of this Policy, We will neither defend nor pay Damages because of Claims that result from any of the following:

   a. Any liability from an Occurrence resulting in Property Damage.

   b. Any liability resulting from an offense resulting in Advertising Injury or Personal Injury, except that this exclusion does not apply to the rendering of, or failure to render, Professional Health Care Services.

   c. Any liability for any costs associated with an Administrative Proceeding or Employment-Related Civil Action.

   d. Any liability from the administration of Your Employee Benefits Program.

   e. Any liability arising from the use, administration or prescription of any drug, pharmaceutical or medical device disapproved or not yet approved by the United States Food and Drug Administration for treatment of human beings; however, this exclusion shall not apply to any Claim resulting from an Insured's participation in a clinical study for which We have issued prior written consent of coverage for such clinical study participation.

f. Any liability for a Medical Incident that took place while the license to practice medicine or the certification of the individual responsible for providing Professional Health Care Services or Professional Committee Activities is not in effect.

g. Any liability for a Medical Incident involving the prescription or dispensing of controlled substances that happened while the license or registration to prescribe or dispense such controlled substances issued to the individual responsible for providing Professional Health Care Services is not in effect.

h. Any liability for a Medical Incident involving You or any person for whom You are legally responsible, in the fraudulent creation, alteration or modification of the medical record of any person.

i. Any liability for a guarantee of the results of any Professional Health Care Services.

j. Any services provided by an Insured while employed by the U.S. Government or any other governmental or public entity.

2. **No Payment of Damages - Defense Only.** In addition to the Common Exclusions in PART VI of this Policy, We will not pay Damages, but will defend any Insured because of Claims that result from any of the following:

a. Any liability arising from an Insured's authorship of an article or paper relating to the technical aspects of an Insured's practice of medicine for a recognized technical or professional publication.

b. Any liability for Personal Injury resulting from an Insured's participation in Professional Committee Activities.

D. CONSENT TO SETTLE

1. We will not settle any Claim against the Named Insured under this Professional Liability Insurance without the consent of the Named Insured. The Named Insured's Authorized Representative is the person responsible for providing Us with a decision on consent for the Named Insured.

2. We will not settle any Claim against an Insured physician without his/her written consent.

3. This requirement will not void any settlement entered into without the written consent of the Insured. The requirement of the written consent can be waived in writing by an Insured and Us.

4. If We recommend settlement of a Claim, the recommendation will be based on consideration of all circumstances surrounding the Insured's potential liability. The Named Insured and/or an Insured physician agree to give careful consideration to Our recommendation. We do not, however, have a duty to recommend settlement of a Claim.

5. If We recommend settlement of a Claim and the Named Insured and/or an Insured physician disagree, then the Named Insured and/or an Insured physician or We may refer the matter to a peer review committee acceptable to both parties. The decision of such committee will be binding.

COVERAGE B – Health Care General Liability Insurance – Occurrence

THIS COVERAGE IS PROVIDED ON AN OCCURRENCE BASIS.

SECTION I – COVERGES AND EXCLUSIONS

I. BODILY INJURY, PROPERTY DAMAGE and FIRE DAMAGE LIABILITY

A. INSURING AGREEMENT

1. **Indemnity.** We will pay on behalf of an Insured all sums, up to the Limits of Liability as stated on the Declarations Page or applicable endorsement that an Insured becomes legally obligated to pay as Damages because of Bodily Injury, Property Damage or Fire Damage caused by an Occurrence if the:

   a. Bodily Injury, Property Damage or Fire Damage is caused by an Occurrence that takes place in the Coverage Territory; and

   b. Bodily Injury, Property Damage or Fire Damage occurs during the Policy Period.

2. **Defense.** We shall have the right and duty to defend an Insured against any Claim because of Bodily Injury, or Property Damage or Fire Damage caused by an Occurrence if that:

   a. Bodily Injury, Property Damage or Fire Damage takes place in the Coverage Territory, and the

   b. Bodily Injury, Property Damage or Fire Damage takes place during the Policy Period.

   We have the exclusive right, using counsel of Our choice, to investigate, negotiate and defend any Claim. Our duty to defend ends, however, when the Limits of Liability stated on the Declarations Page or applicable endorsement have been exhausted by the payment of judgments and/or settlements.

   Defense Costs are payable in addition to the Limits of Liability stated on the Declarations Page or applicable endorsement for Health Care General Liability Insurance.

   This insurance does not apply and We have no duty to defend any Insured against any Claim seeking Damages for Bodily Injury, Property Damage or Fire Damage that Manifests prior to the Effective Date of this Policy, even if the Damages continue into this Policy Period.

   We may investigate any Claim as We deem appropriate. We shall not be liable for the cost of legal services and other costs or fees incurred by any attorney selected by an Insured without Our written consent. We shall not be liable for the cost of any legal services and other costs or fees incurred before Our written receipt of notice of Claim.

B. EXCLUSIONS

No Defense or Payment of Damages. In addition to the Common Exclusions in Part VI of this

Policy, We will neither defend nor pay Damages because of Claims that result from any of the following:

1. Any liability arising from Medical Incidents or costs associated with an Administrative Proceeding or an Employment-Related Civil Action.

2. Any liability arising from Bodily Injury, Property Damage or Fire Damage expected or intended from the standpoint of the Insured. However, this exclusion does not apply to Bodily Injury resulting from the use of reasonable force to protect persons or property.

3. Any liability arising from Bodily Injury, Property Damage or Fire Damage for which any Insured may be held liable by reason of:

   a. Causing or contributing to the intoxication of any person;

   b. The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

   c. Violation of any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

4. Any liability arising from Bodily Injury, Property Damage or Fire Damage arising from the ownership, maintenance, use or entrustment to others of any aircraft, Auto or watercraft owned or operated by or rented or loaned to any Insured. Use includes operation and Loading or Unloading.

   This exclusion does not apply to:

   a. Parking an Auto on premises an Insured owns or rents, provided the Auto is not owned by or rented or loaned to an Insured;

   b. Maintenance or use of any Mobile Equipment, except Bodily Injury, Property Damage or Fire Damage arising from:

      i. The transportation of Mobile Equipment by an Auto owned or operated by or rented or loaned to any Insured; or

      ii. The use of Mobile Equipment in, or while in practice or preparation for, a pre-arranged racing, speed or demolition contest or in any stunting activity;

5. Any liability arising from Property Damage or Fire Damage to:

   a. Property an Insured owns, rents or occupies;

   b. Premises an Insured sells, gives away or abandons, if the Property Damage or Fire Damage arises out of any part of those premises;

   c. Property loaned to an Insured;

d. Personal property in an Insured's care, custody or control;

e. That particular part of real property on which an Insured, or any contractors or subcontractors working directly or indirectly on behalf of an Insured, are performing operations, if the Property Damage or Fire Damage arises out of those operations; or

f. That particular part of any property that must be restored, repaired or replaced because Your Work was incorrectly performed on it.

Paragraph (a) of this exclusion does not apply to Fire Damage.

Paragraph (b) of this exclusion does not apply if the premises are Your Work and were never occupied, rented or held for rental by an Insured.

Paragraphs (c), (d), (e) and (f) of this exclusion do not apply to liability assumed under a sidetrack agreement.

Paragraph (f) of this exclusion does not apply to Property Damage or Fire Damage included in the Products-Completed Operations Hazard.

6. Any liability arising from Property Damage or Fire Damage to Your Work arising from Your Product or any part of it.

7. Any liability arising from Property Damage or Fire Damage to Your Work arising from it or any part of it and included in the Products-Completed Operations Hazard.

This exclusion does not apply if the damaged work or the work from which the damage arises was performed on behalf of an Insured by a subcontractor.

8. Any liability arising from Property Damage or Fire Damage to Impaired Property from:

a. A defect, deficiency, inadequacy or dangerous condition in Your Product or Your Work; or

b. A delay or failure by an Insured or anyone acting on behalf of an Insured to perform a contract or agreement in accordance with its terms.

This exclusion does not apply to the loss of use of other property arising from sudden and accidental physical injury to Your Product or Your Work after it has been put to its intended use.

9. Any liability arising from Damages claimed for any loss, cost or expense incurred by an Insured or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of:

a. Your Product;

b. Your Work; or

c. Impaired Property:

if such product, work or property is withdrawn or recalled from the market or from use by any person or organization because of a known or suspected defect, deficiency, inadequacy or dangerous condition in it.

10. Any liability arising from Damages arising out of the loss of, loss of use of, damage to, corruption of, inability to access or inability to manipulate electronic data.

As used in this exclusion, electronic data means information, facts or programs stored as or on, created or used on, or transmitted to or from computer software, including systems and applications software, hard or floppy disks, CD-ROMs, tapes, drives, cells, data processing devices or any other media which are used with electronically controlled equipment.

II. PERSONAL INJURY AND ADVERTISING INJURY LIABILITY

A. INSURING AGREEMENT

1. **Indemnity.** We will pay those sums, up to the Limits of Liability as stated on the Declarations Page or applicable endorsement that an Insured becomes legally obligated to pay as Damages because of Personal Injury or Advertising Injury if that:

   a. Personal Injury is caused by an offense directly resulting from an Insured's business, excluding advertising, publishing, broadcasting or telecasting done by or for an Insured;

   b. Advertising Injury is caused by an offense committed in the course of advertising an Insured's goods, products or services:

   but only if the offense was committed in the Coverage Territory and during the Policy Period.

2. **Defense.** We shall have the right and duty to defend an Insured against any Claim because of Advertising Injury caused by an offense committed in the course of advertising an Insured's goods, products or services or Personal Injury caused by an offense directly resulting from an Insured's business that takes place:

   a. In the Coverage Territory and

   b. During the Policy Period.

   We have the exclusive right, using counsel of Our choice, to investigate, negotiate and defend any Claim. Our duty to defend ends, however, when the Limits of Liability stated on the Declarations Page or applicable endorsement have been exhausted by the payment of judgments and/or settlements.

   Defense Costs are payable in addition to the Limits of Liability stated on the Declarations Page or applicable endorsement for Health Care General Liability Insurance.

   We may investigate any Claim as We deem appropriate. We shall not be liable for the cost of legal services and other costs or fees incurred by any attorney selected by an Insured without Our written consent. We shall not be liable for the cost of any legal services and other costs or fees incurred before Our receipt of the written notice of Claim.

B. EXCLUSIONS

No Defense or Payment of Damages. In addition to the Common Exclusions in PART VI of this Policy, We will neither defend nor pay Damages because of Claims that result from any of the following:

1. Any liability for Personal Injury or Advertising Injury arising from:

a. Medical Incidents or costs associated with Administrative Proceedings or Employment-Related Civil Actions;

b. Oral or written publication of material, if done by or at the direction of the Insured with knowledge of its falsity;

c. Oral or written publication of material of which the first injurious publication or utterance of the same or similar material by or on behalf of the Insured was made before the beginning of the Policy Period;

d. The willful violation of a penal statute or ordinance committed by or with the consent of the Insured; or

e. Liability the Insured has assumed in a contract or agreement. This exclusion does not apply to liability for Damages that the Insured would have in the absence of the contract or agreement.

2. Any liability for Advertising Injury arising from:

a. Breach of contract;

b. The failure of goods, products or services to conform with advertised quality or performance;

c. The wrong description of the price of goods, products or services; or

d. An offense committed by an Insured whose business is advertising, broadcasting, publishing or telecasting.

III. MEDICAL PAYMENTS

A. INSURING AGREEMENT

1. We will pay Medical Expenses as described below for Bodily Injury caused by an Occurrence:

   a. On premises an Insured owns or rents and that are approved by Us in writing; or

   b. Resulting from an Insured's operations;

   provided that:

   i. The Occurrence takes place during the Policy Period;

   ii. The expenses are incurred and reported to Us within one year of the date of the Occurrence; and

   iii. The injured person submits to examination, at Our expense, by physicians of Our choice as often as We reasonably require.

2. We will make these payments even if an Insured is not legally required to do so. These payments will not exceed the applicable sub-limit of insurance shown on the Declarations Page or applicable endorsement.

B. EXCLUSIONS

We will not pay Medical Expenses for Bodily Injury:

1. To any Insured.

2. To a person hired to work for or on behalf of any Insured or a tenant of any Insured.

3. To a person injured on that part of premises an Insured owns or rents and that the person normally occupies.

4. To a person, whether or not an Employee of any Insured, if benefits for the Bodily Injury are payable or must be provided under a workers' compensation or disability benefits law or a similar law.

5. To a person injured while taking part in athletics.

6. Included within the Products-Completed Operations Hazard.

7. Excluded under Coverage B, Section I, Bodily Injury, Property Damage or Fire Damage Liability, in this Health Care General Liability Insurance.

SECTION IV – WHO IS INSURED

In addition to those persons or organizations included within the definition of Insured, each of the following is an Insured to the extent set forth below, subject to Common Condition Q., "Other Insurance":

1. Employees, Authorized Volunteer Workers and students while acting within the course and scope of their duties for the Named Insured. However, Employees, Authorized Volunteer Workers or students are not Insureds for:

   a. Bodily Injury or Personal Injury to an Insured or a co-Employee, Authorized Volunteer Worker or student while acting within the course and scope of their duties for an Insured;

   b. Property Damage or Fire Damage to property owned or occupied by or rented or loaned to any Employee, Authorized Volunteer Worker or student or any of an Insured's partners or members (if an Insured is a partnership or joint venture).

2. Any member of a duly authorized board or any committee of the Named Insured; any person communicating information to the Named Insured or its medical or professional staff for the purpose of aiding in the evaluation of Professional Health Care Services or the qualifications, professional competence, fitness or character of an applicant for membership or privileges on such medical or professional staff, but only while acting within the course and scope of their duties for the Named Insured.

3. Any administrator or department head while acting within the course and scope of their administrative duties for the Named Insured.

4. With respect to Mobile Equipment registered to the Named Insured under any motor vehicle registration law, any person is an Insured while driving such equipment along a public highway with permission of the Named Insured and while engaged in business on behalf of the Named Insured. Any other person or organization responsible for the conduct of such person is also an Insured, but only with respect to liability arising from the operation of the equipment, and only if no Other Insurance of any kind is available to that person or organization for this liability. However, no person or organization is an Insured with respect to:

   a. Bodily Injury to a co-Employee, Authorized Volunteer Worker or student of the person driving the equipment; or

   b. Property Damage or Fire Damage to property owned by, rented to, in the charge of or occupied by the Named Insured or the employer of any person who is an Insured under this provision.

COVERAGE C – Administration of Your Employee Benefits Program Insurance – Claims Made

THIS INSURANCE IS PROVIDED ON A CLAIMS MADE BASIS.

A. Insuring Agreement

1. **Indemnity.** We will pay on Your behalf all sums, up to the Limits of Liability as stated on the Declarations Page, that You shall become legally obligated to pay as Damages because of a Benefit Error directly resulting from the Administration of Your Employee Benefits Program:

   a. That takes place within the Coverage Territory; and

   b. That takes place on or after the Retroactive Date shown on the Declarations Page and before the expiration or termination date of this Policy; and

   c. That results in a Claim first made against You during the Policy Period and is first reported to Us during the Policy Period.

   Subject to the above provisions, Our total liability for all Claims because of a Benefit Error to which this Administration of Your Employee Benefits Program Liability Insurance applies shall not exceed the Limits of Liability stated on the Declarations Page as the Aggregate Limit during one Policy Period.

2. **Defense.** We shall have the right and duty to defend You against any Claim because of a Benefit Error directly resulting from the Administration of Your Employee Benefits Program:

   a. That takes place within the Coverage Territory; and

   b. That takes place on or after the Retroactive Date shown on the Declarations Page and before the expiration or termination date of this Policy; and

   c. That results in a Claim first made against You during the Policy Period and is first reported to Us during the Policy Period.

   We have the exclusive right, using counsel of Our choice, to investigate, negotiate and defend any Claim.

   Defense Costs are payable in addition to the Limits of Liability stated on the Declarations Page for Administration of Your Employee Benefits Program Liability Insurance.

   Our duty to defend You under this coverage ends when the Limits of Liability are exhausted by payment of Damages.

   We may investigate any Claim as We deem appropriate. We shall not be liable for the cost of legal services and other costs or fees incurred by any attorney You select without Our written consent. We shall not be liable for the cost of any legal services and other costs or fees incurred before Our written receipt of notice of Claim.

B. WHO IS INSURED

In addition to those persons or organizations included within the definition of Insured, each of the following is an Insured to the extent set forth below, subject to Common Condition Q., "Other Insurance":

1. Employees, Authorized Volunteer Workers and students, past or present, whom You authorized to administer Your Employee Benefits Program while acting within the course and scope of their duties for You.

2. Any person as a member of Your duly authorized professional boards or committees or as a person charged with the duty of executing directives of any such board or committee, but only while acting within the course and scope of their duties for You.

3. Any administrator or department head while acting within the course and scope of their administrative duties for You.

C. EXCLUSIONS

No Defense or Payment of Damages

In addition to the Common Exclusions in PART VI of this Policy, We will neither defend nor pay Damages because of Claims that result from any of the following:

1. Any liability arising from the rendering or failure to render Professional Health Care Services.

2. Any liability arising from the failure to perform under a contract by any insurer or other provider of benefits under Your Employee Benefits Program.

3. Any liability arising from the failure of any investment to perform as represented by an Insured or the investment or non-investment of funds in the Employee Benefits Program.

4. Any liability arising from the advice given by an Insured to an Employee to participate or not to participate in stock subscription plans, individual retirement accounts or salary reduction plans.

5. Any liability arising from the failure to provide benefits because they were not properly funded, or because of any insurance company's failure to comply with the terms of its policy, or, because an insurance company becomes insolvent.

6. Any liability arising from an Occurrence resulting in Property Damage or Fire Damage.

7. Any liability arising from Advertising Injury or Personal Injury.

8. Any liability arising from any dishonest, fraudulent, criminal or malicious acts or omissions by an Insured.

9. Any liability arising from the termination of any Employee Benefits Program.

10. Any liability arising from any fines, taxes or penalties imposed by law or other matters that are uninsurable under law.

11. Any liability arising from personal profit or advantage gained by an Insured without the legal right to the gain.

COVERAGE D - Physicians Administrative Defense Reimbursement Coverage

THIS INSURANCE IS PROVIDED ON A CLAIMS MADE BASIS.

PART 1 - INSURING AGREEMENTS

A. DEFENSE COST REIMBURSEMENT COVERAGE

1. Administrative Proceedings

We will reimburse the Named Insured, endorsed physician or employed licensed health care professional for attorney's fees and costs incurred in the defense of an Administrative Proceeding, up to the applicable Limits of Reimbursement as shown on the Declarations Page or applicable endorsement, if the Administrative Proceeding:

a. Arises from an act that takes place within the Coverage Territory; and

b. Arises from an act that takes place on or after the applicable Retroactive Date and before the expiration or termination date of this Policy or coverage; and

c. Is instituted against the Named Insured, endorsed physician or employed licensed health care professional during the Policy Period and is first reported to Us during the Policy Period.

An Administrative Proceeding is considered to have been instituted at the time the Named Insured, endorsed physician or employed licensed health care professional is served with a Charging Document or receives notice that an Administrative Entity may investigate their Professional Conduct.

2. Employment-Related Civil Actions

We will reimburse the Named Insured, endorsed physician or employed licensed health care professional, for attorney's fees and costs incurred in connection with an Employment-Related Civil Action up to the applicable Limits of Reimbursement as shown on the Declarations Page or applicable endorsement, if the Employment-Related Civil Action:

a. Arises from an act that takes place within the Coverage Territory; and

b. Arises from an act that takes place on or after the applicable Retroactive Date and before the expiration or termination date of this Policy or coverage; and

c. Is instituted against the Named Insured, endorsed physician or employed licensed health care professional during the Policy Period and is first reported to Us during the Policy Period.

B. PRACTICE INTERRUPTION EXPENSE REIMBURSEMENT COVERAGE

Subject to proof, We will reimburse the Named Insured, endorsed physician or employed licensed health care professional for all reasonable expenses and earnings lost, up to the applicable Limits of Reimbursement as shown on the Declarations Page or applicable endorsement, in the event they are required to attend any hearings held in connection with an Administrative Proceeding or Employment-Related Civil Action in which the Named Insured, endorsed physician or employed licensed health care professional is named.

PART 2 - CONDITIONS

In addition to the Common Conditions contained in Part V of this Policy, the following Conditions apply to this Coverage:

A. Application of Limits: The Limits of Reimbursement shown on the Declarations Page or applicable endorsement are the most We will reimburse the Named Insured, endorsed physician or employed licensed health care professional regardless of the number of:

1. Named Insureds, endorsed physicians or employed licensed health care professionals insured under this Policy;

2. Persons or entities instituting an Administrative Proceeding or Employment-Related Civil Action against the Named Insured, endorsed physician or employed licensed health care professional;

3. Administrative Proceedings or Employment-Related Civil Actions instituted against the Named Insured, endorsed physician or employed licensed health care professional.

B. Limits of Reimbursement: Our total obligation under this coverage shall not exceed the Limits of Reimbursement shown as the applicable Annual Aggregate Limit on the Declarations Page or applicable endorsement.

C. The Limits of Reimbursement are not cumulative, even if an Administrative Proceeding or Employment-Related Civil Action resulting from related acts spans more than one Policy Period.

D. Multiple Administrative Proceedings or Employment-Related Civil Actions:

1. All Administrative Proceedings or Employment-Related Civil Actions arising from:

   a. The same act, or,

   b. A series of similar or related acts, or,

   c. Audits or reviews of billing or coding practices,

regardless of the number of patients involved or procedures reviewed, shall be treated as a single Administrative Proceeding or Employment-Related Civil Action and deemed reported on the date the first Administrative Proceeding or Employment-Related Civil Action is reported to Us.

2. The only Policy that shall apply to the Administrative Proceedings or Employment-Related Civil Actions is the Policy in force on the date the first Administrative Proceeding or Employment-Related Civil Action is reported to Us.

E. Notice of Administrative Proceeding or Employment-Related Civil Action: The Named Insured, endorsed physician or employed licensed health care professional shall, as soon as practicable, advise Us of the receipt of formal notice of the institution of any Administrative Proceeding or Employment-Related Civil Action.

F. Right to Settle: Nothing in Coverage D shall be construed to deny or otherwise limit the right to effect a settlement of an Administrative Proceeding or Employment-Related Civil Action.

G. Selection of Attorneys: The Named Insured, endorsed physician or employed licensed health care professional shall select attorneys as he/she deems appropriate. We have no right or obligation to select any attorney. Our only responsibility is to reimburse the Named Insured, endorsed physician or employed licensed health care professional for those attorney's fees and costs up to the Limits of Reimbursement shown on the Declarations Page or any applicable endorsement.

PART 3 – EXCLUSIONS

This Coverage is not available for:

A. Any Claims arising from Medical Incidents or Occurrences.

B. Any fees or costs incurred in an action against the Named Insured, endorsed physician or employed licensed health care provider, except for:

1. An action brought by an Administrative Entity seeking injunctive relief;

2. Employment-Related Civil Actions.

C. Any legal action initiated by the Named Insured, endorsed physician or employed licensed health care professional except with Our prior written consent.

D. Any matter involving the initial application for licensure, medical staff membership or clinical privileges, or initial application for participation as a provider under any managed care contract or participation as a provider under any Healthcare Benefit Program.

E. Any matter involving the membership in any professional society or other professional organization or involving the certification by any specialty or subspecialty practice board or college of medical practice.

F. Medical, psychiatric or psychological treatment an endorsed physician or employed licensed health care professional undergoes as required by any physician impairment committee or like body, or any educational or training program, whether or not such treatment or program is requested or mandated by an Administrative Entity.

G. Implementation of any compliance program or any policies, procedures or practices relating to participation as a provider of medical services to a managed care organization or under any Healthcare Benefit Program, whether initiated voluntarily or pursuant to direction by, order of, or in settlement with an Administrative Entity.

H. A demand or order by any agency responsible for regulating disability benefits, unemployment compensation, workers' compensation or any similar law.

I. Any action under the Employee Retirement Income Security Act of 1974 or any amendments thereto, or any similar provisions of any federal, state or local law.

J. Any action under the Occupational Safety Act of 1970 or any amendments thereto, or any similar provisions of any federal, state or local law.

K. Any action under the Worker's Adjustment and Retraining Notification Act and any amendments thereto, or any similar provisions of any federal, state or local law.

L. Any action by any agency responsible for enforcing securities law, Blue Sky laws or any laws relating to securities transactions or fair trade practices.

M. Any action relating to loss of wages, fees or other loss of income, except as provided by Coverage D, Part 1 B, Practice Interruption Expense Reimbursement Coverage.

N. The violation of any lawful order from an Administrative Entity.

PART 4 - DEFINITIONS

There are defined terms that are used throughout this Coverage Part. They are underlined and are defined in this section. When used in this Coverage Part (including endorsements forming a part thereof):

A. **Administrative Proceeding** means a proceeding instituted by:

1. A governmental body responsible for licensure, regulation and professional discipline of physicians and other health care providers.

2. A hospital or other healthcare facility regarding suspension, revocation, limitation of or other corrective action against an endorsed physician or employed licensed health care professional's medical staff membership or action against the medical staff membership or clinical privileges as governed by applicable medical staff by-laws, rules and regulations.

3. A managed care organization regarding the suspension, termination or other limitation of the Named Insured, endorsed physician or employed licensed health care professional's participation as a provider of medical services to patients.

4. Any entity responsible for enforcing compliance with statutes relating to the receipt of payment under any Healthcare Benefit Program.

5. Any governmental entity responsible for investigation and enforcement of statutes and regulations relating to workplace and employment practices.

An appeal from a final disposition of an Administrative Proceeding shall be considered part of the Administrative Proceeding.

B. **Administrative Entity** means any entity empowered to:

1. Conduct an Administrative Proceeding against the Named Insured, endorsed physician or employed licensed health care professional regarding licensure status, clinical privileges, medical staff membership, and status as a provider under any managed care contract or participation as a provider of services to any Healthcare Benefit Program.

2. Investigate and regulate compliance with statutes and regulations relating to workplace and employment practices.

C. **Charging Document** means the formal written notice issued by a state licensing board, hospital credentialing body, managed care organization, entity responsible for enforcement of compliance with statutes or regulations relating to receipt of payment under any Healthcare Benefit Program or governmental entity responsible for enforcing compliance with statutes and regulations relating to workplace and employment practices, setting forth the pending allegations or charges against the Named Insured, endorsed physician or other employed licensed health care provider.

D. **Employment Related Civil Action** means a civil legal action naming the Named Insured, endorsed physician or employed licensed health care professional as a defendant that is based on alleged acts or omissions relating to their conduct as an employer or supervisor.

E. **Healthcare Benefit Program** means any public or private plan or contract under which any medical benefit, item or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract.

F. **Professional Conduct** means any activity engaged in by the Named Insured, endorsed physician or employed licensed health care professional relating to their provision of medical services, or to their conduct as an employer or supervisor in connection with their medical practice.

PART III ADDITIONAL BENEFITS

The following benefits are in addition to the Limits of Liability shown on the Declarations Page. These benefits end when We have exhausted the applicable Limits of Liability.

Coverage under this section is contingent upon compliance with all other sections of this Policy.

A. **Attendance At Trial.** We will pay, with respect to any Claim We defend, all reasonable expenses incurred by an Insured at Our request to assist Us in the investigation or defense of the Claim. We will also pay an Insured's actual loss of earnings up to $500 per half day, subject to proof and Our prior approval, because of time off from work, while attending a trial in connection with such Claim at Our request.

B. **Bonds.** We will pay, with respect to any Claim We defend:

1. The cost of bonds to release attachments, but only for bond amounts within the applicable Limits of Liability.

2. Premiums on appeal bonds if We decide to appeal a legal judgment against an Insured, but only to the extent of a bond premium for that portion of a judgment that does not exceed the applicable Limits of Liability. The decision to appeal at Our expense is solely Ours. In the event We decide not to appeal, You may do so at Your own expense.

3. We will pay the premiums on bonds to release attachments in a suit defended by Us for an amount that does not exceed the applicable Limits of Liability.

   We do not have to apply for or furnish these bonds.

C. **Defense Costs.** We have the right and duty to defend any Claim that is covered by Coverages A, B and/or C of this Policy. In addition to the Limits of Liability for Coverages A, B and C We will pay Defense Costs and will:

1. Pay prejudgment and post-judgment interest only on that part of any judgment We pay. We will not pay any prejudgment interest that accrues after We offer to pay the Limits of Liability that apply. We will not pay any post-judgment interest that accrues after We pay or offer to pay Our share of the judgment;

2. Pay any costs taxed against the Insured in any such Claim.

D. **Patients' Property**

1. We will pay up to $2,500 per patient subject to a maximum of $25,000 per Policy Period, for loss or damage to patients' property while in the care of an Insured.

PART IV DEFINITIONS

There are defined terms used throughout this Policy. They are underlined and are defined in this section. When used in this Policy (including endorsements forming a part thereof):

A. **Administration** means the following acts:

1. Describing the Employee Benefits Programs to Employees or beneficiaries;

2. Interpreting the terms and conditions of the Employee Benefits Programs;

3. Handling of records and processing of benefits in connection with the Employee Benefits Programs; or

4. Enrolling Employees or their beneficiaries in the Employee Benefits Programs, or terminating or canceling their enrollment.

B. **Advertising Injury** means injury arising from one or more of the following offenses:

1. Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;

2. Oral or written publication of material that violates a person's right of privacy;

3. Misappropriation of advertising ideas or style of doing business; or

4. Infringement of copyright, title, service mark, trade name or slogan.

C. **Asbestos** means Asbestos and any other allied compound, substance or product or fibers thereof that is used as a non-combustible, non-conducting or chemically resistant material.

D. **Authorized Representative** means:

1. The person designated in the application, updated application or any other written statements or communications the Named Insured supplies;

2. The person responsible for providing consent decisions on behalf of the Named Insured; and

3. The person who will act on behalf of the Named Insured or other Insureds for all other purposes relating to this Policy.

E. **Authorized Volunteer Worker** means any approved person, group or organization, including an auxiliary, while acting within the course and scope of their duties for the Named Insured and who is not compensated for their services or labor.

F. **Auto** means a land motor vehicle, trailer or semi-trailer licensed for travel on public roads, including any attached machinery or equipment. Auto does not include Mobile Equipment.

G. **Benefit Error** means any negligent act, error or omission in the Administration of Your Employee Benefit Programs.

H. **Bodily Injury** means physical injury, sickness or disease sustained by a person. This includes mental anguish, mental injury, shock, fright or death resulting from physical injury, sickness or disease. Bodily Injury also includes loss of care or services that results from the above.

I. **Claim** means:

1. Actual Claim:
   Written notice or demand for Damages that an Insured has received regarding a Medical Incident, Occurrence, offense or Benefit Error; or

2. Potential Claim;
   Any Medical Incident, Occurrence, offense or Benefit Error that may result in an actual Claim.

An event reported by an Insured to Us as part of risk management or loss control services shall not be considered a report of a Claim.

J. **Coverage Territory** means:

1. Any state We have approved in writing, or

2. Anywhere in the world if the injury or damage arises from goods or products made or sold by You in the Coverage Territory described in 1 above.

K. **Damages** means all sums that an Insured becomes legally obligated to pay by reason of the liability imposed upon an Insured by law because of injury or damage to which this Policy applies, except those sums resulting from:

1. The multiplication of compensatory Damages by statute or regulation;

2. The assessment of fines, penalties, sanctions or fees;

3. Restitution, return or disgorgement of fees or profits, charges for products or services rendered, capitation payments, premiums or any other funds allegedly wrongfully held or obtained;

4. Non-monetary relief or redress in any form other than monetary compensation or monetary Damages, including without limitation, the cost of complying with any injunctive, declaratory or administrative relief;

5. Matters that are uninsurable under applicable law;

6. Defense Costs;

7. Punitive or exemplary Damages; or

8. Interest.

L. **Defense Costs** means the reasonable fees of attorneys, experts and consultants' costs and expenses incurred in the investigation, adjustment, defense and/or appeal of a Claim with Our approval or direction; provided that Defense Costs shall not include: remuneration, salaries, overhead, fees, loss of earning reimbursement or benefit expenses of any Insured.

M. **Discrimination** means the unlawful treatment of individuals based on race, color, ethnic origin, ancestry, gender, sexual orientation, age, religion, pregnancy, physical or mental disability, marital status or other status that is protected under any applicable federal, state or local statute or ordinance.

N. **Employee Benefits Program** means the following:

1. Group plans for life, health, dental, eye care, disability, automobile, homeowners and legal advice insurance;
2. Pension, retirement and profit sharing plans;
3. Individual Retirement Account (IRA) plans;
4. Salary reduction plans under Internal Revenue Code 401(k) or amendments;
5. Employee stock subscription plans;
6. Savings plans;
7. Social Security system benefits;
8. Workers' compensation and unemployment insurance;
9. Employee assistance programs;
10. Travel and vacation plans;
11. Educational tuition reimbursement plans; and
12. Section 125 Health Reimbursement and Dependent Care Plans.

O. **Employee** means a person on the Named Insured's payroll, whose service or labor is provided on behalf of the Named Insured, who is supervised by an Insured and who is subject to the withholding of taxes. Independent contractors are not Employees.

P. **Employment Practices** includes, but is not limited to, any of the following:

1. Breach of any employment contract;
2. Failure or refusal to hire or employ;

3. Dismissal, discharge, reduction in force, downsizing or termination of employment, whether actual or constructive;

4. Demotion, reassignment, failure or refusal to promote, or deprivation of career opportunity;

5. Discipline and evaluation of Employees;

6. Discrimination, defamation or harassment of any kind affecting any present or former Employee or applicant for employment;

7. Retaliatory treatment against an Employee arising from the Employee's attempted or actual exercise of the Employee's rights under the law;

8. Employment-related misrepresentation;

9. Failure to implement appropriate workplace or employment policies or procedures.

Q. **Fire Damage** means Property Damage because of fire to premises You rent or lease from others. Water damage and smoke damage from a fire are also included. The damage from the fire must be caused by You or any Insured.

R. **Fungi** means any type or form of fungus, including mold or mildew and any mycotoxins, spores, scents or byproducts produced or released by Fungi.

S. **Health Care Extender** means a certified registered nurse anesthetist, nurse midwife, nurse perfusionist, nurse practitioner, physician assistant, preceptee or a podiatrist.

T. **Impaired Property** means tangible property, other than Your Product or Your Work, that cannot be used or is less useful because:

1. It incorporates Your Product or Your Work that is known or thought to be defective, deficient, inadequate or dangerous; or

2. You have failed to fulfill the terms of a contract or agreement.

U. **Insured** means each of the following to the extent set forth below and any person or organization qualifying as an Insured under the Who Is Insured sections for the applicable coverages:

1. The Named Insured;

2. If the Named Insured is a partnership, joint venture, or limited liability partnership or corporation, that partnership, joint venture or limited liability partnership or corporation and any partner or member thereof is an Insured, but only for the liability as such. No person or organization is an Insured with respect to the conduct of any current or past partnership, joint venture, or limited liability partnership or corporation that is not set forth in this Policy as a Named Insured;

3. Any executive officer, stockholder, or member of the board of trustees, directors or governors of the Named Insured while acting within the scope of their duties as such, except with respect to the ownership, maintenance, use, Loading or Unloading, or existence of Auto, aircraft or watercraft; or

4. Any organization You newly acquire or form, other than a partnership or joint venture, and in which You maintain ownership or majority interest, and for which a premium has been assessed and paid to Us.

V. **Insured Contract** means:

1. Any written:

   a. Lease of premises;

   b. Obligation, as required by ordinance, to indemnify a municipality, except in connection with work for the municipality;

   c. Elevator maintenance agreement; or

   d. Contract or agreement pertaining to the Named Insured's business (including indemnification of a municipality in connection with work or services performed for a municipality) under which an Insured assumes the tort liability of another to pay for Bodily Injury, Property Damage or Fire Damage to a third party or organization, but only for an Insured's acts or omissions and not the acts or omissions of any third party or organization. Such injury or damage must occur on or after the date the Insured Contract was executed. Tort liability means liability imposed by law in the absence of any contract or agreement.

2. An Insured Contract does not include that part of any contract or agreement:

   a. That indemnifies an architect, engineer building contractor or surveyor for injury or damage arising from:

      i. Preparing, approving or failing to prepare or approve maps, drawings, opinions, reports, surveys, change orders, designs or specifications; or

      ii. Giving directions or instructions, or failing to give them, if that is the primary cause of the injury or damage;

   b. That indemnifies any person or organization for Property Damage or Fire Damage because of a fire unless the Named Insured is held legally liable;

   c. That indemnifies any person or organization for Bodily Injury, Property Damage or Fire Damage arising from construction or demolition operations within 50 feet of any railroad property and affecting any railroad bridge or trestle, tracks, roadbeds, tunnel, underpass or crossing.

W. **Loading or Unloading** means the handling of property:

1. After it is moved from the place where it is accepted for movement into or onto an aircraft, watercraft or Auto;

2. While it is in or on an aircraft, watercraft or Auto; or

3. While it is being moved from an aircraft, watercraft or Auto to the place where it is finally delivered; but Loading or Unloading does not include the movement of property by means of mechanical device, other than a hand truck that is not attached to the aircraft, watercraft or Auto.

X. **Manifests** means:

1. For Bodily Injury when such injury, sickness or disease is first diagnosed by a medical professional; and

2. For Property Damage or Fire Damage when such damage is first discovered by any Insured or by the person or organization whose property suffered such damage, whichever comes first.

Y. **Medical Expenses** means all reasonable and necessary fees for Professional Health Care Services, including the following:

1. First aid at the time of an accident;

2. Medical and surgical services, laboratory tests, dental and prosthetic devices;

3. Ambulance, hospital, professional nursing; or

4. Funeral services.

Z. **Medical Incident** means any act or omission or series of related acts or omissions in the rendering of or failure to render Professional Health Care Services or Professional Committee Activities.

AA. **Mobile Equipment** means any of the following types of land vehicles, including any attached machinery, apparatus, or equipment:

1. Vehicles maintained for use solely on or next to premises You own or rent;

2. Vehicles that travel on crawler treads;

3. Vehicles not described in paragraphs 1 or 2 above that are not self-propelled and are maintained primarily to provide mobility to permanently attached equipment of the following types:

   a. Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting, and well servicing equipment; or

b. Cherry pickers and similar devices used to raise or lower workers;

4. Vehicles that are not described in paragraphs 1 or 2 above maintained primarily for purposes other than the transportation of persons or cargo.

However, self-propelled vehicles with the following types of permanently attached equipment are not Mobile Equipment but will be considered Autos:

a. Equipment designed primarily for:

i. Road maintenance, but not construction or resurfacing; or

ii. Street cleaning;

b. Cherry pickers and similar devices mounted on Auto or truck chassis and used to raise or lower workers; or

c. Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting and well servicing equipment.

AB. **Named Insured** means the organization named on the Declarations Page of this Policy as Named Insured, also identified hereinafter as You and Your.

AC. **Occurrence** means an accident, including continuous or repeated exposure to substantially the same conditions, resulting in Bodily Injury, Property Damage or Fire Damage neither expected nor intended from the standpoint of an Insured. Occurrence includes any intentional act by or at the direction of an Insured that results in Bodily Injury if such injury arises solely from the use of reasonable force for the purpose of protecting persons or property. The date of the Occurrence is the date of the first circumstance regardless of when the Bodily Injury, Property Damage or Fire Damage Manifests itself or is discovered.

AD. **Other Insurance** includes, but is not limited to, coverage or benefits provided by self-insurance arrangements, pools, self-insurance trusts, captive insurance companies, mutual insurance companies, stock insurance companies, risk retention groups, reciprocal exchanges, mutual benefit or assistance programs, or any other plan or agreement of risk assumption, or any other source of indemnification.

AE. **Personal Injury** means injury, other than Bodily Injury, arising from one or more of the following offenses:

1. False arrest, detention or imprisonment;

2. Malicious prosecution;

3. Assault and/or battery;

4. Interference with an advantageous or contractual relationship;

5. Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services; or

6. Oral or written publication of material that violates a person's right of privacy.

AF. **Policy Period** means the period of time indicated on the policy Declarations Page from the Effective Date to the Expiration Date, or the earlier termination of the policy, if any, in accordance with Common Condition F., "Cancellation." All dates shown are 12:01 a.m. Your Local time.

AG. **Pollutant** means any solid, liquid, gaseous, nuclear or thermal irritant or contaminant, including but not limited to, smoke, vapor, soot, fumes, acids, alkalis, chemicals, lead and other waste material or irritants. Waste includes, but is not limited to, spent fuel and byproducts, medical waste and any material to be recycled, reconditioned or reclaimed.

AH. **Pollution Incident** means emission, discharge, release or escape of Pollutants into or upon land, the atmosphere, or any watercourse or body of water. The entirety of such emission, discharge, release or escape shall be deemed one Pollution Incident.

AI. **Products-Completed Operations Hazard**

1. Includes all Bodily Injury, Property Damage and Fire Damage occurring away from premises You own or rent and arising from Your Product or Your Work except:

   a. Products that are still in Your physical possession; or

   b. Work that has not yet been completed or abandoned.

2. Your Work will be deemed completed at the earliest of the following times:

   a. When all of the work called for in Your contract has been completed.

   b. When all of the work to be done at the site has been completed if Your contract calls for work at more than one site.

   c. When the part of the work done at a job site has been put to its intended use by any person or organization other than another contractor or subcontractor working on the same project.

   Work that may need service, maintenance, correction, repair or replacement, but which is otherwise complete, will be treated as completed.

3. This hazard does not include Bodily Injury, Property Damage or Fire Damage arising from:

   a. The transportation of property, unless the injury or damage arises out of a condition in or on a vehicle created by the Loading or Unloading of it;

   b. The existence of tools, uninstalled equipment or abandoned or unused materials.

AJ. **Professional Committee Activities** means:

1. An Insured's duties as a member of a health care facility staff committee that conducts credentialing, quality assurance, peer review or medical ethics review, provided such facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or similarly constituted organization;

2. An Insured's duties as a member of a committee of the American Medical Association or an Insured's state or county medical association or medical specialty society that conducts credentialing, quality assurance, peer review or medical ethics review; or

3. An Insured's duties as a member of the Named Insured's duly authorized committee that conducts credentialing, quality assurance, peer review, utilization review or medical ethics review on behalf of the Named Insured.

AK. **Professional Health Care Services** means those health care or medical services an Insured provides including, but not limited to:

1. Direct medical, surgical, dental or nursing treatment, including the furnishing of food or beverages in connection therewith;

2. Making medical diagnoses and rendering medical opinions and/or medical advice;

3. Furnishing or dispensing of drugs or medical, dental or surgical supplies or appliances; or

4. The handling, treatment or performing of postmortem examinations on deceased human bodies, including autopsies, organ donation or other procedures.

AL. **Property Damage** means:

1. Physical injury to or destruction of tangible property that occurs within the Coverage Territory, including all resulting loss of use of that property occurring at any time. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or

2. Loss of use of tangible property that is not physically injured or destroyed provided such loss of use is caused by an Occurrence within the Coverage Territory. All such loss of use shall be deemed to occur at the time of the Occurrence that caused it.

AM. **Retroactive Date** as set forth in Item 3 of the Declarations Page, or applicable endorsement, is the earliest date on which a Medical Incident, Benefit Error, Administrative Proceeding or Employment-Related Civil Action may occur and for which coverage may be afforded under this Policy.

AN. **Sexual Misconduct** means physical or mental assault, harassment or contact of a sexual nature.

AO. **We, Us, and Our** refer to NORCAL Mutual Insurance Company, identified hereinafter as NORCAL.

AP. **You and Your** refer to the Named Insured shown on the Declarations Page.

AQ. **Your Product** means:

1. Any goods or products, other than real property, manufactured, sold, handled, distributed or disposed of by:

   a. You;

   b. Others trading under Your name; or

   c. A person or organization whose business or assets You have acquired if the Occurrence takes place after the date of acquisition.

2. Containers (other than vehicles), material, parts or equipment furnished in connection with such goods or products.

3. Your Product includes warranties or representations made at any time with respect to the fitness, quality, durability or performance of:

   a. Your Product; and

   b. The providing of or the failure to provide warnings or instructions.

4. Your Product does not include vending machines or other property rented to or located for the use of others but not sold.

AR. **Your Work** means:

1. Work or operation performed by You on Your behalf.

2. Materials, parts or equipment furnished in connection with such work or operations.

3. Your Work includes:

   a. Warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of Your Work; and

   b. The providing of or failure to provide warnings or instructions.

PART V COMMON CONDITIONS

The following Conditions apply to the entire policy.

A. **Application Form.**

The completed and signed Application Form, and any materials submitted as part of the application, are the basis for the issuance of the Policy. By signing the Application Form and any materials submitted as part of the Application, the person who signs warrants that the particulars and statements contained in the Application are truthful. The Application and any materials submitted as part of the Named Insured's Application shall be retained and deemed attached to and made part of the Policy.

B. **Application of Limits of Liability.**

1. Application of Limits of Liability – General. Subject to Common Condition N, Multiple Claims Arising from the Same Circumstances":

   a. The Each Claim Limit shown on the Declarations Page or applicable endorsement is the most We will pay for all Damages arising from a Medical Incident, Benefit Error, Occurrence or offense regardless of the number of:

      i. Insureds under the policy;

      ii. Persons or organizations sustaining Damages;

      iii. Claims; or

      iv. Coverage parts attached hereto.

   b. Subject to the above provision, Our total liability for all Claims because of all injury to which this Policy applies shall not exceed the Limits of Liability shown on the Declarations Page or applicable endorsement as the Aggregate Limit per Policy Period.

   c. It is further agreed that in no event shall We be liable for any additional payments, including Defense Costs, under this Policy once the applicable Limits of Liability shown on the Declarations Page or applicable endorsement have been exhausted by payments of judgments or settlements.

2. Application of Limits of Liability – Each Policy Period.

   The applicable Limit of Liability applies separately to each consecutive annual Policy Period or to any Policy Period of less than twelve months. If We extend the Policy Period after issuance for an additional period of less than twelve months, the additional period will be deemed part of the last preceding period for purposes of determining the Limits of Liability.

3. Application of Limits of Liability – Claim Covered Under Two or More Insuring Agreements of this Policy.

If a Claim is covered under more than one Insuring Agreement provided by this Policy, only one Limit of Liability shall apply. The Limit of Liability applying to that Claim shall not exceed the highest applicable limit available under any one Insuring Agreement that applies.

4. Application of Limits of Liability – An Insured Covered Under More Than One Policy Issued by Us.

   If this Policy and any other policy issued by Us apply to the same Insured, only one such policy shall apply. The Limits of Liability available to that Insured shall not exceed the highest applicable Limits of Liability available under any one policy that applies. However, this paragraph does not apply to any policy issued specifically to apply as excess insurance above this Policy.

5. Application of Limits of Liability – New Limits.

   If You change the Limits of Liability provided by this Policy, the new Limits of Liability do not apply to any Claim that an Insured knew or should have known about or was reported to Us prior to the Effective Date of the Limits of Liability change.

C. **Arbitration of Disputes with Us.** Any dispute arising from this Policy will be submitted to and resolved by binding arbitration at a mutually agreed upon location. Arbitrators shall follow the law of the state in which the Named Insured is principally domiciled. Arbitration will be conducted in accordance with the following rules:

   1. Unless barred by the statute of limitations, an Insured or We may initiate arbitration by serving all parties with notice of the nature of the claim and demand for arbitration. A claim will be waived and forever barred if on the date of the demand for arbitration the claim would be barred by the applicable statute of limitations in a civil action.

   2. Within 30 days after initial service of the demand for arbitration, an Insured and We must each designate an arbitrator and give written notice of this arbitrator to the other. Within 30 days after these notices have been received, the two arbitrators will select a neutral arbitrator and give notice of the arbitrator to the Insured and Us.

   3. The parties will be entitled to conduct discovery as permitted by the laws of the state in which the Named Insured is principally domiciled. All discovery disputes will be brought before, and solely resolved by, the neutral arbitrator.

   4. Except as otherwise agreed to in writing between the parties, the arbitration will be completed within 120 days after initial service of the demand for arbitration. The arbitration will be held at a time and place designated by the neutral arbitrator. Failure by the party initiating arbitration to make a good faith effort to complete arbitration within 120 days of the issuance of the demand for arbitration will be deemed a waiver of any and all Claims for declaratory relief or Damages asserted on behalf of the party initiating arbitration.

   5. Each party will pay the fees of the arbitrator that party has selected. We will pay for the expense and fees of the neutral arbitrator, as well as the expenses of arbitration approved

by the neutral arbitrator, not including attorney's fees or witness fees or other expenses incurred by a party for that party's own benefit.

6. Either party has the right to separately arbitrate issues of liability and Damages upon written request to the neutral arbitrator.

7. All Claims based upon the same incident, transaction or related circumstances will be arbitrated in one proceeding.

8. Any arbitration decision given pursuant to these rules will be final, subject only to confirmation, correction or vacation under the law of the state in which the Named Insured is principally domiciled.

9. All notices or other written materials required to be served in the conduct of the arbitration proceedings following the initial service of the demand must be served in an appropriate manner to ensure delivery within two (2) days after service.

10. The parties will make every effort to maintain the confidentiality of information and evidence developed in arbitration.

D. **Assignment.** Assignment of an Insured's interest under this Policy shall not bind Us unless Our consent is endorsed onto this Policy.

E. **Bankruptcy.** Bankruptcy or insolvency of an Insured or of an Insured's estate will not relieve Us of Our obligations under this Policy, nor does bankruptcy or insolvency of an Insured or of an Insured's estate relieve an Insured of an Insured's obligations under this Policy.

F. **Cancellation.** The Named Insured may cancel this Policy at any time, by surrendering the Policy to Us or by mailing to Us a written notice stating when the cancellation shall be effective. If the cancellation occurs at any date other than the Policy Expiration Date, return premium will be computed using the customary short rate cancellation table.

We may cancel this Policy or an Insured's coverage by mailing or delivering written notice of Our intent to cancel at least:

1. Ten (10) days before the Effective Date of cancellation if We cancel for non-payment of premium or fraud.

2. Thirty (30) days before the Effective Date of cancellation if We cancel for any other reason.

If the policy or an Insured's coverage has been in effect less than sixty (60) days since the applicable Effective Date, either may be canceled at any time upon written notice.

Such written notice of Our intent to cancel shall be mailed to the last known address as shown in Our records. The mailing of this notice shall be sufficient proof of notice.

Either the requested cancellation date or the Effective Date and hour of cancellation as stated in the cancellation notice shall become the Expiration Date of the Policy Period or

coverage. Delivery of such written notice either by You or by Us shall be acceptable in place of mailing.

If We cancel, other than for non-payment of premium or fraud, earned premium shall be computed pro-rata. If We cancel for non-payment of premium or fraud, return premium may be computed using the customary short rate cancellation table. Premium adjustment, if any, may be made either at the time cancellation is effective or as soon as practicable after cancellation becomes effective. However, the cancellation will be effective even if We have not made or offered a return of premium.

G. **Changes to Policy.** Any request to change this Policy must be communicated to Us in writing by the Named Insured or Authorized Representative and received by Us. Notice to any agent or broker, or knowledge possessed by any agent or broker or by any other person, does not effect a waiver or a change in any part of this Policy or stop Us from asserting any right under the terms of this Policy. Nor shall the terms of this Policy be waived or changed, except by an endorsement issued by Us to form a part of this Policy.

If We modify the Policy by filing changes that are approved or accepted by the insurance supervisory authority of the state in which the Named Insured is principally domiciled and the changes would broaden coverage during the Policy Period, without changing the premium, this Policy will automatically receive the broader coverage.

Any endorsement that We issue modifies the coverage. Where the terms of any endorsement are inconsistent with the terms of this Policy, the terms of the endorsement shall control.

H. **Changes to Operations of the Insured.** This insurance is issued based on Your written representation of Your operations and services. You must notify Us immediately, in writing, if there are any changes from those You have previously described in Your original application, application update or other written communication, including changes in Your operations and services, in Your premises, operations or service locations, medical procedures, or administrative responsibilities or changes in the status of any Insured's licenses or certificates to operate. Coverage for Claims that result from Medical Incidents, Benefit Errors, Occurrences or offenses happening on or after the date of any of these changes is contingent upon such notification.

I. **Duties In The Event Of Claim.**

1. In the event of a Claim, the Insured must provide Us written notice as soon as practicable. The written notice must include the following information:

   a. How, when and where the Medical Incident, Benefit Error, Occurrence or offense took place;

   b. The names, addresses and ages of any claimants and witnesses, and

   c. The nature and location of any injury or damage arising from the Medical Incident, Benefit Error, Occurrence or offense.

2. All Insureds agree to submit to examination, provide information and permit Us, Our

representative or attorneys to take statements, or at Our discretion, sworn depositions, concerning any and all facts underlying each and every Claim made against an Insured by a third party and submitted to Us for defense and/or indemnification coverage under this Policy. It is further agreed that all Insureds will make every effort to maintain the confidentiality of any such statement. The Insured's provision of a sworn statement or deposition, if requested by Us, shall be a condition precedent to ongoing defense or indemnification coverage for the Claim.

3. All Insureds agree to maintain patients' medical records in accordance with the laws of the state in which the Named Insured is principally domiciled. The Insured will allow Us unfettered access to those patients' medical records as needed in the defense and investigation of a Claim.

4. All Insureds must cooperate with Us, Our representatives, and defense counsel appointed by Us, and upon Our request will assist in the investigation and management of any Claim. That cooperation includes:

   a. Immediately send Us any demands, notices, summonses or legal documents received in connection with the Claim;

   b. Authorize Us to obtain records and other information;

   c. Assist Us in the enforcement of any right against any person or organization that may be liable to an Insured because of injury or damage to which this Policy applies;

   d. Submitting to a sworn statement or deposition, whether or not a formal coverage or contractual dispute has arisen;

   e. Assist in effecting settlements;

   f. Obtain the attendance of witnesses;

   g. Attend depositions, conferences, hearings and trials;

   h. Assist in any other aspect of the investigation and defense; and

      i. If a Claim involves both covered and non-covered Claims and/or causes of action, all Insureds must agree to allow bifurcation of the hearing, arbitration or trial as to covered Claims and Damages, as well as to non-covered Claims and Damages. All Insureds additionally agree to secure a special verdict form that segregates covered Claims from non-covered Claims, as well as covered and non-covered Damages, if requested by Us.

5. All Insureds will continue to cooperate with Us in the event that We elect to appeal a verdict or continue to require assistance pursuing remedies and procedures available to an Insured or Us.

6. No Insured will, except at its own cost, voluntarily make any payment, assume any obligation or incur any expense.

J. **False and Fraudulent Reports of Claims, Administrative Proceedings or Employment-Related Civil Actions.** If any Insured reports a Claim, Administrative Proceeding or Employment-Related Civil Action knowing it to be in any way false or fraudulent, this insurance shall become null and void with respect to that Claim, Administrative Proceeding or Employment-Related Civil Action. If so, We have the right to full recovery of any payment We have already made.

K. **Inspection and Audit.** We, or Our representative, shall be permitted but not obligated to inspect Your locations and operations, books and records of any Insured during the Policy Period and within three years after the termination of this Policy. Neither Our right to make inspections nor any report thereon shall constitute an undertaking to determine or warrant that such property or operations are safe or healthful, or are in compliance with any law, rule or regulation.

L. **Legal Action Against Us.** No person or organization has a right under this Policy to join Us as a party or otherwise bring Us into a suit asking for Damages from an Insured, nor sue Us on this Policy unless all the terms of the policy have been complied with and a judgment has been rendered against an Insured. However, We will not be liable for Damages that are not payable under the terms of this Policy or that are in excess of the applicable Limit of Liability.

M. **Mergers, Acquisitions or Newly Created Entities.** If during the Policy Period the Named Insured acquires or creates another entity or subsidiary or becomes a member of a joint venture or partner in a partnership, or if the Named Insured merges or consolidates with another entity such that the Named Insured is the surviving entity (any of which events is referred to as a "Transaction" in this CONDITION M.), We shall have the option of providing coverage to such entity or subsidiary.

Coverage under this provision is afforded only until the 30th day after the Named Insured acquires or forms the organization, or the end of the Policy Period, whichever is earlier, unless specifically endorsed on the Policy.

Coverage under this provision is not afforded for liability arising from any Medical Incident, Benefit Error, Occurrence or offense that happened before the Named Insured acquired or formed the organization.

No coverage shall be afforded under this Policy for any Claim involving the entity or subsidiary that is acquired, created, merged or consolidated with, unless:

1. The Named Insured gives Us notice of such Transaction as soon as possible but in no event later than thirty (30) days after the Effective Date of the Transaction;

2. The Named Insured gives Us such information regarding the Transaction as We request; and

3. The Named Insured accepts any terms, conditions, exclusions and limitations and pays any additional premium as We, at Our sole discretion, impose. If We, at Our sole discretion, elect to provide coverage, this Policy shall not apply to, and We will not pay any loss or Defense Costs for any Claim arising from any Medical Incident, Benefit Error, Occurrence or offense happening before:

   a. The Effective Date of the transaction; or

b. The Effective Date of coverage under this Policy for such entity or subsidiary as set forth in any endorsement to be issued for which premium has been paid.

In the event We, at Our sole discretion, choose not to offer coverage beyond the thirty (30) day period, the Named Insured must pay any premium assessed by Us for that aforementioned period.

For purposes of this CONDITION M., "subsidiary" means any entity for which the Named Insured:

1. Owns or possesses fifty percent (50%) or more of the issued and outstanding capital stock; or

2. Has or controls the right to elect or appoint more than fifty percent (50%) of the directors or trustees.

N. **Multiple Claims Arising From the Same Circumstances.**

1. All Claims that arise from:

   a. The same Medical Incident, Occurrence, offense or Benefit Errors; or

   b. A series of similar or related Medical Incidents, Occurrences, offenses or Benefit Errors;

   will be deemed to be a single Claim:

   i. On the date the first of such Claims is reported if coverage is on a claims made basis; or

   ii. When the Occurrence or offense first took place if coverage is on an occurrence basis.

2. The only policy that shall apply to the Claim is the policy in force:

   a. On the date the first of such Claims is reported if coverage is on a claims made basis; or

   b. When the Occurrence or offense first took place if coverage is on an occurrence basis.

O. **Named Insured.** Except as otherwise specifically provided for herein, the Named Insured as stated in Item I on the Declarations Page, or the Authorized Representative as stated in the Application, is authorized to act on behalf of all Named Insureds and other Insureds for all purposes relating to this Policy for all matters as may be required by Us, including but not limited to, providing consent to settle.

P. **Non-renewal.** The Named Insured may non-renew this Policy.

We may non-renew the Named Insured's policy or an Insured's coverage for any reason permitted by law.

If We decide not to renew this Policy or an Insured's coverage, We will mail or deliver written notice of the non-renewal sixty (60) days before the Expiration Date of this Policy or coverage or in accordance with the laws of the state in which the Named Insured is principally domiciled. If the notice is mailed, proof of mailing will be sufficient proof of notice.

Q. **Other Insurance.**

1. If there is Other Insurance covering a Claim, this Policy will apply on an excess basis, unless that Other Insurance was specifically purchased to apply in excess of the Limits of Liability of this Policy. When this insurance is excess, We will only pay for the amount of the covered Claim, up to the applicable Limits of Liability, that exceeds:

   a. The total amount that would be payable by that Other Insurance in the absence of this insurance; and

   b. The total of all applicable deductibles and self-insured amounts, if any.

2. When this insurance applies on an excess basis, We will have no duty to defend any Claim that any other insurer has a duty to defend. If no other insurer defends, We will have the right, but not the duty, to provide a defense. If We do defend, We will be entitled to assume the Insured's right against all those other insurers.

R. **Premium.** All premiums for this policy will be computed in accordance with Our rules, rates, and those rating plans in effect with respect to the period for which premiums are due.

You shall pay all premiums including deposit and audit premiums by the due date specified on the premium billings. There is no grace period in this Policy for payment of premium.

You shall cooperate with Us, shall maintain records of visits and such other information as is necessary for premium computation, and shall send copies of such records to Us as We may request.

S. **Sales or Dissolution of Insured Entities; Cessation of Business.**

If during the Policy Period:

1. The Named Insured is dissolved, sold, acquired by, merged into or consolidated with another entity such that the Named Insured is not the surviving entity; or

2. Any person, entity, or affiliated group of persons or entities obtains:

   a. Ownership or possession of fifty percent (50%) or more of the used and outstanding capital stock of the Named Insured, or

   b. The right to elect or appoint more than fifty percent (50%) of the Named Insured's directors or trustees; or

3. The Named Insured ceases to do business for any reason other than any of the events listed in 1 or 2 above, coverage under this Policy shall continue in full force and effect until the Expiration Date or any earlier cancellation date, but this Policy shall apply only to Medical Incidents, Benefit Errors, Occurrences or offenses happening before the Effective Date of such transaction. This Policy shall not apply to and We will not pay any Damages or Defense Costs for any Claim arising from any Medical Incident, Benefit Error, Occurrence or offense happening on or after the Effective Date of such transaction.

T. **Separation of Insureds.** Except with respect to the Limits of Liability, and any rights or duties specifically assigned to the Named Insured, this insurance applies separately to each Insured against whom a Claim is made, except with respect to Common CONDITION Q., "Other Insurance."

U. **Special Statutes.** We agree that all provisions of this Policy that are in conflict with statutes of Your State are amended to conform to such statutes.

V. **Subrogation.** If an Insured has rights to recover all or part of any payment We have made under this Policy, those rights are transferred to Us. The Insured must do nothing after the loss to impair those rights. At Our request, the Insured will bring suit or transfer those rights to Us and help Us enforce them.

W. **Voting Rights.** As an insured member of a mutual insurance company, the Named Insured, and each physician to whom a separate limit of liability has been afforded, shall have the right to one vote at any general or special meeting of members of NORCAL held during the Policy Period in accordance with the by-laws of NORCAL.

X. **When A Claim Is Made.**

1. We will consider a Claim to be made at the earlier of the following:

   a. On the date an Insured first gives Our Claims Department written notice of a Claim made against an Insured; or

   b. On the date Our Claims Department receives written notice of a Medical Incident, Benefit Error, Occurrence or offense that is likely to result in a Claim being made against an Insured.

2. The written notice must include the following information:

   a. How, when and where the Medical Incident, Benefit Error, Occurrence or offense took place;

   b. The names, addresses and ages of any injured persons and witnesses; and,

   c. The nature and location of any injury or damage arising from the Medical Incident, Benefit Error, Occurrence or offense.

An event reported by an Insured to Us as part of Our risk management or loss control services shall not be considered a report of a Claim.

Y. **Continued Right to Report Claims Under Deleted Benefits Or Coverage.** If We delete a benefit or coverage from this Policy, an Insured can report Claims that occurred after the applicable Retroactive Date and prior to the deletion of the benefit or coverage from the Policy that would have triggered the deleted benefit or coverage. The ability to report such Claims will continue as long as the Named Insured maintains continuous coverage with Us or an Extended Reporting Period Endorsement is issued to an Insured and remains in force.

PART VI COMMON EXCLUSIONS

No Defense or Payment of Damages

We will neither defend nor pay Damages because of Claims that result from any of the following:

A. Any liability that results from any disciplinary or administrative proceeding such as a State Department of Health Services review; or a review of the quality of the Insured's care by agencies or entities conducting utilization review for government or private insurance programs, except as may be afforded under the Coverage D, Physicians Administrative Defense Reimbursement Coverage.

B. Any actual or alleged: price fixing, unfair competition or trade practice, a dispute over fees, income or revenue, the inducement to enter into, the interference with or the dissolution or termination of any business or economic relationship, or violation of any law or regulation including, but not limited to, Title 15 of the United States Code or any similar state statute or regulation that prohibits the unlawful restraining of trade, business or profession.

   We will provide a defense against allegations of restraint of trade, business or profession arising from Professional Committee Activities. However, the Insured will reimburse Us for those Defense Costs if liability is admitted or established by judgment or any other way that the Insured committed restraint of trade, business or profession.

C. Asbestos including, but not limited to:

   1. Manufacture of, mining of, use of, sale of or exposure to Asbestos products, fibers or dust;

   2. Transportation, storage or disposal of Asbestos or goods or products containing Asbestos;

   3. Removal of Asbestos from any goods, products or structures;

   4. Testing, monitoring, removal of, containment of or in any way responding to or assessing the effects of Asbestos;

   5. Inhalation, ingestion or physical exposure to Asbestos or goods or products containing Asbestos.

D. Any liability:

   1. That an Insured has assumed under a written or oral contract or agreement; or

   2. Arising from any allegation of an Insured's failure to perform under a contract or breach of any contract or agreement, whether written or oral.

   This exclusion does not apply to liability for Damages:

      a. Assumed in a contract or agreement that is an Insured Contract; or

b. That an Insured would have had in the absence of the contract or agreement.

E. Any liability for a Claim that is initiated, alleged or caused to be brought about by any Insured covered by this Policy against any other Insured covered by this Policy. However, this exclusion does not apply to Coverage A, Professional Liability Insurance, to an Insured rendering Professional Health Care Services or engaged in Professional Committee Activities.

F. Any liability arising from an actual or alleged act of Discrimination, harassment or humiliation, whether or not such a Claim alleges the violation of any law or regulation prohibiting Discrimination, harassment or humiliation, except as may be provided in Coverage D, Physicians Administrative Defense Reimbursement Coverage.

G. Any liability arising from any Employment Practices, including consequential Bodily Injury, except as may be provided in Coverage D, Physicians Administrative Defense Reimbursement Coverage.

H. Any liability arising from the actual or alleged violation of the Employee Retirement Income Security Act of 1974, commonly referred to as the Pension Reform Act of 1974, as amended in part by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and amendments to either or similar provisions of any federal, state or local statutory law or common law.

I. Any dishonest, fraudulent, willful, criminal or malicious act or omission.

However, at the specific request of an Insured, We will defend an Insured in a civil action involving alleged criminal acts that would be otherwise covered by this Policy, but only if such acts directly result from providing Professional Health Care Services by an Insured on behalf of the Named Insured.

J. Any liability of any individual(s) or organization acting as an independent contractor for You unless specifically endorsed on the policy.

K. Any liability for a Claim whose circumstances were known, or should have been known, to an Insured or any insurer before the "Policyholder Since" date shown on the Declarations Page, or, in the case of a newly acquired entity, before the acquisition date of that entity.

L. Any liability arising from administrative or management services provided by an Insured, or independent contractors retained by an Insured, to another organization not owned by the Named Insured unless specifically endorsed onto this Policy. This exclusion applies whether or not monetary or other consideration is received for such services.

M. Any liability arising from nuclear reaction, radiation, or radioactive contamination, or any consequence of these, except as a direct result of providing Professional Health Care Services.

N. Any liability arising from any actual, alleged or threatened Pollution Incident. Nor will We pay any Damages arising from any demand, order or request that any Insured test for, monitor, clean-up, remove, contain, treat, detoxify or neutralize, or in any way respond to or assess the effects of Pollutants. This exclusion applies to any Damages that in any way arise from a Pollution Incident whether the incident:

1. Results from the activities of any Insured, or the activities of others; or

2. Is sudden, gradual, accidental, intended, foreseeable, expected, unexpected, fortuitous, inevitable, preventable or not preventable or wherever or however it occurs.

O. Any liability for:

1. Bodily Injury, Property Damage or Fire Damage that would not have occurred, in whole or in part, but for the actual, alleged or threatened inhalation of, ingestion of, contact with, exposure to, existence or presence of any Fungi or bacteria on or within a building or structure, including its contents, regardless of whether any other cause, event, material or product contributed concurrently or in any sequence to such injury or damage.

2. Any loss, cost or expense arising out of the abating, testing for, monitoring, cleaning up, removing, containing, treating, detoxifying, neutralizing, re-mediating or disposing of, or in any way responding to or assessing the effects of Fungi or bacteria, by any Insured or by any other person or entity.

P. Any liability arising from the rendering of or failure to render services as an attorney, architect, insurance agent, broker, management consultant, real estate agent or broker or other professional services.

Q. Any sums demanded or awarded as punitive or exemplary Damages or the multiplication of compensatory Damages by statute or regulation or the assessment of fines or penalties.

However, We will defend any Claim for punitive or exemplary Damages as long as the Damages result from a Claim for Damages otherwise covered by this Policy. Our duty to defend ends, however, when a judgment and/or settlement has been reached on a Claim otherwise covered by this Policy.

R. Any liability arising from alleged or actual Sexual Misconduct. However, under Coverage A, "Professional Liability Insurance":

1. We will defend any Claim directly resulting from Sexual Misconduct to a patient. However, the Insured who allegedly committed Sexual Misconduct will reimburse Us for those Defense Costs if liability is admitted or found by judgment or any other way that they committed Sexual Misconduct.

2. We will pay Damages on behalf of any Insured, other than the Insured who allegedly committed Sexual Misconduct, that directly result from Sexual Misconduct to a patient, unless that other Insured:

a. Knew or should have known about the Sexual Misconduct but failed to prevent or stop it; or

b. Knew or should have known that the Insured who allegedly committed Sexual Misconduct had a prior history of or propensity for Sexual Misconduct.

S. Any liability arising from a willful violation of any statute or ordinance committed with the knowledge or consent of an Insured.

T. Any liability occasioned by, happening through, or in consequence of war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, confiscation, nationalization, requisition of, destruction of, or damage to property by, or under the order of, any government, public or local authority.

U. Any obligation that an Insured or any of its insurers may have under Workers' Compensation, Employers' Liability, Unemployment Compensation, Disability Benefits or any indemnification obligation the entity has as an employer under California Labor Code Section 2802, California Corporations Code Section 317 or any similar law, code or statute in any state in which the entity operates, including, but not limited to, any injury to:

1. An Employee of the Insured arising from and in the course of employment by the Insured; or

2. The spouse, child, parent, brother or sister of that Employee as a consequence of paragraph 1 above.

This exclusion applies;

a. Whether the Insured may be liable as an employer or in any other capacity; and,

b. To any obligation to share Damages with or repay someone else who must pay Damages because of the injury.

However, We may provide limited coverage as described in PART II, Coverage C., Administration of Your Employee Benefits Program Liability Coverage.

PART VII EXTENDED REPORTING PERIOD OPTION

IF AN EXTENDED REPORTING PERIOD ENDORSEMENT IS NOT ISSUED OR PURCHASED, THERE WILL BE NO COVERAGE FOR CLAIMS ARISING FROM MEDICAL INCIDENTS or BENEFIT ERRORS, or ADMINISTRATIVE PROCEEDINGS OR EMPLOYMENT-RELATED CIVIL ACTIONS THAT ARE FIRST REPORTED TO US ON OR AFTER THE EXPIRATION OR TERMINATION DATE OF THIS POLICY OR THE APPLICABLE COVERAGE.

This Extended Reporting Period Endorsement must be requested by written notice to Us within thirty (30) days from the expiration or termination date of this Policy or applicable coverage.

A. **MUTUAL RIGHTS**

The Named Insured may have the right to purchase an Extended Reporting Period Endorsement (frequently known as "tail coverage") if this Policy or applicable coverage is canceled or non-renewed. This endorsement provides an extended period of time for reporting Claims arising from Medical Incidents or Benefit Errors, or Administrative Proceedings or Employment-Related Civil Actions as follows:

1. Medical Incidents or Benefit Errors that take place on or after the Retroactive Date as shown on the Declarations Page or applicable endorsement and before the expiration or termination of an Insured's coverage; and

2. Results in a Claim against an Insured that is first reported to Us under the Extended Reporting Period Endorsement; or

3. Acts that take place on or after the applicable Retroactive Date and before the expiration or termination of an Insured's coverage that result in an Administrative Proceeding or Employment-Related Civil Action instituted against that Insured and first reported to Us under the Extended Reporting Period Endorsement.

To purchase an Extended Reporting Period Endorsement the Named Insured must be in compliance with all terms and conditions of the Policy. We will not issue an Extended Reporting Period Endorsement to the Named Insured whose coverage has been cancelled or non-renewed for fraud, misrepresentation, concealment or breach of warranty. Nor will We issue an Extended Reporting Period Endorsement to the Named Insured if this Policy is cancelled for non-payment or rescinded.

All outstanding earned premiums must be paid. Any additional premium for the Extended Reporting Period Endorsement will be computed in accordance with Our rules, rates and rating plans in effect at the time of the expiration or termination of coverage and must be paid to Us. This additional premium is fully earned and non-refundable. If We do not receive full payment of all billed premiums on or before the due date of the premium notice, We will not issue an Extended Reporting Period Endorsement and We will cancel any previously issued Extended Reporting Period Endorsement.

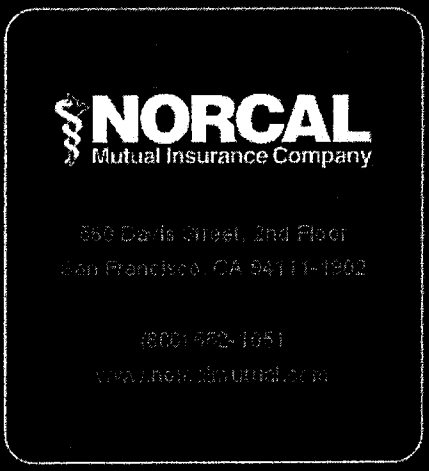
Additionally:

1. Once in effect, the Extended Reporting Period Endorsement may not be canceled unless the Named Insured to whom this Extended Reporting Period Endorsement was issued has committed a material breach of the terms or conditions of this Policy or any endorsement attached to it.

2. The Extended Reporting Period Endorsement does not extend the Policy Period or change the scope of coverage provided under this Policy and any attached endorsement. Except as otherwise provided by this endorsement, any Claim arising from Medical Incidents or Benefit Errors, or Administrative Proceeding or Employment-Related Civil Action reported to Us must be covered by this Policy.

3. The Extended Reporting Period Endorsement is subject to all of the provisions of the policy in existence at the time Your active coverage ceases.

4. The Extended Reporting Period Endorsement provides one set of Limits of Liability that are applicable only to those Claims first reported during the Extended Reporting Period. Those Limits of Liability will be eroded by payment of judgments and settlements. Our duty to defend ends when the Limits of Liability are exhausted by payment of judgments and settlements.



560 Davis Street, 2nd Floor
San Francisco, CA 94111-1902

(800) 422-1951
www.norcalmutual.com

Professional Liability Insurance POLICY

For individual physicians and their solo medical corporations, medical partnerships and medical corporations having more than one physician shareholder

NORCAL Mutual Insurance Company

Important

This policy does not become effective unless a Declarations Page and applicable endorsements are issued to form a part of it.

This is a Claims Made Professional Liability Insurance Policy. The coverage afforded by this policy is limited to liability for only those claims resulting from medical incidents or occurrences which happened on or after the Retroactive Date specified on the Declarations Page and which are first reported to NORCAL while the policy is in effect.

This policy requires arbitration of disputes with NORCAL.

Please review this policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance advisor, agent or broker.

IE - 9101 10/1/2005

WHAT TO DO IN CASE OF A CLAIM, ADMINISTRATIVE PROCEEDING OR EMPLOYMENT-RELATED CIVIL ACTION

In the event an Insured directly or indirectly becomes involved in any situation which an Insured believes may result in a Claim while covered under this policy, You should immediately report the details to the NORCAL Mutual Insurance Company Professional Claims Department.

CALIFORNIA
If You are located in the following counties: Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego

Telephone: (800) 356-5513 (toll free)
(626) 577-4300

Mailing Address: NORCAL Mutual Insurance Company
Two North Lake Avenue, Suite 500
Pasadena, CA 91101-1867

If You are located in any county not listed above:

Telephone: (800) 416-0791 (toll free)
(415) 397-9700

Mailing Address: NORCAL Mutual Insurance Company
560 Davis Street, 2nd Floor
San Francisco, CA 94111-1902
Attn: Professional Claims Department

ALASKA
If You are located in Alaska:

Telephone: (800) 770-3414 (outside Anchorage)
(907) 563-3414 (in Anchorage)

Mailing Address: NORCAL Mutual Insurance Company
4000 Old Seward Hwy., Suite 203
Anchorage, AK 99503

RHODE ISLAND
If You are located in Rhode Island:

Telephone: (800) 230-1004 (toll free)
(401) 276-7500

Mailing Address: NORCAL Mutual Insurance Company
Fleet Center
50 Kennedy Plaza, 7th Floor
Providence, RI 02903

Please see Common Condition I., "Duties In The Event of Claim."

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NORCAL MUTUAL INSURANCE COMPANY
INSURANCE POLICY FOR
INDIVIDUAL PHYSICIANS AND THEIR SOLO MEDICAL CORPORATIONS,
MEDICAL PARTNERSHIPS, AND MEDICAL CORPORATIONS HAVING MORE
THAN ONE PHYSICIAN SHAREHOLDER

THIS POLICY IS A NON-ASSESSABLE CLAIMS MADE POLICY

PART I POLICY INTRODUCTION

The insurance provided by this policy is contained in multiple coverage sections. These coverages are provided on a "claims made" basis and the cost of defending Claims is in addition to Your Limits of Liability.

This policy is provided based on the statements, representations and agreements made in any application, updated application or any other written statements or communications an Insured supplies or is supplied on behalf of an Insured. In reliance upon the above information and subject to all the terms of this policy, We agree with You to provide the insurance coverage described in this policy.

Various provisions in this policy restrict coverage. Read the entire policy carefully to determine Your rights and duties, and what is covered and is not covered. We will not pay sums or perform acts or services unless explicitly provided for in this policy.

The words You and Your in this policy refer to the Named Insured shown on the Declarations Page. The words We, Us and Our refer to the Company providing this insurance.

Other words and phrases that are underlined have special meaning. Refer to the Definitions section for their meanings.

This policy is not effective unless a Declarations Page and Applicable Endorsements are issued as part of the policy.

IN WITNESS WHEREOF: NORCAL Mutual Insurance Company has caused this policy to be signed by its President and Secretary at San Francisco, California.

T. Scott Diener
President & CEO

Katherine H. Crocker
Secretary

PART II COVERAGES

In consideration of the payment of premium, NORCAL Mutual Insurance Company, hereinafter called the Company, agrees with You as follows:

COVERAGE A - Professional Liability Insurance - Claims Made

THIS INSURANCE IS PROVIDED ON A CLAIMS MADE BASIS.

A. INSURING AGREEMENTS

1. **Indemnity.** We will pay on behalf of an Insured all sums, up to the Limits of Liability shown on the Declarations Page, that an Insured shall become legally obligated to pay as Damages because of injury caused by a Medical Incident directly resulting from Professional Health Care Services or Professional Committee Activities:

   a. That takes place within the Coverage Territory; and

   b. That takes place on or after the Retroactive Date and before the expiration or termination date of this policy; and

   c. That results in a Claim first made against an Insured during the Policy Period and that is first reported to Us during the Policy Period.

2. **Defense.** We shall have the right and duty to defend an Insured against any Claim because of injury caused by a Medical Incident directly resulting from Professional Health Care Services or Professional Committee Activities:

   a. That takes place within the Coverage Territory; and

   b. That takes place on or after the Retroactive Date and before the expiration or termination date of this policy; and

   c. That results in a Claim first made against an Insured during the Policy Period and that is first reported to Us during the Policy Period.

   We have the exclusive right, using counsel of Our choice, to investigate, negotiate and defend any Claim. Our duty to defend ends, however, when the Limits of Liability shown on the Declarations Page have been exhausted by the payment of judgments and/or settlements.

   Defense Costs are payable in addition to the Limits of Liability shown on the Declarations Page for Professional Liability Insurance. We may investigate any Claim, as We deem appropriate. We shall not be liable for the cost of legal services and other costs or fees incurred by an Insured without Our written consent. We shall not be liable for the cost of any legal services and other costs or fees incurred before Our written receipt of notice of Claim.

B. WHO IS INSURED

In addition to those persons or organizations included within the definition of Insured, each of the following is an Insured to the extent set forth below, subject to Common Condition Q., "Other Insurance":

1. Employees, Authorized Volunteer Workers and students while acting within the course and scope of their duties for You.

2. This policy provides coverage for You or Your Health Care Extenders, interns, externs, residents, dentists, osteopathic or other medical doctors when such professionals are endorsed onto this Policy.

C. EXCLUSIONS

1. **No Defense or Payment of Damages.** In addition to the Common Exclusions in PART V of this policy, We will not defend any Insured nor pay Damages because of Claims that result from any of the following:

   a. Any liability arising from an Occurrence or costs associated with an Administrative Proceeding or Employment-Related Civil Action.

   b. Any liability arising from the use, administration or prescription of any drug, pharmaceutical or medical device disapproved or not yet approved by the United States Food and Drug Administration for treatment of human beings; however, this exclusion shall not apply to any Claim resulting from an Insured's participation in a clinical study for which We have issued prior written consent of coverage for such clinical study participation.

   c. Any liability arising from a Medical Incident that took place while the license to practice medicine or the certification of the individual responsible for providing Professional Health Care Services or Professional Committee Activities is not in effect.

   d. Any liability arising from a Medical Incident involving the prescription or dispensing of controlled substances that happened while the license or registration to prescribe or dispense such controlled substances issued to the individual responsible for providing Professional Health Care Services is not in effect.

   e. Any liability arising from a Medical Incident that took place on or after the date of an involuntary declination, restriction or reduction of hospital privileges (except for temporary restriction due to incomplete medical records), or of a hospital-imposed punitive or disciplinary observation, proctorship, preceptorship or required consultation that You have not reported to Us immediately in writing.

   f. Any liability arising from a Medical Incident involving You or any person for whom You are legally responsible, in the fraudulent creation, alteration, or modification of the medical record of any person.

g. Any liability arising from a guarantee of the results of any Professional Health Care Services or Professional Committee Activities.

h. Any services provided by You while employed by the U.S. Government or any other governmental or public entity.

i. Any liability arising from any actual or alleged: price fixing, unfair competition or trade practice; a dispute over fees, income or revenue, the inducement to enter into, the interference with or the dissolution or termination of any business or economic relationship; or violation of any law or regulation including, but not limited to, Title 15 of the United States Code or any similar state statute or regulation that prohibits the unlawful restraining of trade, business or profession.

We will provide a defense against allegations of restraint of trade, business or profession arising from Professional Committee Activities. However, the Insured will reimburse Us for those Defense Costs if liability is admitted or established by judgment or any other way that the Insured committed restraint of trade, business or profession.

j. Any liability arising from publications or utterances in the course of or related to advertising, broadcasting, publishing, or telecasting activities conducted by or on behalf of You.

k. Any liability arising from providing Professional Health Care Services (not limited to obstetrical care) during delivery (including the immediate labor, puerperium and/or neonatal period) in any facility, or any place other than a licensed acute care hospital except:

i. In the case of a bonafide medical emergency requiring immediate intervention; or

ii. A facility named in an endorsement to this policy.

l. Any liability arising from business disputes, except as may be provided under Coverage C, Physicians Administrative Defense Reimbursement Coverage.

2. **No Payment of Damages - Defense Only.** In addition to the Common Exclusions in PART V of this policy, We will not pay Damages, but will defend any Insured because of Claims that result from any of the following:

a. Any liability arising from an Insured's authorship of an article or paper relating to the technical aspects of Your practice of medicine for a recognized technical or professional publication.

b. Any liability for Personal Injury resulting from Your participation in Professional Committee Activities.

D. CONSENT TO SETTLE

1. We will not settle any Claim against an Insured under this Professional Liability Insurance without Your written consent.

2. The Authorized Representative may be requested to obtain consent on behalf of the Named Insured. The Authorized Representative is designated in the application and any subsequent written amendments thereto. If the Insured is a physician, then his or her written consent is also required and any and all consents must be obtained by the Authorized Representative.

3. The failure to obtain the written consent of the Insured will not void any settlement entered into without the written consent of the Insured. The requirement of the written consent can be waived in writing by both You and Us.

4. If We recommend settlement of a Claim, the recommendation will be based on consideration of all circumstances surrounding the Insured's potential liability. You agree to give careful consideration to Our recommendation. We do not, however, have a duty to recommend settlement of a Claim.

5. If We recommend settlement of a Claim and You disagree, then You or We may refer the matter to a Peer Review Committee acceptable to both parties. The decision of such committee will be advisory only and will not be binding on either You or Us.

COVERAGE B - Limited Professional Office Premises Liability Insurance - Claims Made

THIS INSURANCE IS PROVIDED ON A CLAIMS MADE BASIS.

A. INSURING AGREEMENTS

1. **Indemnity.** We will pay on behalf of an Insured all sums that an Insured becomes legally obligated to pay as Damages, up to the Limits of Liability shown on the Declarations Page, because of Bodily Injury or Property Damage caused by an Occurrence:

   a. That takes place at a Covered Premise; and

   b. That takes place on or after the Retroactive Date and before the expiration or termination date of this policy; and

   c. That results in a Claim first made against an Insured during the Policy Period and that is first reported to Us during the Policy Period.

2. **Defense.** We shall have the right and duty to defend an Insured against any Claim because of Bodily Injury or Property Damage caused by an Occurrence:

   a. That takes place at the Covered Premise; and

   b. That takes place on or after the Retroactive Date and before the expiration or termination date of this policy; and

   c. That results in a Claim first made against an Insured during the Policy Period and that is first reported to Us during the Policy Period.

   We have the exclusive right, using counsel of Our choice, to investigate, negotiate and defend any Claim. Our duty to defend ends, however, when the Limits of Liability shown on the Declarations Page have been exhausted by the payment of judgments and/or settlements.

   Defense Costs are payable in addition to the Limits of Liability shown on the Declarations Page for Limited Professional Office Premises Liability Coverage.

   We may investigate any Claim, as We deem appropriate. We shall not be liable for the cost of legal services and other costs or fees incurred by an Insured without Our written consent. We shall not be liable for the cost of any legal services and other costs or fees incurred before Our written receipt of notice of Claim.

B. WHO IS INSURED

In addition to those persons or organizations included within the definition of Insured, each of the following is an Insured to the extent set forth below, subject to Common Condition Q., "Other Insurance":

1. Employees, Authorized Volunteer Workers and students while acting within the course and scope of their duties for You.

2. This Policy provides coverage for You or Your Health Care Extenders, interns, externs, residents, dentists, osteopathic or other medical doctors when such professionals are endorsed onto this policy.

C. EXCLUSIONS

No Defense or Payment of Damages. In addition to the Common Exclusions in PART V of this policy, We will not defend any Insured nor pay Damages because of Claims that result from any of the following:

a. Medical Incidents or costs associated with an Administrative Proceeding or Employment-Related Civil Action.

b. Bodily Injury or Property Damage for which any Insured may be held liable by reason of:

   i. Causing or contributing to the intoxication of any person;

   ii. The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

   iii. Violation of any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

c. Bodily Injury or Property Damage arising from the ownership, maintenance, use or entrustment to others of any aircraft, Auto or watercraft owned or operated by or rented or loaned to any Insured. Use includes operation and Loading or Unloading.

This exclusion does not apply to liability arising from the maintenance or use of any Mobile Equipment, except Bodily Injury or Property Damage arising from:

   i. The transportation of Mobile Equipment by an Auto owned or operated by or rented or loaned to any Insured; or

   ii. The use of Mobile Equipment in, or while in practice or preparation for, a prearranged racing, speed or demolition contest or in any stunting activity.

d. Property Damage to:

   i. Property You own, rent or occupy; however, We may provide limited coverage as described in PART III, Additional Benefits, Item D., Fire and Water Damage Legal Liability Coverage;

   ii. Premises You sell, give away or abandon, if the Property Damage arises out of any part of those premises;

iii. Property loaned to You;

iv. Personal property in Your care, custody or control; or

v. That particular part of real property on which You or any contractors or subcontractors working directly or indirectly on Your behalf are performing operations, if the Property Damage arises out of those operations.

e. Bodily Injury or Property Damage arising from the interference with a person's right to occupy his or her property undisturbed, including wrongful entry and wrongful eviction.

f. Bodily Injury to You or an Employee, Authorized Volunteer Worker or student while acting within the course and scope of their duties for You.

COVERAGE C - Physicians Administrative Defense Reimbursement Coverage

THIS INSURANCE IS PROVIDED ON A CLAIMS MADE BASIS.

PART 1 - INSURING AGREEMENTS

A. DEFENSE COST REIMBURSEMENT COVERAGE

1. Administrative Proceedings

We will reimburse the Named Insured, endorsed physician, or employed licensed health care professional, for attorney's fees and costs incurred in the defense of an Administrative Proceeding, up to the applicable Limits of Reimbursement as shown on the Declarations Page or applicable endorsement, if the Administrative Proceeding:

a. Arises from an act that takes place within the Coverage Territory; and

b. Arises from an act that takes place on or after the applicable Retroactive Date and before the expiration or termination date of this Policy or coverage; and

c. Is instituted against the Named Insured, endorsed physician, or employed licensed health care professional during the Policy Period and is first reported to Us during the Policy Period.

An Administrative Proceeding is considered to have been instituted at the time the Named Insured, endorsed physician or employed licensed health care professional is served with a Charging Document or receives notice that an Administrative Entity may investigate their Professional Conduct.

2. Employment-Related Civil Actions

We will reimburse the Named Insured, endorsed physician or employed licensed health care professional for attorney's fees and costs incurred in connection with an Employment-Related Civil Action, up to the applicable Limits of Reimbursement as shown on the Declarations Page or applicable endorsement, if the Employment-Related Civil Action:

a. Arises from an act that takes place within the Coverage Territory; and

b. Arises from an act that takes place on or after the applicable Retroactive Date and before the expiration or termination date of this Policy or coverage; and

c. Is instituted against the Named Insured, endorsed physician or employed licensed health care professional during the Policy Period and is first reported to Us during the Policy Period.

An Employment-Related Civil Action is considered to have been instituted at the time the Named Insured, endorsed physician or employed licensed health care professional is

served with a Charging Document or receives notice that an Administrative Entity may investigate their Professional Conduct.

B. PRACTICE INTERRUPTION EXPENSE REIMBURSEMENT COVERAGE

Subject to proof, We will reimburse the Named Insured, endorsed physician or employed licensed health care professionals for all reasonable expenses and earnings lost, up to the applicable Limits of Reimbursement as shown on the Declarations Page or applicable endorsement, in the event they are required to attend any hearings held in connection with an Administrative Proceeding or Employment-Related Civil Action in which the Named Insured or endorsed physician or employed licensed health care professional is named.

PART 2 - CONDITIONS

In addition to the Common Conditions contained in Part IV of this Policy, the following Conditions apply to this Coverage:

A. Application of Limits: The Limits of Reimbursement shown on the Declarations Page or applicable endorsement are the most We will reimburse the Named Insured, endorsed physicians or employed licensed health care professional regardless of the number of:

1. Named Insureds, endorsed physicians or employed licensed health care professionals insured under this Policy;

2. Persons or entities instituting an Administrative Proceeding or Employment-Related Civil Action against the Named Insured, endorsed physicians or employed licensed health care professionals;

3. Administrative Proceedings or Employment-Related Civil Actions instituted against the Named Insured, endorsed physicians or employed licensed health care professionals;

B. Limits of Reimbursement: Our total obligation under this coverage shall not exceed the Limits of Reimbursement shown as the applicable Annual Aggregate Limit on the Declarations Page or applicable endorsement.

C. The Limits of Reimbursement are not cumulative, even if an Administrative Proceeding or Employment-Related Civil Action resulting from related acts spans more than one Policy Period.

D. Multiple Administrative Proceedings or Employment-Related Civil Actions

1. All Administrative Proceedings or Employment-Related Civil Actions arising from:

a. The same act, or,

b. A series of similar or related acts, or,

c. Audits or reviews of billing or coding practices,

regardless of the number of patients involved or procedures reviewed, shall be treated as a single Administrative Proceeding or Employment-Related Civil Action and deemed reported on the date the first Administrative Proceeding or Employment-Related Civil Action is reported to Us.

2. The only Policy that shall apply to the Administrative Proceedings or Employment-Related Civil Actions is the Policy in force on the date the first Administrative Proceeding or Employment-Related Civil Action is reported to Us.

E. Notice of Administrative Proceeding or Employment-Related Civil Action: The Named Insured, endorsed physician or employed licensed health care professional shall, as soon as practicable, advise Us of the receipt of formal notice of the institution of any Administrative Proceeding or Employment-Related Civil Action.

F. Right to Settle: Nothing in Coverage C shall be construed to deny or otherwise limit the right to effect a settlement of an Administrative Proceeding or Employment-Related Civil Action.

G. Selection of Attorneys: The Named Insured, endorsed physician or employed licensed health care professional shall select attorneys as he/she deems appropriate. We have no right or obligation to select any attorney. Our only responsibility is to reimburse the Named Insured, endorsed physician or employed licensed healthcare professional for those attorney's fees and costs up to the Limits of Reimbursement shown on the Declarations Page or any applicable endorsement.

PART 3 – EXCLUSIONS

This Coverage is not available for:

A. Any Claims arising from Medical Incidents or Occurrences.

B. Any fees or costs incurred in an action against the Named Insured, endorsed physician or employed licensed health care provider, except for:

1. An action brought by an Administrative Entity seeking injunctive relief;

2. Employment-Related Civil Actions.

C. Any legal action initiated by the Named Insured, endorsed physician or employed licensed health care professional except with Our prior written consent.

D. Any matter involving the initial application for licensure, medical staff membership or clinical privileges, or initial application for participation as a provider under any managed care contract or participation as a provider under any Healthcare Benefit Program.

E. Any matter involving the membership in any professional society or other professional organization or involving the certification by any specialty or subspecialty practice board or college of medical practice.

F. Medical, psychiatric or psychological treatment the Named Insured, endorsed physician or employed licensed health care professional undergoes as required by any physician impairment committee or like body, or any educational or training program, whether or not such treatment or program is requested or mandated by an Administrative Entity.

G. Implementation of any compliance program or any policies, procedures or practices relating to participation as a provider of medical services to a managed care organization or under any Healthcare Benefit Program, whether initiated voluntarily or pursuant to direction by, order of, or in settlement with an Administrative Entity.

H. A demand or order by any agency responsible for regulating disability benefits, unemployment compensation, workers' compensation or any similar law.

I. Any action under the Employee Retirement Income Security Act of 1974 or any amendments thereto, or any similar provisions of any federal, state or local law.

J. Any action under the Occupational Safety Act of 1970 or any amendments thereto, or any similar provisions of any federal, state or local law.

K. Any action under the Worker's Adjustment and Retraining Notification Act and any amendments thereto, or any similar provisions of any federal, state or local law.

L. Any action by any agency responsible for enforcing securities law, Blue Sky laws or any laws relating to securities transactions or fair trade practices.

M. Any action relating to loss of wages, fees or other loss of income, except as provided by Coverage C, Part 1B, Practice Interruption Expense Reimbursement Coverage.

N. The violation of any lawful order from an Administrative Entity.

PART 4 - DEFINITIONS

There are defined terms that are used throughout this Coverage Part. They are underlined and are defined in this section. When used in this Coverage Part (including endorsements forming a part thereof):

A. **Administrative Proceeding** means a proceeding instituted by:

1. A governmental body responsible for licensure, regulation and professional discipline of physicians and all other licensed health care professionals.

2. A hospital or other healthcare facility regarding suspension, revocation, limitation of or other corrective action against the Named Insured, endorsed physician or employed licensed health care professional's medical staff membership or action against the medical staff membership or clinical privileges as governed by applicable medical staff by-laws, rules and regulations.

3. A managed care organization regarding the suspension, termination or other limitation of the Named Insured, endorsed physician or employed licensed health care professional's participation as a provider of medical services to patients.

4. Any entity responsible for enforcing compliance with statutes relating to the receipt of payment under any Healthcare Benefit Program.

5. Any governmental entity responsible for investigation and enforcement of statutes and regulations relating to workplace and employment practices.

An appeal from a final disposition of an Administrative Proceeding shall be considered part of the Administrative Proceeding.

B. **Administrative Entity** means any entity empowered to:

1. Conduct an Administrative Proceeding against the Named Insured, endorsed physician or employed licensed health care professional regarding licensure status, clinical privileges, medical staff membership, and status as a provider under any managed care contract or participation as a provider of services to any Healthcare Benefit Program.

2. Investigate and regulate compliance with statutes and regulations relating to workplace and employment practices.

C. **Charging Document** means the formal written notice issued by a state licensing board, hospital credentialing body, managed care organization, entity responsible for enforcement of compliance with statutes or regulations relating to receipt of payment under any Healthcare Benefit Program or governmental entity responsible for enforcing compliance with statutes and regulations relating to workplace and employment practices, setting forth the pending allegations or charges against the Named Insured, endorsed physician or other employed licensed health care professional.

D. **Employment-Related Civil Action** means a civil legal action naming the Named Insured, endorsed physician or employed licensed health care professional as a defendant that is based on alleged acts or omissions relating to their conduct as an employer or supervisor.

E. **Healthcare Benefit Program** means any public or private plan or contract, under which any medical benefit, item or service is provided to any individual and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract.

F. **Professional Conduct** means any activity engaged in by the Named Insured, endorsed physician or employed licensed health care professional relating to their provision of medical services, or to their conduct as an employer or supervisor in connection their medical practice.

PART III ADDITIONAL BENEFITS

The following benefits are in addition to the Limits of Liability shown on the Declarations Page. These benefits end when We have exhausted the applicable Limits of Liability.

Coverage under this section is contingent upon compliance with and subject to all other sections of this policy.

A. **ATTENDANCE AT TRIAL.** We will pay, with respect to any Claim We defend, all reasonable expenses incurred by an Insured at Our request to assist Us in the investigation or defense of the Claim. We will also pay an Insured's actual loss of earnings up to $500 per half day, subject to proof and Our prior approval, because of time off from work, while attending a trial in connection with such Claim at Our request.

B. **BONDS.** We will pay, with respect to any Claim We defend:

1. Premiums on appeal bonds if We decide to appeal a legal judgment against an Insured, but only to the extent of a bond premium for that portion of a judgment that does not exceed the applicable Limits of Liability. The decision to appeal at Our expense is solely Ours. In the event We decide not to appeal, You may do so at Your own expense.

2. Premiums on bonds to release attachments in a suit defended by Us for an amount that does not exceed the applicable Limits of Liability.

We do not have to apply for or furnish these bonds.

C. **DEFENSE COSTS.** We have the right and duty to defend any Claim that is covered by COVERAGES A and/or B of this policy. In addition to the Limits of Liability for COVERAGES A and B We will pay Defense Costs and will:

1. Pay prejudgment and post-judgment interest only on that part of any judgment We pay. We will not pay any prejudgment interest that accrues after We offer to pay the Limits of Liability that apply. We will not pay any post-judgment interest that accrues after We pay or offer to pay Our share of the judgment.

2. Pay any costs taxed against the Insured in any such Claim.

D. **FIRE AND WATER DAMAGE LEGAL LIABILITY COVERAGE.** We will pay on Your behalf all sums up to $500,000 for each Claim and $500,000 aggregate per Policy Period that You become legally obligated to pay as Damages resulting from an Occurrence that causes Property Damage to non-owned Covered Premises or, portions thereof, You rent, use, occupy or control, including fixtures permanently attached thereto, caused by:

1. Fire including smoke, heat and fumes resulting therefrom;

2. Discharge, leaking or overflow of water or steam from plumbing, heating or refrigeration or air conditioning systems; or

3. Rain coming into the building through open or defective doors, windows, skylights, transoms or ventilators.

This policy does not otherwise cover damage to property owned, occupied, rented, used or controlled by You.

E. **MEDICAL PAYMENTS.**

1. We will pay on Your behalf reasonable and necessary Medical Expenses not exceeding $10,000 per person for Bodily Injury caused by an Occurrence resulting from Your operations on Covered Premises and on ways next to Covered Premises.

2. We will not pay Medical Expenses for Bodily Injury:

   a. To any Insured.

   b. To a person hired to work for or on behalf of any Insured or a tenant of any Insured.

   c. To a person injured on that part of Covered Premises that the person normally occupies.

   d. To a person, whether or not an Employee of any Insured, if benefits for the Bodily Injury are payable or must be provided under a workers' compensation, disability benefits law or a similar law.

   e. To a person injured while taking part in athletics.

   f. To a person while receiving Professional Health Care Services.

PART IV COMMON CONDITIONS

The following Conditions apply to the entire policy.

A. **Application Form.**

The completed and signed application form, and any supplement thereto, are the basis for the issuance of the policy. They warrant that the particulars and statements contained in the Application are truthful. The Application and any materials submitted as part of Your application shall be retained and shall be deemed attached to, and made part of the Policy.

B. **Application of Limits of Liability.**

1. Application of Limits of Liability - General. Subject to Common Condition O, "Multiple Claims Arising From The Same Circumstances":

   a. The Each Claim Limit shown on the Declarations Page is the most We will pay for all Damages arising from a Medical Incident or Occurrence regardless of the number of:

      i. Insureds under the policy;

      ii. Persons or organizations sustaining Damages;

      iii. Claims; or

      iv. Coverage parts attached hereto.

   b. Subject to the above provision, Our total liability for all Claims because of all injury to which this policy applies shall not exceed the Limits of Liability shown on the Declarations Page as the Aggregate Limit per Policy Period.

   c. It is further agreed that in no event shall We be liable for any additional payments, including Defense Costs, under this policy once the applicable Limits of Liability shown on the Declarations Page have been exhausted by payments of judgments or settlements.

2. Application of Limits of Liability - Each Policy Period.

   The applicable Limits of Liability applies separately to each consecutive annual Policy Period or to any Policy Period of less than twelve months. If We extend the Policy Period after issuance for an additional period of less than twelve months, the additional period will be deemed part of the last preceding period for purposes of determining the Limits of Liability.

3. Application of Limits of Liability - An Insured Covered by More Than One Policy Issued by Us.

   If this policy and any other policy issued by Us apply to the same Insured, only one such policy shall apply. The Limits of Liability available to that Insured shall not exceed the highest applicable Limits of Liability available under any one policy that applies. However, this

paragraph does not apply to any policy issued specifically to apply as excess insurance above this policy.

4. Application of Limits of Liability - New Limits.

   If You change the Limits of Liability provided by this policy the new Limits of Liability do not apply to any Claim an Insured knew or should have known about or was reported to Us prior to the effective date of the Limits of Liability change.

C. **Arbitration of Disputes with Us.** Any dispute arising from this policy will be submitted to and resolved by binding arbitration at a mutually agreed upon location. Arbitrators shall follow the law of the state in which You are principally domiciled. Arbitration will be conducted in accordance with the following rules:

   1. Unless barred by the statute of limitations, You or We may initiate an arbitration by serving all parties with notice of the nature of the claim and demand for arbitration. A claim will be waived and forever barred if on the date of the demand for arbitration, the claim would be barred by the applicable statute of limitations in a civil action.

   2. Within 30 days after initial service of the demand for arbitration, You and We must each designate an arbitrator and give written notice of this arbitrator to the other. Within 30 days after these notices have been received, the two arbitrators will select a neutral arbitrator and give notice of the arbitrator to You and Us.

   3. The parties will be entitled to conduct discovery as permitted by the laws of the state in which You are principally domiciled. All discovery disputes will be brought before, and solely resolved by, the neutral arbitrator.

   4. Except as otherwise agreed to in writing between the parties, the arbitration will be completed within 120 days after initial service of the demand for arbitration. The arbitration will be held at a time and place designated by the neutral arbitrator. Failure by the party initiating arbitration to make a good faith effort to complete arbitration within 120 days of the issuance of the demand for arbitration will be deemed a waiver of any and all claims for declaratory relief or Damages asserted on behalf of the party initiating arbitration.

   5. Each party will pay the fees of the arbitrator that party has selected. We will pay for the expense and fees of the neutral arbitrator, as well as the expenses of arbitration approved by the neutral arbitrator, not including Attorney's fees or witness fees or other expenses incurred by a party for that party's own benefit.

   6. Either party has the right to separately arbitrate issues of liability and Damages upon written request to the neutral arbitrator.

   7. All claims based upon the same incident, transaction or related circumstances will be arbitrated in one proceeding.

   8. Any arbitration decision given pursuant to these rules will be final, subject only to confirmation, correction or vacation under the law of the state in which You are principally domiciled.

9. All notices or other written materials required to be served in the conduct of the arbitration proceedings following the initial service of the demand must be served in an appropriate manner to ensure delivery within two (2) days after service.

10. The parties will make every effort to maintain the confidentiality of information and evidence developed in arbitration.

D. **Assignment.** Assignment of Your interest under this policy shall not bind Us unless Our consent is endorsed onto this policy.

E. **Bankruptcy.** Bankruptcy or insolvency of an Insured or of an Insured's estate will not relieve Us of Our obligations under this policy, nor does bankruptcy or insolvency of an Insured or of an Insured's estate relieve You of Your obligations under this policy.

F. **Cancellation.** You may cancel this policy at any time, by surrendering the policy to Us or by mailing to Us a written notice stating when the cancellation shall be effective. If the cancellation occurs at any date other than the policy expiration date, return premium will be computed using the customary short rate cancellation table.

We may cancel this policy by mailing or delivering to You written notice of Our intent to cancel at least:

1. Ten (10) days before the effective date of cancellation if We cancel for non-payment of premium or fraud.

2. Thirty (30) days before the effective date of cancellation if We cancel for any other reason.

3. If Your policy has been in effect less than sixty (60) days since the policy's Effective Date, it may be canceled at any time upon written notice to You.

Such written notice of Our intent to cancel shall be mailed to Your last known address as shown in Our records. The mailing of this notice shall be sufficient proof of notice.

Either the date You request cancellation or the effective date and hour of cancellation as stated in the cancellation notice shall become the expiration date of the Policy Period. Delivery of such written notice either by You or by Us shall be acceptable in place of mailing.

If We cancel, other than for non-payment of premium or fraud, earned premium shall be computed pro-rata. If We cancel for non-payment of premium or fraud, return premium may be computed using the customary short rate cancellation table. Premium adjustment, if any, may be made either at the time cancellation is effective or as soon as practicable after cancellation becomes effective. However, the cancellation will be effective even if We have not made or offered a return of premium.

G. **Changes to Policy.** Any request to change this policy must be communicated to Us and received by Us, in writing. Notice to any agent or broker, or knowledge possessed by any agent or broker or by any other person, does not effect a waiver or a change in any part of this policy or stop Us 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 Us to form a part of this policy.

If We modify the policy by filing changes that are approved or accepted by the insurance supervisory authority of Your state and the changes filed would broaden coverage without changing the premium, this policy will automatically receive the broader coverage.

Any endorsement that We issue modifies the coverage. Where the terms of any endorsement are inconsistent with the terms of this policy, the terms of the endorsement shall control.

H. **Dividends/Premium Credits.** As an insured member of a mutual insurance company, You may be eligible to receive dividends/premium credits during Your Policy Period. Dividends/premium credits are subject to the laws of the state in which You practice.

The record date, amount of the dividends/premium credits and form of the dividends/premium credits are determined by the Board of Directors of NORCAL. Dividends/premium credits are available to You only if the date of distribution specified by the Board of Directors in the dividend declaration resolution is within Your Policy Period.

I. **Duties In The Event Of Claim.**

1. In the event a Claim is made against any Insured, You must provide Us written notice as soon as practicable. The written notice must include the following information:

   a. How, when and where the Medical Incident or Occurrence took place;

   b. The names, addresses and ages of any claimants and witnesses, and

   c. The nature and location of any injury or damage arising from the Medical Incident or Occurrence.

2. All Insureds agree to submit to examination, provide information and permit Us, Our Authorized Representatives or Attorneys to take statements, or at Our discretion, sworn depositions, concerning any and all facts underlying each and every Claim made against an Insured by a third party and submitted to Us for defense and/or indemnification coverage under this policy. It is further agreed that all Insureds will make every effort to maintain the confidentiality of any such statement. The Insured's provision of a sworn statement or deposition, if requested by Us, shall be a condition precedent to ongoing defense or indemnification coverage for the Claim.

3. All Insureds agree to maintain patients' medical records in accordance with the laws of the state in which the Covered Premises are located. You will allow Us unfettered access to those patients' medical records as needed in the defense and investigation of a Claim made against You.

4. All Insureds must cooperate with Us, Our Authorized Representatives, and defense counsel appointed by Us and upon Our request will assist in the investigation and management of any Claim. That cooperation includes:

a. Immediately send Us any demands, notices, summonses or legal documents received in connection with the Claim;

b. Authorize Us to obtain records and other information;

c. Assist Us in the enforcement of any right against any person or organization that may be liable to an Insured because of injury or damage to which this policy applies;

d. Submitting to a sworn statement or deposition, whether or not a formal coverage or contractual dispute has arisen;

e. Assist in effecting settlements;

f. Obtain the attendance of witnesses;

g. Attend depositions, conferences, hearings and trials;

h. Assist in any other aspect of the investigation and defense; and

i. If a Claim involves both covered and non-covered Claims and/or causes of action, all Insureds must agree to allow bifurcation of the hearing, arbitration or trial as to covered Claims and Damages, as well as to non-covered Claims and Damages. All Insureds additionally agree to secure a special verdict form that segregates covered Claims from non-covered Claims, as well as covered and non-covered Damages, if requested by Us.

5. All Insureds will continue to cooperate with Us in the event that We elect to appeal a verdict or continue to require assistance pursuing remedies and procedures available to You or Us.

6. No Insured will, except at its own cost, voluntarily make any payment, assume any obligation or incur any expense.

J. **False and Fraudulent Reports of Claims, Administrative Proceedings or Employment-Related Civil Actions.** If any Insured reports a Claim, Administrative Proceeding or Employment-Related Civil Action knowing it to be in any way false or fraudulent, this insurance shall become null and void with respect to that Claim, Administrative Proceeding or Employment-Related Civil Action. If so, We have the right to full recovery of any payment We have already made.

K. **First Named Insured.** Except as otherwise specifically provided for herein, the Named Insured as stated in Item 1 on the Declarations Page, or the Authorized Representative as stated in the application, is authorized to act on behalf of all Named Insureds and other Insureds for all purposes relating to this policy for all matters as may be required by Us including, but not limited to, providing consent to settle.

L. **Inspection and Audit.** We, or Our Designated Agent, shall be permitted but not obligated to inspect Your Covered Premise(s) and operations, books and records at any time. Neither Our right to make inspections nor the making thereof, nor any report thereon shall constitute an

undertaking, on behalf of or for the benefit of You or others, to determine or warrant that such property or operations are safe or healthful, or are in compliance with any law, rule or regulation.

We, or Our Designated Agent, may examine and audit Your books and records at any time during the Policy Period and within three years after the final termination of this policy, as far as they relate to the subject matter of this insurance.

M. **Legal Action Against Us.** No person or organization has a right under this policy to join Us as a party or otherwise bring Us into a suit asking for Damages from an Insured, nor sue Us on this policy unless all the terms of the policy have been complied with and a judgment has been rendered against an Insured. However, We will not be liable for Damages that are not payable under the terms of this policy or that are in excess of the applicable Limits of Liability.

N. **Mergers, Acquisitions or Newly Created Entities.** If during the Policy Period the Named Insured acquires or creates another entity or subsidiary or becomes a member of a joint venture or partner in a partnership, or if the Named Insured merges or consolidates with another entity such that the Named Insured is the surviving entity (any of which events is referred to as a transaction in this CONDITION N.), We shall have the option of providing coverage to such entity or subsidiary.

Coverage under this provision is afforded only until the 30th day after You acquire or form the organization unless specifically endorsed on the policy or the end of the Policy Period, whichever is earlier.

Coverage under this provision is not afforded for liability arising from any Medical Incident or Occurrence that happened before You acquired or formed the organization.

No coverage shall be afforded under this Policy for any Claim in any way involving the entity or subsidiary that is acquired, created, merged or consolidated with, unless:

1. The Named Insured gives Us notice of such transaction as soon as possible but in no event later than thirty (30) days after the effective date of the transaction;

2. The Named Insured gives Us such information regarding the transaction as We request; and

3. The Named Insured accepts any terms, conditions, exclusions and limitations and pays any additional premium as We, at Our sole discretion, impose. If We, at Our sole discretion, elect to provide coverage, this policy shall not apply to, and We will not pay any loss or Defense Costs for any Claim arising from any Occurrence or Medical Incident happening before:

   a. the effective date of the transaction; or

   b. the effective date of coverage under this policy for such entity or subsidiary as set forth in any endorsement to be issued for which premium has been paid.

In the event We, at Our sole discretion, choose not to offer coverage beyond the thirty (30) day period, the Insured must pay any premium assessed by Us for that aforementioned period.

For purposes of this CONDITION N., "subsidiary" means any entity for which the Named Insured:

1. Owns or possesses fifty percent (50%) or more of the issued and outstanding capital stock; or

2. Has or controls the right to elect or appoint more than fifty percent (50%) of the directors or trustees.

O. **Multiple Claims Arising From The Same Circumstances.**

1. All Claims that arise from:

   a. The same Medical Incident or Occurrence; or

   b. A series of similar or related Medical Incidents or Occurrences;

   will be deemed to be a single Claim on the date the first of such Claims is reported to Us.

2. The only policy that shall apply to the Claim is the policy in force on the date the first of such Claims is reported to Us.

P. **Non-renewal.** We may non-renew Your policy for any reason permitted by law.

If We decide not to renew this policy, We will mail or deliver to the Named Insured shown on the Declarations Page, written notice of the non-renewal not less than sixty (60) days before the expiration date of this policy. If the notice is mailed, proof of mailing will be sufficient proof of notice.

You may non-renew Your policy at the end of the Policy Period.

Q. **Other Insurance.**

1. If there is Other Insurance covering a Claim, this policy will apply on an excess basis, unless that Other Insurance was specifically purchased to apply in excess of the Limits of Liability of this policy. When this insurance is excess, We will only pay for the amount of the covered Claim, up to the applicable Limit of Liability, that exceeds:

   a. The total amount that would be payable by that Other Insurance in the absence of this insurance; and

   b. The total of all applicable deductibles and self-insured amounts, if any.

2. When this insurance applies on an excess basis, We will have no duty to defend any Claim that any other insurer has a duty to defend. If no other insurer defends, We will have the right, but not the duty, to provide a defense. If We do defend, We will be entitled to assume the Insured's right against all those other insurers.

R. **Practice Changes.** This insurance is issued based on Your written representation of Your practice.

You must notify Us immediately, in writing, if there are any changes from what You have previously described in Your original application, application update or other written communication, including changes in Your practice, in Your partners and associates, medical license, professional office premises, interns, externs, residents, dentists, osteopathic or other medical doctors and Health Care Extenders, practice locations, medical procedures, or administrative responsibilities or changes in the status of any Insured's hospital privileges. Coverage for Claims that result from Medical Incidents or Occurrences happening on or after the date of any of these changes is contingent upon such notification and Our approval thereof.

S. **Premium.** All premiums for this policy will be computed in accordance with Our rules, rates and rating plans in effect for the period in which those premiums are due.

You shall pay all premiums including deposit and audit premiums by the due date specified on the premium billings. There is no grace period in this policy for payment of premium.

You shall cooperate with Us, shall maintain records of visits and such other information as is necessary for premium computation, and shall send copies of such records to Us, as We may request.

T. **Sales or Dissolution of Insured Entities; Cessation of Business.**

If during the Policy Period:

1. The Named Insured is dissolved, sold, acquired by, merged into or consolidated with another entity such that the Named Insured is not the surviving entity; or

2. Any person, entity, or affiliated group of persons or entities obtains;

   a. Ownership or possession of fifty percent (50%) or more of the used and outstanding capital stock of the Named Insured, or

   b. The right to elect or appoint more than fifty percent (50%) of the Named Insured's directors or trustees; or

3. If the Named Insured ceases to do business for any reason other than any of the events listed in 1. or 2. above, coverage under this policy shall continue in full force and effect until the expiration date or any earlier cancellation date, but this Policy shall apply only to Medical Incidents or Occurrences happening before the effective date of such transaction. This Policy shall not apply to and We will not pay any Damages or Defense Costs for any Claim arising from any Medical Incident or Occurrence happening on or after the effective date of such transaction.

U. **Separation of Insureds.** Except with respect to the Limits of Liability or Common Condition Q., "Other Insurance", and any rights or duties specifically assigned to the First Named Insured, this insurance applies separately to each Insured against whom a Claim is made.

V. **Special Statutes.** All provisions of this policy that are in conflict with statutes of Your State are amended to conform to such statutes.

W. **Subrogation.** If an Insured has rights to recover all or part of any payment We have made under this policy, those rights are transferred to Us. The Insured must do nothing after the loss to impair those rights. At Our request, the Insured will bring Suit or transfer those rights to Us and help Us enforce them.

If required by a written Insured Contract, We will waive any right of recovery We may have against any person or organization because of payments We have made under this policy arising from Your operations or Your work for that person or organization.

X. **Voting Rights.** As an insured member of a mutual insurance company, You have the right to one vote at any general or special meeting of members of NORCAL held during Your Policy Period in accordance with the by-laws of NORCAL.

Y. **When A Claim Is Made.**

1. We will consider a Claim to be made at the earlier of the following:

   a. On the date You first give Our Claims Department written notice of a Claim made against an Insured; or

   b. On the date Our Claims Department receives written notice of a Medical Incident or Occurrence that is likely to result in a Claim being made against an Insured.

2. The written notice must include the following information:

   a. How, when and where the Medical Incident or Occurrence took place;

   b. The names, addresses and ages of any injured persons and witnesses; and

   c. The nature and location of any injury or damage arising from the Medical Incident or Occurrence.

An event reported by an Insured to Us as part of Our risk management or loss control services shall not be considered a report of a Claim.

Z. **Continued Right to Report Claims Under Deleted Benefits Or Coverage.** If We delete a benefit or coverage from Your policy, You can report Claims that occurred after Your Retroactive Date and prior to the deletion of the benefit or coverage that would have triggered the deleted benefit or coverage. The ability to report such Claims will continue as long as You maintain continuous coverage with Us or an Extended Reporting Period Endorsement is issued to You and remains in force.

We reserve the right to assess and collect a premium for the ability to continue to report such Claims. If a premium is assessed by Us and not paid by You, You will have no right to report such Claims.

PART V COMMON EXCLUSIONS

No Defense or Payment of Damages.

We will not defend any Insured nor pay Damages because of Claims that result from any of the following:

A. Any liability:

1. That an Insured has assumed under a written or oral contract or agreement; or

2. Arising from any allegation of an Insured's failure to perform under a contract or breach of any contract or agreement, whether written or oral.

This exclusion does not apply to liability for Damages:

a. Assumed in a contract or agreement that is an Insured Contract; or

b. That an Insured would have had in the absence of the contract or agreement.

B. Any dishonest, fraudulent, willful, criminal or malicious act or omission.

However, at Your specific request, We will defend You in a civil action involving alleged criminal acts that would be otherwise covered by this policy, but only if such acts directly result from providing Professional Health Care Services by You or on Your behalf.

C. Any liability for a Claim that is initiated, alleged or caused to be brought about by any Insured covered by this policy against any other Insured covered by this policy. However, this exclusion does not apply to Coverage A, Professional Liability Insurance, to an Insured rendering Professional Health Care Services or engaged in Professional Committee Activities.

D. Any liability arising from an actual or alleged act of Discrimination, harassment or humiliation, whether or not such a Claim alleges the violation of any law or regulation prohibiting Discrimination, harassment or humiliation, except as may be provided in Coverage C, Physicians Administrative Defense Reimbursement Coverage.

E. Any liability arising from any Employment Practices, including consequential Bodily Injury, except as may be provided in Coverage C, Physicians Administrative Defense Reimbursement Coverage.

This exclusion applies whether the Insured may be held liable as an employer or in any other capacity and to any obligation to share Damages with or to repay someone else who must pay Damages because of the injury.

F. Any liability of any individual(s) or organization(s) acting as an independent contractor for You unless specifically endorsed on the policy.

G. Any liability for a Claim whose circumstances were known, or should have been known, to an

Insured or any insurer before the "Policyholder Since" date shown on the Declarations Page, or, in the case of a newly acquired entity, before the acquisition date of that entity.

H. Any liability arising from administrative or management services provided by an Insured, or independent contractors retained by an Insured, to another organization not owned by You, unless specifically endorsed on to this policy. This exclusion applies whether or not monetary or other consideration is received for such services.

I. Any liability arising from any actual, alleged or threatened Pollution Incident. Nor will We pay any Damages arising from any demand, order or request that any Insured test for, monitor, clean-up, remove, contain, treat, detoxify or neutralize, or in any way respond to or assess the effects of Pollutants. This exclusion applies to any Damages that in any way arise from a Pollution Incident whether the incident:

1. Results from the activities of any Insured, or the activities of others; or

2. Is sudden, gradual, accidental, intended, foreseeable, expected, unexpected, fortuitous, inevitable, preventable or not preventable or wherever or however it occurs.

J. Any liability for:

1. Bodily Injury or Property Damage which would not have occurred, in whole or in part, but for the actual, alleged or threatened inhalation of, ingestion of, contact with, exposure to, existence or presence of any Fungi or bacteria on or within a building or structure, including its contents, regardless of whether any other cause, event, material or product contributed concurrently or in any sequence to such injury or damage.

2. Any loss, cost or expense arising out of the abating, testing for, monitoring, cleaning up, removing, containing, treating, detoxifying, neutralizing, re-mediating or disposing of, or in any way responding to or assessing the effects of Fungi or bacteria, by any Insured or by any other person or entity.

K. Any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by You or others trading under Your name.

L. Any sums demanded or awarded as punitive or exemplary Damages or the multiplication of compensatory Damages by statute or regulation or the assessment of fines or penalties.

However, We will defend any Claim for punitive or exemplary Damages as long as the Damages result from a Claim for Damages otherwise covered by this policy. Our duty to defend ends, however, when a judgment and/or settlement has been reached on a Claim otherwise covered by this policy.

M. Any liability arising from alleged or actual Sexual Misconduct. However, under Coverage A., Professional Liability Insurance:

1. We will defend any Claim directly resulting from Sexual Misconduct to a patient. However, the Insured who allegedly committed Sexual Misconduct will reimburse Us for Defense

Costs if liability is admitted or found by judgment or any other way that they committed Sexual Misconduct;

2. We will pay Damages on behalf of any Insured, other than the Insured who allegedly committed Sexual Misconduct, that directly result from Sexual Misconduct to a patient, unless that other Insured:

   a. knew or should have known about the Sexual Misconduct but failed to prevent or stop it; or

   b. knew or should have known that the Insured who allegedly committed Sexual Misconduct had a prior history of or propensity for Sexual Misconduct.

N. Any liability arising from the willful violation of any statute or ordinance committed with the knowledge or consent of an Insured.

O. Any obligation that an Insured or any of its insurers may have under Workers' Compensation, Employers' Liability, Unemployment Compensation, Disability Benefits, or any indemnification obligation the entity has as an employer under California Labor Code Section 2802, California Corporations Code Section 317 or any similar law, code or statute in any state in which the entity operates including, but not limited to, any injury to:

   1. An Employee of the Insured arising from and in the course of employment by the Insured; or

   2. The spouse, child, parent, brother or sister of that Employee as a consequence of paragraph 1 above.

   This exclusion applies:

   a. Whether the Insured may be liable as an employer or in any other capacity; and

   b. To any obligation to share Damages with or repay someone else who must pay Damages because of the injury.

P. Any liability arising from Asbestos including, but not limited to:

   1. Manufacture of, mining of, use of, sale of, or exposure to Asbestos products, fibers or dust;

   2. Transportation, storage or disposal of Asbestos or goods or products containing Asbestos;

   3. Removal of Asbestos from any goods, products or structures;

   4. Testing, monitoring, removal of, containment of or in any way the responding to or assessing the effects of Asbestos; or

   5. Inhalation, ingestion or physical exposure to Asbestos or goods or products containing Asbestos.

Q. Any liability arising from the actual or alleged violation of the Employee Retirement Income Security Act of 1974, commonly referred to as the Pension Reform Act of 1974, as amended in part by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and amendments to either or similar provisions of any federal, state or local statutory law or common law.

R. Any liability arising from nuclear reaction, radiation or radioactive contamination, or any consequence of these, except as a direct result of providing Professional Health Care Services.

S. Any liability occasioned by, happening through or in consequence of war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, confiscation, nationalization, requisition of, destruction of, or damage to property by, or under the order of, any government, public or local authority.

PART VI DEFINITIONS

There are defined terms that are used throughout this policy. They are underlined and are defined in this section. When used in this policy (including endorsements forming a part thereof):

A. **Asbestos** means Asbestos and any other allied compound, substance or product or fibers thereof that is used as a non-combustible, non-conducting or chemically resistant material.

B. **Authorized Volunteer Worker** means any approved person, group or organization, including an auxiliary, whose services or labor are directed by You and are not compensated for their services or labor.

C. **Auto** means a land motor vehicle, trailer or semi-trailer licensed for travel on public roads, including any attached machinery or equipment. Auto does not include Mobile Equipment.

D. **Bodily Injury** means physical injury, sickness or disease sustained by a person. This includes mental anguish, mental injury, shock, fright or death resulting from physical injury, sickness or disease. Bodily Injury also includes loss of care or services that results from the above.

E. **Claim** means:

1. Actual Claim:
   Written notice or demand for Damages that an Insured has received regarding a Medical Incident or Occurrence; or

2. Potential Claim:
   Any Medical Incident or Occurrence that may result in an actual Claim.

An event reported by an Insured to Us as part of Our risk management or loss control services shall not be considered a report of a Claim.

F. **Company** means NORCAL Mutual Insurance Company, hereinafter also referred to as NORCAL, We, Us and Our.

G. **Coverage Territory** means any state We approved in writing and for which any Insured holds current and applicable licensure to provide Professional Health Care Services and Professional Committee Activities.

H. **Covered Premise** means any professional office premise that is owned, occupied, rented, used or controlled by You and that has been reported to Us and approved by Us in writing. Covered Premise does not include any premise that has been abandoned or has been vacant for 90 days or more.

I. **Damages** means all sums that an Insured becomes legally obligated to pay by reason of the liability imposed upon an Insured by law because of injury or damage to which this policy applies, except those sums resulting from:

1. The multiplication of compensatory Damages by statute or regulation;

2. The assessment of fines, penalties, sanctions or fees;

3. Restitution, return or disgorgement of fees, profits, charges for products or services rendered, capitation payments, premium or any other funds allegedly wrongfully held or obtained;

4. Non-monetary relief or redress in any form other than monetary compensation or monetary Damages, including without limitation, the cost of complying with any injunctive, declaratory or administrative relief;

5. Matters that are uninsurable under applicable law;

6. Defense Costs;

7. Punitive or exemplary Damages; or

8. Interest.

J. **Defense Costs** mean the reasonable fees of Attorneys, experts and consultants' costs and expenses incurred in the investigation, adjustment, defense and/or appeal of a Claim with Our approval or direction, provided that Defense Costs shall not include remuneration, salaries, overhead, fees, loss of earning reimbursement or benefit expenses of any Insured.

K. **Discrimination** means the unlawful treatment of individuals based on race, color, ethnic origin, ancestry, gender, sexual orientation, age, religion, physical or mental disability, marital status or other status that is protected under any applicable federal, state or local statute or ordinance.

L. **Employee** means a person whose service or labor is supervised by You, who is on Your payroll, and is subject to the withholding of taxes, whether working on a full or part time basis. Independent contractors are not Employees.

M. **Employment Practices** means any of the following:

1. Breach of any employment contract;

2. Failure or refusal to hire or employ;

3. Dismissal, discharge, reduction in force, downsizing or termination of employment, whether actual or constructive;

4. Demotion, reassignment, failure or refusal to promote, or deprivation of career opportunity;

5. Discipline and evaluation of Employees;

6. Discrimination, defamation or harassment of any kind affecting any present or former Employee or applicant for employment;

7. Retaliatory treatment against an Employee arising from the Employee's attempted or actual exercise of the Employee's rights under the law;

8. Employment-related misrepresentation; or

9. Failure to implement appropriate workplace or employment policies or procedures.

N. **Fungi** means any type or form of fungus, including mold or mildew and any mycotoxins, spores, scents or byproducts produced or released by Fungi.

O. **Health Care Extender** means a certified registered nurse anesthetist, nurse midwife, nurse perfusionist, nurse practitioner, physician assistant, preceptee or podiatrist.

P. **Insured** means each of the following to the extent set forth below and any person or organization qualifying as an Insured under the Who Is Insured sections for the applicable coverages:

1. The Named Insured;

2. If the Named Insured is a partnership, joint venture, limited liability partnership or corporation, that partnership, joint venture, limited liability partnership or corporation, and any partner or member thereof, is an Insured, but only for their liability as such. No person or organization is an Insured with respect to the conduct of any current or past partnership, joint venture, limited liability partnership or corporation that is not set forth in this policy as a Named Insured;

3. Any executive officer, stockholder, or member of the board of trustees, directors or governors of the Named Insured while acting within the scope of their duties as such, except with respect to the ownership, maintenance, use, Loading or Unloading, or existence of an Auto, aircraft or watercraft; or

4. Any organization You newly acquire or form, other than a partnership or joint venture in which You maintain ownership or majority interest, and for which the premium has been paid to Us, is an Insured if there is no other similar insurance available to that organization.

Q. **Insured Contract** means:

1. Any written:

a. Lease of premises;

b. Obligation, as required by ordinance, to indemnify a municipality, except in connection with work for the municipality;

c. Elevator maintenance agreement; or

d. Contract or agreement pertaining to Your business (including an indemnification of a municipality in connection with work or services performed for a municipality) under which You assume the tort liability of another party to pay for Bodily Injury or Property

Damage to a third party or organization, but only for Your acts or omissions and not of any third party or organization. Such injury or damage must occur on or after the Insured Contact was executed. Tort liability means liability imposed by law in the absence of any contract or agreement.

2. An Insured Contract does not include that part of any contract or agreement:

   a. That indemnifies an architect, engineer building contractor or surveyor for injury or damage arising from:

      i. Preparing, approving or failing to prepare or approve maps, drawings, opinions, reports, surveys, change orders, designs or specifications; or

      ii. Giving directions or instructions, or failing to give them, if that is the primary cause of the injury or damage;

   b. That indemnifies any person or organization for Property Damage because of a fire unless You are held legally liable; or

   c. That indemnifies any person or organization for Bodily Injury or Property Damage arising from construction or demolition operations within 50 feet of any railroad property and affecting any railroad bridge or trestle, tracks, roadbeds, tunnel, underpass or crossing.

R. **Loading or Unloading** means the handling of property:

   1. After it is moved from the place where it is accepted for movement into or onto an aircraft, watercraft or Auto;

   2. While it is in or on an aircraft, watercraft or Auto; or

   3. While it is being moved from an aircraft, watercraft or Auto to the place where it is finally delivered; but Loading or Unloading does not include the movement of property by means of mechanical device, other than a hand truck that is not attached to the aircraft, watercraft or Auto.

S. **Medical Expenses** means all reasonable and necessary fees for Professional Health Care Services, including the following:

   1. First aid at the time of an accident;

   2. Medical and surgical services, laboratory tests, dental and prosthetic devices;

   3. Ambulance, hospital, professional nursing; or

   4. Funeral services.

T. **Medical Incident** means any act or omission or series of related acts or omissions in the rendering of or failure to render Professional Health Care Services or Professional Committee Activities.

U. **Mobile Equipment** means any of the following types of land vehicles, including any attached machinery, apparatus, or equipment:

1. Vehicles maintained for use solely on or next to premises You own or rent;

2. Vehicles that travel on crawler treads;

3. Vehicles not described in paragraphs 1 or 2 above that are not self-propelled and are maintained primarily to provide mobility to permanently attached equipment of the following types:

   a. Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting, and well servicing equipment; or

   b. Cherry pickers and similar devices used to raise or lower workers; or

4. Vehicles not described in paragraphs 1 or 2 above maintained primarily for purposes other than the transportation of persons or cargo.

   However, self-propelled vehicles with the following types of permanently attached equipment are not Mobile Equipment but will be considered Autos:

   a. Equipment designed primarily for:

      i. Road maintenance, but not construction or resurfacing; or

      ii. Street cleaning;

   b. Cherry pickers and similar devices mounted on Auto or truck chassis and used to raise or lower workers; or

   c. Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting and well servicing equipment.

V. **Named Insured** means the person or organization named on the Declarations Page of this policy as Named Insured, also identified hereinafter as You and Your.

W. **Occurrence** means an accident including continuous or repeated exposure to substantially the same conditions, resulting in Bodily Injury or Property Damage neither expected nor intended from the standpoint of an Insured. Occurrence includes any intentional act by or at the direction of an Insured that results in Bodily Injury if such injury arises solely from the use of reasonable force for the purpose of protecting persons or property.

X. **Other Insurance** includes, but is not limited to, coverage or benefits provided by self-insurance arrangements, pools, self-insurance trusts, captive insurance companies, mutual insurance companies, stock insurance companies, risk retention groups, reciprocal exchanges, mutual benefit or assistance programs, or any other plan or agreement of risk assumption, or any other source of indemnification.

Y. **Personal Injury** means injury, other than Bodily Injury, arising from one or more of the following offenses:

1. False arrest, detention or imprisonment;

2. Malicious prosecution;

3. Assault and/or battery;

4. Interference with an advantageous or contractual relationship;

5. Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services; or

6. Oral or written publication of material that violates a person's right of privacy.

Z. **Policy Period** means the period of time indicated on the policy Declarations Page from the Effective Date to the Expiration Date, or the earlier termination of the policy, if any, in accordance with Common Condition F., "Cancellation". All dates shown are 12:01 a.m. Your Local Time.

AA. **Pollutant** means any solid, liquid, gaseous, nuclear or thermal irritant or contaminant including, but not limited to, smoke, vapor, soot, fumes, acids, alkalis, chemicals, lead, and other waste materials or irritants. Waste includes, but is not limited to, spent fuel and by products, medical waste and any material to be recycled, reconditioned or reclaimed.

AB. **Pollution Incident** means emission, discharge, release or escape of Pollutants into or upon land, the atmosphere, or any watercourse or body of water. The entirety of such emission, discharge, release or escape shall be deemed one Pollution Incident.

AC. **Professional Committee Activities** means:

1. Your duties as a member of a health care facility staff committee that conducts credentialing, quality assurance, peer review or medical ethics review, provided such facility is accredited by the Joint Commission of Accreditation of Hospitals and Health Care Organizations, the Accreditation Association for Ambulatory Health Care, Inc., or similarly constituted organization;

2. Your duties as a member of a committee of the American Medical Association or Your state or county medical association or medical specialty society that conducts credentialing, quality assurance, peer review or medical ethics review; or

3. Your duties as a member of Your medical group's duly authorized committee that conducts credentialing, quality assurance, peer review, utilization review or medical ethics review on Your behalf.

AD. **Professional Health Care Services** means those health care or medical services You provide including, but not limited to:

1. Direct medical, surgical, dental or nursing treatment, including the furnishing of food or beverages in connection therewith;

2. Making medical diagnoses and rendering medical opinions and or medical advice;

3. Furnishing or dispensing of drugs or medical, dental or surgical supplies or appliances; or

4. The handling, treatment or performing of postmortem examinations on deceased human bodies, including autopsies, organ donation or other procedures.

AE. **Property Damage** means:

1. Physical injury to or destruction of tangible property that occurs within the Coverage Territory, including all resulting loss of use of that property occurring at any time. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or

2. Loss of use of tangible property that is not physically injured or destroyed provided such loss of use is caused by an Occurrence within the Coverage Territory. All such loss of use shall be deemed to occur at the time of the Occurrence that caused it.

AF. **Retroactive Date** as set forth in Item 3 of the Declarations Page or applicable endorsement is the earliest date on which a Medical Incident or Occurrence may occur and for which coverage may be afforded under this policy.

AG. **Sexual Misconduct** means any physical or mental assault, harassment or contact of a sexual nature.

AH. **We, Us, and Our** refers to NORCAL Mutual Insurance Company, identified hereinafter as NORCAL or the Company.

AI. **You and Your** refers to the Named Insured shown on the Declarations Page.

PART VII EXTENDED REPORTING PERIOD OPTION

IF YOU DO NOT PURCHASE AN EXTENDED REPORTING PERIOD ENDORSEMENT, YOU WILL HAVE NO COVERAGE FOR CLAIMS, ADMINISTRATIVE PROCEEDINGS OR EMPLOYMENT-RELATED CIVIL ACTIONS THAT YOU FIRST REPORT TO US ON OR AFTER THE EXPIRATION OR TERMINATION DATE OF THIS POLICY OR THE APPLICABLE COVERAGE.

You must request issuance of this Extended Reporting Period Endorsement by written notice to Us within thirty (30) days from the expiration or termination date of this policy.

A. **YOUR AND OUR RIGHTS**

You may have the right to purchase an Extended Reporting Period Endorsement (frequently known as "tail coverage") if this policy or applicable coverage is canceled or non-renewed. This endorsement provides an extended period of time for reporting Claims, Administrative Proceedings or Employment-Related Civil Actions as follows:

1. Medical Incidents or Occurences that take place on or after the Retroactive Date as shown on the Declarations Page or applicable endorsement and before the expiration or termination of an Insured's coverage; and

2. Results in a Claim against an Insured that is first reported to Us under the Extended Reporting Period Endorsement; or

3. Acts that take place on or after the applicable Retroactive Date and before the expiration or termination of an Insured's coverage that result in an Administrative Proceeding or Employment-Related Civil Action instituted against that Insured and first reported to Us under the Extended Reporting Period Endorsement.

To purchase an Extended Reporting Period Endorsement You must be in compliance with all terms and conditions of the policy. You must also pay any outstanding earned premium and an additional premium for the Extended Reporting Period Endorsement that will be computed in accordance with Our rules, rates, and rating plans in effect at the time of the expiration or termination of the policy. This additional premium is fully earned and non-refundable.

Upon payment of the premium, You will receive an endorsement that describes Your extended reporting period. If We do not receive full payment of all billed premiums on or before the due date of the premium notice, We will not issue an Extended Reporting Period Endorsement, and We will cancel any previously issued reporting endorsements.

Additionally:

1. You will not have the right to purchase nor are We required to offer an Extended Reporting Period Endorsement if Your policy is rescinded, or, canceled or non-renewed for: non-payment of premium, fraud, misrepresentation, concealment, or breach of warranty.

2. Once in effect, the Extended Reporting Period Endorsement may not be canceled unless an Insured under this policy commits a material breach of the terms or conditions of this

policy or any endorsements attached to it.

3. The Extended Reporting Period Endorsement does not extend the Policy Period or change the scope of coverage provided under this policy form and any attached endorsements.

4. The Extended Reporting Period Endorsement is subject to all of the provisions of the policy in existence at the time Your active coverage ceases.

5. The Extended Reporting Period Endorsement provides one set of Limits of Liability that are applicable only to those Claims first reported during the Extended Reporting Period. Those Limits of Liability will be eroded by payment of judgments and settlements. Our duty to defend ends when the Limits of Liability are exhausted by payment of judgments and settlements.

B. **SPECIAL PROVISIONS IF YOU ARE A PHYSICIAN**

1. **Waiver of Extended Reporting Endorsement Premium in the Event of Disability.**

   a. If You become totally and permanently disabled during the Policy Period as a result of Bodily Injury and are therefore completely unable to continue practicing as a physician or surgeon, We will provide You an Extended Reporting Period Endorsement without cost. This waiver of premium is contingent upon receipt of evidence satisfactory to Us, which may include a physical examination by physicians of Our choice, that You are totally and permanently disabled. However, We must receive a written request from You or Your personal representative for this benefit within 30 days after the end of the Policy Period.

   b. We will require reasonable proof that Your disability continues on each anniversary of the issuance of the Extended Reporting Period Endorsement. If at any time in the future You resume practicing as a physician to any extent, any Extended Reporting Period Endorsement issued pursuant to this provision will terminate on the date You resumed practice. You will have the right to purchase an Extended Reporting Period Endorsement upon payment of the full premium. If You fail to purchase this Extended Reporting Period Endorsement following Your resumption of practice, You will have no coverage for Claims, Administrative Proceedings, or Employment-Related Civil Actions reported to Us after the termination of the Extended Reporting Period Endorsement issued pursuant to this paragraph.

2. **Waiver of Extended Reporting Period Endorsement Premium in the Event of Death.**

   In the event of Your death during the Policy Period an Extended Reporting Period Endorsement will be issued to Your estate without any premium charge. This Extended Reporting Period Endorsement will become effective on the date of Your death. However, We must receive a written request together with proof of death within sixty (60) days after Your death.

3. **Phase-out Provision – Waiver of Extended Reporting Period Endorsement Premium Upon Retirement at Age 55.**

a. At age 55 You may be eligible for a full waiver of Your Extended Reporting Period Endorsement if You were insured with Us on September 30, 2005, remain insured with Us continuously until You retire and You:

i. Were age 50 or older on September 30, 2005;

ii. Were insured with Us for the 12 months, and had continuous coverage for the 60 months, prior to reaching age 55;

iii. Retire completely from the practice of medicine; and

iv. Request this benefit on or before December 31, 2015.

b. We must receive a written request for this benefit at least 30 days in advance of Your retirement date. We will periodically require proof satisfactory to Us that You remain retired from the practice of medicine. If at any time in the future You resume practicing as a physician to any extent, You will lose Your right to this waiver as of the date You resumed practice. However, You will have the right to purchase an Extended Reporting Period Endorsement upon payment of the full premium. If You fail to purchase this Extended Reporting Period Endorsement following Your resumption of practice, You will have no coverage for any Claims, Administrative Proceedings, or Employment-Related Civil Actions reported to Us after the termination of the Extended Reporting Period Endorsement issued above.

4. **Waiver of Extended Reporting Period Endorsement Premium upon Retirement at Age 60.**

a. If during the Policy Period, You choose to retire completely from the practice of medicine, You may be eligible for a full waiver of Your Extended Reporting Period Endorsement premium. To be eligible You must, as of Your requested cancellation date:

i. Have been continuously insured with Us for the 60 months immediately prior to requesting this benefit; and

ii. Be at least 60 years of age; and

iii. Retire completely from the practice of medicine.

b. We must receive a written request for this benefit at least 30 days in advance of Your retirement date. We will periodically require proof satisfactory to Us that You remain retired from the practice of medicine. If at any time in the future You resume practicing as a physician to any extent, You will lose Your right to this waiver as of the date You resumed practice. However, You will have the right to purchase an Extended Reporting Period Endorsement upon payment of the full premium. If You fail to purchase this Extended Reporting Period Endorsement following Your resumption of practice, You will have no coverage for any Claims, Administrative Proceedings, or Empoyment-Related Civil Actions reported to Us after the termination of the Extended Reporting Period Endorsement issued above.

5. **Waiver of Extended Reporting Period Endorsement Premium at Age 65.**

If You were insured with Us on September 30, 2005, You may be eligible for a full waiver of Your Extended Reporting Period Endorsement premium at age 65 if You were insured with Us for the 60 months immediately prior to reaching age 65.

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AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Protecting your assets: Why medical liability insurance isn't enough

By Howard B. Yeon, MD, JD, and James H. Herndon, MD, MBA

Medical liability is a ubiquitous concern for orthopaedic surgeons. The prospect of a lawsuit brings well-justified fears of a prolonged, unpleasant, and costly judicial process that could result not only in professional stigma but also in financial ruin.[1]

Laws capping tort damages have been effective in some states, but in many states, political forces make the adoption of such limits unlikely. Because hospitals in some states are protected under the doctrine of charitable immunity, individual physicians may be seen as the ultimate deep pockets in medical liability litigation.

Medical liability insurance is imperfect protection

Most physicians trust that medical liability insurance will protect their personal and business assets, but this reliance may be misplaced. Premiums have risen sharply over the past decade as insurers have adjusted to changes in legal and administrative costs and to the rising fraction of paid closed claims.[4-6]

Despite its increasing cost, medical liability insurance provides limited protection from the full range of tort liability. For example, medical liability insurance does not cover liability arising from activities inherent in running a medical practice but not directly related to the physician-patient relationship. These potential liabilities include employment lawsuits and

tort claims from injuries sustained on the office premises.

Jury awards in medical liability cases are often unpredictable and can exceed coverage limits. When this occurs, physicians' personal assets and revenue stream are vulnerable to collection by the plaintiff.

More isn't necessarily better

One way to address this risk is to pay for more insurance coverage. Harvard-affiliated physicians, for example, have medical liability coverage with limits of $5 million per suit and an annual aggregate of $10 million. High-limit policies may be somewhat effective in protecting physicians' personal assets from loss as a result of medical liability litigation.

In Texas, for example, a jury awarded $269 million to the family of a girl with cerebral palsy who died as a result of an overdose of propofol administered as a medication error. But the family later settled privately for $3 million—just under the total insurance policy limit of the three physicians involved.

A "high-low" agreement between a plaintiff and defendant before trial may guarantee the plaintiff a sizeable minimum payment but limit the maximum payment amount to the insurance policy limit, regardless of the actual damages awarded at trial. Because such agreements are quite common, high medical liability insurance policy limits may also directly increase settlement amounts in high verdict cases.[8]

High-limit policies may also encourage lawsuits because they ensure a large pool of liquid assets available to tort plaintiffs and their attorneys. Because most plaintiffs' attorneys are compensated on a contingency fee basis, lawyers have become the de facto gatekeepers of the medical liability tort system.[9] An attorney working on a contingent basis may decide whether to accept a case by considering its merits and various economic factors.

Before accepting a medical liability client, an attorney may estimate the probability (P) that the case has merit and the likely monetary recovery (L) should the client settle or win at trial. The *a priori* value of the case to the attorney is P times L times the contingency percentage (usually around 33 percent). If the value of the case is greater than the attorney's predicted cost, he or she will proceed, but if the value of the case is lower than the cost, he or she is unlikely to continue and may even try to dissuade the potential client from pursuing the lawsuit.

The potential monetary recovery depends both on the severity of the patient's injury and on the physician's ability to pay. To determine a defendant physician's available assets, a plaintiff attorney's first inquiry is invariably the policy limits of the physician's insurance coverage. Insurance companies are ideal deep-pocket payors because they can make large lump-sum payments without the added transactional and legal complications implicit in

seizure of personal assets or garnishment of income.

Personal assets at risk

A physician's personal assets, if substantial and otherwise unprotected, also contribute to the pool of funds available to the plaintiff and the plaintiff's attorney. A search of state and county records can uncover real estate, corporations, and other assets held in the name of the physician or his or her spouse. Private financial investigators and tactics such as "phishing"—attempting to discover account balances and other sensitive information by posing as the physician—may also be used.

A large pool of medical liability insurance revenue contributes to a public perception and expectation that well-heeled and well-insured physicians have pockets deep enough to compensate patients who have adverse outcomes. Although the physicians' medical liability coverage limits cannot generally be mentioned at trial, juries typically assume that doctors carry liability insurance adequate to compensate injured patients. In Florida, where some physicians elect to practice without medical liability insurance, state law requires them to post a sign in their offices informing patients that they have assets sufficient to cover at least $250,000 of any medical liability award.

Expanding the boundaries

To obtain monetary damages in an environment in which physicians have substantial insurance coverage and other vulnerable assets, attempts to expand the duties of physicians within the standard of care may be made.

One illustrative case involved a 30-year-old man who underwent two hip surgeries—a left total hip arthroplasty (THA) and a right hip core decompression—in 1990. The two procedures were scheduled 7 days apart during the same hospitalization. Prior to the THA, the patient consented to participate in an experimental protocol and receive RD-Heparin, a low molecular-weight heparin being tested at the defendant's hospital.

After the patient failed to receive the first dose of the experimental medication at the time prescribed by the clinical trial due to a nursing error, he was excluded from the study and was started on aspirin on the first postoperative day in accordance with the surgeon's standard anticoagulation prophylaxis protocol. The patient continued to receive aspirin through his hospital stay and after discharge to his home, but he suffered a fatal pulmonary embolism 6 days after discharge. Despite the experimental nature of the alternative medication and testimony that aspirin was an acceptable choice for anticoagulation, the jury awarded a total verdict of $539,275 for the plaintiff.

The cumulative effect of such cases is to expand the boundaries of legally enforceable physician responsibility as perceived by physicians and by patients. As a result of this asymmetric development and dissemination of case law, accepted boundaries of physician

responsibility have expanded, creating additional legal theories under which physicians can be found liable and reducing the role of patient self-accountability in medical practice. Reporting bias may also cause plaintiffs to overestimate their chances of prevailing in medical liability litigation and the monetary value of their case.[11]

What's the alternative?

If physicians cannot rely on insurance to protect their property from tort liability, what can they do? One alternative is asset protection—the use of statutory protections, business entities, and strategic financial transactions to limit financial risk. Most business enterprises with significant risk exposure take advantage of asset protection techniques to limit tort liability, but most orthopaedic surgeons do not use asset protection effectively. Next month, we will describe simple, functional, and inexpensive asset protection strategies that can be used by orthopaedic surgeons.

Howard B. Yeon, MD, JD, is a graduate of Harvard Medical School, Harvard Law School, and the Harvard Combined Orthopaedic Residency Program. James H. Herndon, MD, MBA, is past president of the AAOS and currently program director of the Harvard Combined Orthopaedic Residency Program. Comments from members on this article are welcome; e-mail them to aaoscomm@aaos.org

Did you know?

- Fewer than 2 percent of injuries caused by medical negligence resulted in a medical liability claim, and only 17 percent of medical liability lawsuits filed were in fact found to involve medical negligence, according to the Harvard Medical Practice review of 30,000 hospital discharges and 3,500 medical liability claims in New York state.[2]
- More than one third of written demands for payment for medical injury did not involve medical error, based on a recent closed claims analysis of 1,452 medical liability claims from five large liability insurers.[3]
- Claims not involving error were more than twice as likely to result in trial rather than settlement.[3]
- Meritless claims led to compensation through settlement in more than 25 percent of cases.
- Overhead costs—including litigation costs and attorney fees—typically account for more than half of settlement costs.[3]
- The average time between injury and resolution is 5 years.[3]
- Professional liability insurance rates in Massachusetts have increased 132 percent since 1992, and professional liability premiums account for more than 11 percent of operating costs in four out of 10 physician practices.[7]

- The New York state insurance department approved a 14 percent increase in medical liability premiums in 2007 to prevent a looming insurance industry crisis.

References

[1] *See* Kennedy v. McKesson Co., 58 N.Y.2d 500 (1983) holding that damage to a dental surgeon's professional reputation and mental condition rendering him unable to carry on his professional work as a result of a medical malpractice action and associated criminal investigation stated a valid cause of action permitting recovery for monetary damages.

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AAOS *Now*
January 2008 Issue
http://www.aaos.org/news/aaosnow/jan08/managing6.asp

The California Department of Insurance has issued their annual report outlining the market share and written premiums of insurers writing medical malpractice insurance policies in California. This is closely watched data as the failure rate for medical malpractice insurance companies is among the highest in the insurance industry. The failure rate for companies looking to participate in the medical malpractice insurance industry exceeds 76% – a daunting figure for physician insureds. Scores of physicians have been caught up in the catastrophic failures of various risk retention groups and interdeminty trusts, leaving physicians in a lurch as the insurance policies they paid thousands of dollars for now prove totally worthless. Physicians and surgeons in California remember all too vividly the years of litigation prompted by the infamous failure of Physicians Interindemnity Trust in the mid 90s.

The state of California attempts to provide consumers with the information they need to obtain coverage from an insurer they deem financial stable. Generally, the total written premium (all the money to be collected on policies the company issues to health-care providers like physicians and surgeons) and the incurred loss (a figure which represents claims paid out by the insurer plus this figure can include an adjustment for reserves set aside for claims to be paid) can provide a picture of medical malpractice insurers financial stability. However, actual financial documents are also available on the insurance department website for further inquiry into the financial stability of any medical malpractice insurance company.

The Doctors Company easily topped the group market share list of medical malpractice insurance companies in California with over $200 Million ($210,609,883) in written premium. Norcal Mutual Insurance Company a distant second with over $150 Million in written premium. Medical Protective, the Berkshire Hathaway company, comes in at just under $30 Million in California. Its worth noting The Doctors Company acquired SCPIE (AHI) and this acquisition is reflected in thewritten premium, and Berkshire Hathaway remains strong on a national level though the California market share reflects a conservative and stringent underwriting approach offering medical malpractice insurance only for the best of the best. A newer player in the medical malpractice industry, Fairway RRG reported just over $7 million in written premium for all of 2009 (and even more worrisome is the Fairway RRG incurred losses reported of over $3 Million for 2009).

California market share data should be considered prior to purchasing medical malpractice insurance - lest you find yourself with a medical malpractice carrier touting great discounted rates without the money to actually pay the claims. With the exorbitant costs of medical malpractce insurance, you definetely need to consider if you get what you paid for. Always, always, always check the AM Best Ratings and financial data before purchasing a policy because in medical malpractice insurance there is always safety in numbers!

FILED UNDER: INDUSTRY UPDATES, INSURANCE ISSUES TAGGED WITH: CALIFORNIA MEDICAL MALPRACTICE, FAIRWAY, FAIRWAY INSURANCE, FAIRWAY RRG, MEDICAL MALPRACTICE INSURANCE, NORCAL, NORCAL INSURANCE, NORCAL MUTUAL, THE DOCTORS COMPANY

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