I. INSURING AGREEMENT.

In consideration of the payment of the premium due for this policy, and in reliance upon the information provided by or on behalf of the Insured for obtaining or continuing this policy, and subject to the Declarations made a part hereof, the limits of liability, exclusions, conditions and other terms of this policy, Medical Mutual Insurance Company of North Carolina ("the Company") agrees with the Insured that:

Coverage A. Individual Professional Liability

The Company will pay on behalf of the Insured listed under “Coverage A” of the Declarations all damages that the Insured shall become legally obligated to pay for an Injury to which this insurance applies because of a Medical Incident that takes place on or after the Retroactive Date stated in the Declarations and which claim is first made and reported during the Policy Period.

Coverage B. Medical Practice and Non-Physician Employee Professional Liability

The Company will pay on behalf of the Medical Practice listed under “Coverage B” of the Declarations and, when the Medical Practice is listed under “Coverage B” of the Declarations, on behalf of Non-physician Employees all damages that an Insured becomes legally obligated to pay for an Injury to which this insurance applies because of a Medical Incident that takes place on or after the Retroactive Date stated in the Declarations and which claim is first made and reported during the Policy Period.

The Company shall have the right and duty to defend any Suit seeking damages covered by this policy, even if the allegations of the Suit are groundless, false or fraudulent. The Company may make such investigation of any Medical Incident, claim, or Suit as it deems appropriate. The Company has no duty to defend an Insured against a Suit seeking damages to which this insurance does not apply, except as otherwise specifically provided in this policy.

The Company’s duty to defend an Insured ends when the Company has used up the applicable limit of liability stated in the Declarations in payment of settlements, or in full or partial satisfaction of judgments.

Coverage C. Per Diem Reimbursement

Whenever an Insured physician is required by the Company to attend a trial of a claim covered by this policy, that Insured is entitled to reimbursement from the Company of up to $1,000.00 per day, or part of a day, not to exceed the aggregate sum of $20,000.00 for all claims made during the Policy Period, for loss of actual earnings as a licensed physician in the practice of medicine.
II. WHEN A CLAIM IS MADE AND REPORTED.

A claim shall be considered to be first made against an Insured upon the earliest of:

(a) knowledge by an Insured of the happening of a Medical Incident that by its nature may result in a claim for damages against an Insured;

(b) receipt by an Insured of a notice of a demand for money or for services, or other notice indicating that a claim may be made because of a Medical Incident; or;

(c) receipt by an Insured of a Suit naming an Insured because of a Medical Incident.

A claim shall be deemed reported when the Company receives:

(a) a written report of a Medical Incident that by its nature may result in a claim for damages against an Insured, and which report contains: (1) the name of the Insured; (2) the name(s) of the patient(s) involved; (3) the date and location of the Medical Incident; (4) a description of the Professional Services rendered giving rise to the Medical Incident; (5) the names of all known witnesses with any knowledge of the Medical Incident, and; (6) the dated signature of the Insured;

(b) a copy of any written notice of a demand for money or for services, or the substance of any other notice indicating that a claim may be made, against an Insured because of a Medical Incident; or;

(c) a copy of a Suit naming an Insured because of a Medical Incident.

Notwithstanding any other policy provisions contained herein, a claim first made against an Insured during the Policy Period shall be deemed to have been reported, for purposes of subsections (b) and (c) above only, within the Policy Period so long as the written report of the claim is received by the Company within five (5) business days after the end of the Policy Period, or, if such Insured is covered under a renewal of this policy and has been insured continuously with the Company since the claim was made, the written report of the claim is received within any succeeding Policy Period.

All claims arising out of, or in connection with, the same Medical Incident shall be deemed to have been made at the time the first claim is made.

III. DEFINITIONS.

“Disability” or “Disabled” means either (1) the inability to carry out the Insured’s profession or practice; and/or; (2) the positive diagnosis of Human Immuno-deficiency Virus (HIV) or Hepatitis B virus, and provided that the diagnosis of the Disability results in the Insured ceasing the practice of medicine. A positive diagnosis for HIV must have been established by an HIV test that is considered reliable by the Federal Center for Disease Control. The Company reserves its right to require the Insured to undertake an independent medical exam by a physician of the Company’s choice to confirm the diagnosis of any Disability. The results of such an examination will be binding on the Company and the Insured.

“Injury” means physical harm, mental anguish, mental illness, emotional upset or distress, sickness, disease or death, and which is neither expected nor intended by the Insured. Injury does not include any form of harm arising out of or in connection with molestation, sexual act, sexual encounter, sexual contact, sexual assault, sexual misconduct, sexual intimacy, statements or comments with sexual innuendo, erotic conduct or physical contact, undue familiarity, sexual harassment, sexual exploitation, alienation of affections, criminal conversation, or any act of commission or omission, whether or not consensual, of a sexual or erotic nature or connotation, regardless of whether such conduct occurred as a part of, in relation to, as a result of, under the guise of, or during the performance of, Professional Services or in relation to the mishandling of transference or counter-transference.
“Insured” means:

(a) Each individual listed in the Declarations under “Coverage A”;

(b) Any physician providing Locum Tenens Coverage in an Insured’s Medical Practice;

(c) The Medical Practice listed in “Coverage B” of the Declarations and Non-physician Employees acting within the course and scope of and in furtherance of their employment by such Medical Practice or by an Insured listed in the Declarations under “Coverage A”;

(d) If there is nothing listed in the Declarations for “Coverage B”:
   
   (i) the Medical Practice of the Insured listed in the Declarations under “Coverage A”;  
   
   (ii) Non-physician Employees while acting within the course and scope of and in furtherance of their employment by any Insured listed in the Declarations under “Coverage A” or the Insured’s Medical Practice.

“Locum Tenens Coverage” means the process by which a licensed physician works in the place of a physician Insured listed in the Declarations under “Coverage A” due to vacation, illness, or other non-routine absence, subject to a limitation of sixty (60) days per policy period per physician Insured. Any physician Insured working in this capacity must be appropriately licensed by the state regulatory agency responsible for licensing physicians and surgeons in the specific U.S. state contained in the Named Insured’s address listed in the Declarations, and must have substantially similar qualifications to those of the Insured in whose place the physician is working.

“Medical Incident” means an act, error or omission arising out of or in connection with the rendering of or failure to render Professional Services. A continuing course of treatment of a patient shall be considered one Medical Incident.

“Medical Practice” means an insured physician’s corporation, professional association, partnership, or other legal entity established for the providing of Professional Services by the Insured.

“Named Insured” means the physician or Medical Practice listed in the Declarations in the box titled “Name and Address of Insured”.

“Non-physician Employees” means those individuals employed by either the Medical Practice or a physician named in the Declarations under “Coverage A”, except for: nurse practitioners, physician assistants, certified registered nurse anesthetists, certified nurse midwives, psychotherapists, licensed clinical social workers, podiatrists, chiropractors, and dentists.

“Policy Period” means the period of time commencing with the Effective Date and ending with the Expiration Date as stated in the Declarations to this policy.

“Professional Services” means:

(a) services requiring the use or application of special learning or intellectual skill performed, or which should have been performed by, an Insured in furtherance of medical or surgical treatment or care of patients provided that: (1) if a license is required under state law to provide such services, an Insured shall be duly licensed by the state at the time to provide such services, and; (2) if such services are performed in a hospital or similar facility where privileges are required, an Insured at the time shall either have been granted privileges or is being proctored incident to a pending privilege application;

(b) services by an Insured: (1) as a member of a formal accreditation, standards review, or similar committee of a licensed acute care hospital, provided that such hospital is accredited by the Joint Commission on Accreditation of Hospital and Health Care Organization, or; (2)
on a formal committee of a professional medical society or association, or; (3) on a peer review or credentialing committee of a lawfully structured physician or physician/hospital organization or association.

“Professional Services” does not include any molestation, sexual act, sexual encounter, sexual contact, sexual assault, sexual misconduct, sexual intimacy, statements or comments with sexual innuendo, erotic conduct or physical contact, undue familiarity, sexual harassment, sexual exploitation, alienation of affections, criminal conversation, or any act of commission or omission, whether or not consensual, of a sexual or erotic nature or connotation, regardless of whether such conduct occurred as a part of, in relation to, as a result of, under the guise of, or during the performance of Professional Services or in relation to the mishandling of transference or counter-transference.

“Retirement” or “Retired” means the complete and permanent withdrawal from the practice of medicine by the Insured if, at the time of such Retirement, the Insured holds a medical license in good standing with the medical board in the Insured’s state of licensure.

“Sexual Misconduct” shall mean any molestation, sexual act, sexual encounter, sexual contact, sexual assault, sexual intimacy, statements or comments with sexual innuendo, erotic conduct or physical contact, undue familiarity, sexual harassment, sexual exploitation, alienation of affections, criminal conversation, or any act of commission or omission, whether or not consensual, of a sexual or erotic nature or connotation, where such conduct occurred or is alleged to have occurred, arising out of, in connection with, as part of, in relation to, as a result of, under the guise of, or during the performance of, Professional Services or in relation to the mishandling of transference or counter transference.

“Suit” means legal process, including: (1) a civil summons and/or complaint, (2) a civil summons and order extending time for filing a complaint, (3) a demand for arbitration, or; (4) the equivalent, naming an Insured as a party thereto and which initiates a civil action for the recovery of money damages against an Insured.

IV. EXCLUSIONS.

This insurance does not apply to any of the following:

(a) damages arising out of or in connection with a claim against an Insured physician in the capacity of owner, administrator, superintendent, officer, director, trustee or medical director of a hospital (or any department or section thereof), sanitarium, clinic with or without bed and board facilities, laboratory, managed care entity, business enterprise, nursing home or as a member of any governing body of such institution or entity, except an entity listed in “Coverage B” of the Declarations. However, this exclusion does not apply to Professional Services by the Insured for the Insured’s own patient at such an institution or entity;

(b) damages arising out of or in connection with the liabilities of others assumed by the Insured under any contract or agreement. However, this exclusion does not apply to any written indemnification agreement between an Insured and a third party where the liabilities of the third party under such an agreement are based solely upon Professional Services by the Insured, where such agreement was entered into prior to the Medical Incident and where the Insured would have been liable to such third party without regard to the agreement;

(c) damages arising out of or in connection with advertising, marketing, warranting (express or implied) or solicitation for Professional Services;

(d) damages arising out of or in connection with any unfair or deceptive act or practice, anti-trust, or restraint of trade, commerce or services;
(e) damages arising out of or in connection with the operation of any patient referral service in which the Insured has an investment interest, or from which any Insured received compensation not solely attributable to the actual rendering of Professional Services;

(f) under Coverage A, Individual Professional Liability, all damages sought in a claim or Suit where an allegation of Sexual Misconduct is made against any Insured. This exclusion shall apply regardless of whether the claim or Suit seeking such damages would otherwise be covered but for the application of this exclusion. Notwithstanding this exclusion, the Company shall have such rights and duties to defend and investigate as are otherwise applicable to Coverage A;

(g) under Coverage B, Medical Practice and Non-Physician Employee Professional Liability, all damages sought in a claim or Suit where an allegation of Sexual Misconduct is made against any Insured. This exclusion shall apply regardless of whether the claim or Suit seeking such damages would otherwise be covered but for the application of this exclusion, but this exclusion shall apply to damages only to the extent that the Medical Practice, other than the individual Insured under Coverage A whose conduct is addressed by Exclusion (f) above, knew or should have known about an Insured’s Sexual Misconduct and failed to appropriately investigate or act to prevent damages from any such conduct. Notwithstanding this exclusion, the Company shall have such rights and duties to defend and investigate as are otherwise applicable to Coverage B;

(h) damages arising out of or in connection with any act, error or omission by an Insured prior to the Policy Period if:

(i) on or before the effective date of this policy an Insured knew of the happening of a Medical Incident that by its nature may result in a claim for damages against an Insured for that Injury, or

(ii) a claim or Suit arising out of, or in connection with, the same Medical Incident was reported to any other insurance company or a self-insured, retained risk, or risk sharing plan or program, or

(iii) Medical Incident giving rise to the claim has been reported to another insurance company or a self-insured, retained risk, or risk sharing plan or program;

(i) damages arising out of or in connection with invasion of privacy, slander, libel, or defamation. However, this exclusion does not apply to damages because of any Injury to a patient or former patient, unless the claim is based upon utterances by an Insured in any print or electronic media;

(j) damages arising out of or in connection with discrimination by an Insured on any basis, including but not limited to, race, creed, age, sex, sexual orientation, marital status, or disability;

(k) damages arising out of or in connection with an Insured’s criminal act or an Insured’s violation of any statute, ordinance or regulation that provides for any criminal penalty whether or not there is a criminal charge, prosecution, or conviction;

(l) damages arising out of or in connection with any willful, fraudulent, malicious (including malicious prosecution or abuse of process) or intentional acts or omissions, including but not limited to battery;

(m) damages arising out of or in connection with nuclear reaction, radiation, radioactive contamination, or the discharge, dispersal, release, or escape of pollutants, or any consequence of these;
(n) damages arising out of or in connection with the rendering of or failure to render
Professional Services occurring in any location where the Insured was not licensed to
practice medicine and where such a license was required;

(o) damages arising out of or in connection with the rendering of or failure to render
Professional Services outside the geographical boundaries of the specific U.S. state
contained in the Named Insured’s address listed in the Declarations, unless the Named
Insured has advised the Company in writing in advance of the intention of any Insured
under the policy to practice medicine in any other U.S. state or territory and the Company
has agreed in writing to extend coverage to such Professional Services;

(p) damages arising out of or in connection with any Professional Services that are outside the
scope of the Insured’s specialty as stated in the Insured’s most recent application or
practice profile;

(q) under Coverage A, Individual Professional Liability, damages arising out of, in
connection with, or enhanced, exacerbated, or aggravated by, an Insured’s abuse of or
being under the influence of alcohol, drugs, or any other impairing substance and, under
Coverage B, Medical Practice and Non-Physician Employee Professional Liability,
damages arising out of, in connection with, or enhanced, exacerbated, or aggravated by, an
Insured’s abuse of or being under the influence of alcohol, drugs, or any other impairing
substance, but this exclusion shall apply only to the extent that the Medical Practice, other
than the individual Insured under Coverage A, whose conduct is addressed by this
Exclusion (q), knew or should have known about an Insured’s abuse of alcohol, drugs, or
any other impairing substance and failed to appropriately investigate or act to prevent
damages from any such conduct. Notwithstanding this exclusion as to Coverage A and B,
the Company shall have such rights and duties to defend and investigate as otherwise
applicable to Coverage A and B.

(r) damages awarded or costs taxed against an Insured caused by, due to, or because of, any
act or omission by an Insured that constitutes a failure to cooperate with the Company,
untimely notice to the Company, or that violates any other policy conditions;

(s) damages arising out of or in connection with any unauthorized activity by an Insured
relating to the prescribing or dispensing of controlled substances;

(t) damages arising out of or in connection with an Insured’s services as an expert witness or
litigation consultant;

(u) damages arising out of or in connection with providing Professional Services while the
denial, restriction, involuntary reduction, or suspension of hospital or clinical privileges
(except for temporary restrictions due to incomplete medical records, or failure of the
Insured to attend hospital medical staff meetings) of the Insured are in effect, unless the
Insured has first notified the Company of such hospital or clinic-imposed action and the
Company has agreed in writing to extend coverage during the period of such action;

(v) damages arising out of or in connection with providing Professional Services while a
hospital or clinic-imposed punitive or disciplinary observation, supervision, proctorship,
preceptorship or required consultation involving the Insured are in effect, unless the
Insured has first notified the Company of such action and the Company has agreed in
writing to extend coverage during the period of such action;

(w) damages arising out of or in connection with providing Professional Services during the
suspension, revocation or surrender of an Insured’s license or certificate to practice
medicine, or which providing of Professional Services constitutes a violation of or falls
outside the scope of any restriction imposed upon such license or certificate;
(x) damages arising out of or in connection with any act, error or omission of a physician, nurse practitioner, physician assistant, certified registered nurse anesthetist, certified nurse midwife, psychotherapist, licensed clinical social worker, podiatrist, chiropractor or dentist who is not listed as an Insured in the Declarations, unless the Insured has purchased from the Company an endorsement insuring the vicarious liability of the Insured for the acts, errors or omission of any such person. However, this exclusion shall not apply to the Insured’s supervision of physician residents or physician fellows who are employed in a formal postgraduate training program, provided that: (i) such physician residents or physician fellows are covered for any liability arising from their rendering of or failure to render professional services under an insurance or self-insurance program, and; (ii) no Insured has agreed, by written contract or otherwise, to indemnify any health care facility, any individual, or any other entity for any liability arising from the acts or omissions of the same physician residents or physician fellows; or (y) damages arising out of, in connection with, or enhanced, exacerbated, or aggravated by an Insured’s misrepresentation or concealment of any material fact or circumstance relating to a claim, or of any involvement in the alteration of patient records.

V. LIMIT OF LIABILITY.

The limit of liability stated in the Declarations as applicable to “each claim” is the limit of the Company’s liability for all damages resulting from any one claim subject, however, to the available limit of liability and the following:

(a) All claims arising out of, or in connection with, the same Medical Incident shall be considered one claim subject to the limit of liability as stated in the Declarations as applicable to “each claim”;

(b) All claims arising out of, or in connection with, the obstetrical treatment of mother and fetus, or fetuses, from conception through postpartum care, shall be considered one claim subject to the limit of liability as stated in the Declarations as applicable to “each claim”;

(c) The limit of liability for “each claim” as stated in the Declarations under “Coverage A” shall apply separately to each Insured listed under “Coverage A” in the Declarations, subject to the “annual aggregate” for all claims against each such Insured;

(d) The limit of liability for any Insured physician providing Locum Tenens Coverage shall apply collectively to and be shared between that Insured and the Insured in whose place the physician is working;

(e) The limit of liability for “each claim” as stated in the Declarations under “Coverage B” shall apply as an single, shared limit for the Medical Practice and its Non-physician Employees, subject to the “annual aggregate” for all claims against all such Insureds;

(f) If there is no limit of liability stated in the Declarations under “Coverage B”, then the limit of liability for “each claim” stated in the Declarations under “Coverage A” shall apply as a single, shared limit for the Insured physician, the Medical Practice, and their Non-physician Employees, subject to the “annual aggregate” applicable to that Insured physician;

(g) The limit of liability stated in the Declarations applies to, and is inclusive of, any and all costs, fees, expenses, prejudgment and post-judgment interest, and any other sums that are awarded or taxed against an Insured.
The limit of liability stated in the Declarations as “annual aggregate” is the total limit of the Company’s liability for all claims first made and reported during the policy period. The “annual aggregate” applies separately for each Insured listed under “Coverage A” in the Declarations. The “annual aggregate” applies as a single, shared “annual aggregate” for all Insureds under “Coverage B” in the Declarations.

Except as provided for in any Coverage listed in the Declarations, the Company has no other obligation or liability to pay sums or perform acts or services, unless explicitly provided in Section XI, Supplementary Payments.

VI. EXTENDED REPORTING PERIOD.

In the event of non-renewal or cancellation of this policy, except for cancellation due to nonpayment of premium, a Medical Practice listed under Coverage B and an Insured listed under Coverage A shall have the right, upon payment of an additional premium computed in accordance with the Company’s rules, rates, and rating plans then in effect, to an Extended Reporting Period of unlimited duration, during which claims may be reported under this policy. The Extended Reporting Period permits the reporting of a claim arising out of, or in connection with, a Medical Incident that takes place on or after the Retroactive Date stated in the Declarations and prior to the non-renewal or cancellation of this policy. Such right to purchase an Extended Reporting Period must be exercised by an Medical Practice listed under Coverage B or an Insured listed under Coverage A by written notice to the Company not later than thirty (30) days after the effective date of the non-renewal or cancellation.

In the event an Insured listed under coverage A dies, or becomes permanently Disabled and is unable to carry out the Insured’s profession or practice, while this policy is in force, the Company will provide an Extended Reporting Period of unlimited duration, during which a claim may be reported under this policy, without payment of any additional premium, effective on the date of death or permanent Disability. Proof of death or permanent Disability must be furnished to the Company as soon as practicable. The Extended Reporting Period provided to a deceased Insured or to a Disabled Insured permits the reporting of a claim arising out of, or in connection with, a Medical Incident that takes place on or after the Retroactive Date stated in the Declarations and prior to the Insured’s death or permanent Disability.

An Insured listed under coverage A who retires from the practice of medicine while this policy is in force will be provided an Extended Reporting Period of unlimited duration, during which a claim may be reported under this policy, without payment of any additional premium, provided:

(a) the Insured is fifty (50) years of age or older, and has been insured continuously with the Company for at least one (1) year immediately preceding Retirement, and who, as of the date of Retirement, holds a license in good standing issued from the medical board in the Insured’s state of licensure, or;
(b) the Insured has been insured continuously with the Company for at least seven (7) consecutive years immediately preceding Retirement, and who, as of the date of Retirement, holds a license in good standing issued from the medical board in the Insured's state of licensure, or;
(c) the Insured is sixty-two (62) years of age or older, and has been insured continuously with the Company for at least one (1) year immediately preceding Retirement, and who, as of the date of Retirement, holds a license in good standing issued from the medical board in the Insured’s state of licensure, but does not meet the definition of Retirement due to either the planned or the potential future engagement in the practice of medicine in a substantially different practice arrangement than the arrangement existing at the time of retirement, and where such future practice of medicine does not exceed eighty (80) hours per month.
The Extended Reporting Period provided to a Retired Insured permits the reporting of a claim arising out of, or in connection with, a Medical Incident that takes place on or after the Retroactive Date stated in the Declarations and prior to the Insured’s Retirement. The Company may demand proof of Retirement from the practice of medicine. If any Insured receiving such endorsement subsequently resumes the practice of medicine the Extended Reporting Period shall be deemed cancelled effective the date that the Insured resumes the practice of medicine.

The limit of liability for the Extended Reporting Period shall be that stated in Section V., and the Extended Reporting Period shall be subject to all of the exclusions, conditions and other terms of this policy not specifically amended thereby.

Notwithstanding any provisions in this policy or in the Extended Reporting Endorsement issued to evidence an Extended Reporting Period, the period for reporting claims as provided in the Extended Reporting Period ends upon the closing of a deceased Insured’s estate.

VII. POLICY TERRITORY.

Subject to all policy terms, conditions and exclusions, this insurance applies to claims because of a Medical Incident that occurs anywhere in the world, as long as the Suit against the Insured based thereon is filed in the United States of America, its territories or possessions.

VIII. POLICY PERIOD.

The Policy Period is that stated in the Declarations.

IX. CANCELLATION AND NON-RENEWAL.

The Named Insured may cancel this policy only by providing the Company written notice stating when such cancellation shall be effective. In such event, the earned premium shall be computed in accordance with the customary short rate table and procedure. Premium adjustment may be made either at the time cancellation is effective, or as soon as practicable after cancellation becomes effective, but delay of payment of unearned premium by the Company shall not be deemed to delay or otherwise affect the cancellation.

If this policy has been in effect for less than sixty (60) days, and is not a renewal of a policy the Company has issued, the Company may cancel this policy for any reason by furnishing to the Named Insured at least fifteen (15) days prior written notice of and reasons for cancellation.

If this policy has been in effect for sixty (60) days or more, or is a renewal of a policy the Company has issued, the Company may cancel this policy prior to the expiration of the policy term stated in the policy by mailing or delivering written notice of such cancellation, including the reason for cancellation, to the Named Insured not less than fifteen (15) days before the proposed effective date of cancellation for one or more of the following reasons:

(a) non-payment of premium in accordance with the policy terms;

(b) an act or omission by an Insured that constitutes a material misrepresentation or non-disclosure of a material fact in obtaining this policy, continuing this policy or presenting a claim under this policy;

(c) an increased hazard or a material change in the risk assumed that could not have been reasonably contemplated by the parties at the time of the assumption of the risk;

(d) a breach by an Insured of a contractual duty, condition, or warranty that materially affects the insurability of the risk;

(e) a fraudulent act against the Company by an Insured that materially affects the insurability of the risk;
(f) willful failure of an Insured to maintain reasonable loss control measures that materially affect the insurability of the risk after written notice of the need to implement such measures from the Company;

(g) loss of facultative reinsurance, or loss by the Company of or substantial changes in applicable reinsurance as provided by statute;

(h) conviction of an Insured for a crime arising out of acts that indicate a material change in the insurability of the risk;

(i) a determination that the continuation of this policy would place the Company in violation of state law; or

(j) an Insured fails to comply with any requirement of membership in the Company.

The Company may elect at its sole discretion to non-renew this policy on the policy anniversary date. In the event this policy is non-renewed, the Company will provide written notice of non-renewal to the Named Insured not less than forty-five (45) days prior to the anniversary date of the policy. The notice must contain the reason for the non-renewal.

Written notice to the Named Insured shall be deemed notice to all Insureds for all purposes under this policy.

X. POLICY CONDITIONS.

A. An Insured’s Duties

(1) If, during the Policy Period, an Insured shall have knowledge of, or become aware of, any Medical Incident that by its nature may result in a claim for damages against that Insured or an Insured receives written notice of a demand for money or for services or other notice indicating that a claim may be made against an Insured because of a Medical Incident, then, as soon as practicable, such Insured shall give written notice thereof to the Company.

(2) If, during the Policy Period, or at any time thereafter if that claim has previously been made and reported to the Company, an Insured receives notice of a Suit or any other related legal papers because of a Medical Incident, the Insured shall give immediate written notice to the Company.

(3) An Insured shall cooperate with the Company and assist in any investigation by the Company of any claim and in enforcing any right of contribution or indemnity against any person or organization that may be liable to an Insured for damages with respect to which insurance is afforded under this policy. An Insured shall, among other things, attend hearings and trials, assist in securing and giving evidence, and assist in securing the attendance of witnesses.

(4) An Insured shall not, except at the Insured’s own cost, voluntarily make any payment, assume any obligation, or incur any expense other than for first aid to others at the time of a Medical Incident.

(5) An Insured shall notify the Company, as soon as is practicable, in writing, of material changes in the Insured’s practice, including, but not limited to, the following: changes in medical specialty, additions to or changes in practice locations, a merger or acquisition or change in ownership of a Medical Practice, an Insured’s intention to practice or actual practice of medicine in a state other than that listed in the Declarations, a change in an Insured’s medical licensing status, the addition of physicians to the Insured’s practice, an Insured’s treatment for alcohol or drug abuse or dependency, any Disability, and any investigations of an Insured
by a state medical licensing agency, licensed hospital or healthcare facility, or medical review board.

(6) An **Insured** shall notify the Company, as soon as is practicable, in writing, of any investigation, arrest, indictment, or conviction of an **Insured** for any crime.

(7) An **Insured** shall not, before or after a **Medical Incident** or claim, willfully conceal or misrepresent any material fact or circumstance concerning this insurance, the subject thereof, or a **Medical Incident** or claim.

(8) An **Insured** physician listed under “Coverage A” of the Declarations shall notify the Company within thirty (30) days of the conclusion of any **Locum Tenens Coverage** arrangement involving that **Insured**. Such notification must include the name of the physician providing such coverage, that physician’s license number and board certification status, and the dates that physician provided **Professional Services** in the **Insured’s Medical Practice**.

**B. Consent to Settle**

The Company shall not make any indemnity payment to settle any claim prior to judgment or award without the written consent of the **Insured** on whose behalf such indemnity payment is made, which consent shall not be unreasonably withheld.

Consent to settle shall not be required when:

(1) The **Insured** is deceased or has been adjudicated incompetent, or;

(2) The **Insured’s** license to practice medicine has been suspended or revoked, or;

(3) The **Insured** is no longer insured by the Company.

**C. Subrogation**

In the event of any payment under this policy, the Company shall be subrogated to all of the **Insured’s** rights of recovery thereof against any person or organization and the **Insured** shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The **Insured** shall do nothing after loss to prejudice such rights.

**D. Assignment**

The interest of the **Insured** is not assignable.

**E. Other Coverage**

This insurance is excess over any other valid and collectable insurance or self-insured retained risk or risk sharing plan or program, whether primary, pro rata, contributory, excess, contingent or on any other basis, unless such other insurance, plan or program is written only as specific excess insurance over the limits of this policy. When this insurance is excess, the Company will have no duty to defend an **Insured** against a covered **Suit** if any other insurer has a duty to defend the **Insured** against the **Suit**. If no other insurer defends the **Insured**, the Company will undertake the defense, but will be entitled to the **Insured’s** rights against all those other insurers.

**F. Entire Policy**

This policy embodies all agreements existing between the **Insured** and the Company, or any of its agents, relating to this insurance. The terms of this policy may be waived or changed only by an endorsement issued by the Company to form a part of this policy.
G. **Action Against Company**

No legal action may be brought against the Company until there has been full compliance with all of the terms of this policy. In addition, no legal action may be brought against the Company until the amount of the Insured’s obligation to pay will have been finally determined either by judgment after trial, by arbitration, or by written agreement of the claimant and the Company.

No person or organization has any right under this policy to bring the Company into any action to determine the Insured’s liability.

H. **Declarations, Policy Application, and Practice Profile**

By acceptance of this policy, the Insured verifies that the information provided by or on behalf of the Insured that is contained in the Declarations is true and accurate and acknowledges that this policy is issued in reliance upon the truth and accuracy of (1) all information provided by the Insured, or on behalf of the Insured, in the Insured’s written application for this coverage or in a practice profile and, (2) any information provided by the Insured, or on behalf of the Insured, as required by the Conditions of this policy.

I. **Premiums**

All premiums for this policy shall be computed in accordance with the Company’s rules, rates, rating plans, premium, and minimum premiums applicable to the insurance afforded herein. All coverage will expire automatically at the end of the period for which the Company has received payment, unless the Company has extended the time, in writing, for making payment.

J. **Loss Information**

The Named Insured or an Insured listed under “Coverage A” of the Declarations may request, in writing, from the Company all or any part of the following loss information for all or any part of the three-year period immediately preceding the request:

(a) Aggregate information on total closed claims and Suits, including the date and description of the occurrence and any paid losses;

(b) Aggregate information on total open claims and Suits, including the date and description of the occurrence and the amounts of any payments;

(c) Information on notice of any Medical Incident, including the date and description of the Medical Incident.

The Company shall mail or deliver the requested loss information to the requestor within forty-five (45) days after receipt of the request from the Named Insured or Insured listed under “Coverage A” of the Declarations. The Company will only provide loss information that is applicable to the requestor.

K. **Extra-Contractual Benefits**

From time to time the Company may offer or provide certain persons who apply for coverage with the Company, or become Insured’s with the Company, with risk management and/or practice management services, education and products. In addition, the Company may arrange for third party service providers, such as academic institutions, health care consultants, lawyers, accountants and others who service the practice needs of health care professionals, to provide discounted goods and services to those persons who apply for coverage with the Company, or who become Insured’s of the Company. While the Company has arranged for the provision of these goods, services and/or third party provider discounts, the third party service providers are liable to the applicants or Insureds
for the provision of such goods and/or services. The Company is not responsible for the provision of such goods and/or services, nor is it liable for the failure of the provision of the same. Further, the Company is not liable to the applicants/Insureds for the negligent provision of such goods and/or services by third party service providers.

XI. SUPPLEMENTARY PAYMENTS.

The Company shall make the following supplementary payments as additional benefits to the Insured:

(a) Claim Expense. The Company shall pay all expenses the Company incurs, and all reasonable expenses and costs incurred by the Insured at our request, in defending a Suit which the Company has agreed to defend. These expenses include, but are not limited to, attorney fees and expenses, expert consultants fees and expenses, costs of transcripts, and all other court costs, all of which are incurred in any Suit defended by the Company;

(b) Appeal Bond. If the Company continues to provide a defense on appeal, it shall pay the premiums on appeal bonds required to release attachments or stay execution on a judgment against an Insured, but only for bond amounts within the applicable limits of liability.

XII. MUTUAL COMPANY POLICY PROVISIONS.

A. Members Of The Company

Each physician named in the Declarations under “Coverage A”, by virtue of the issuance of this policy, is a member of the Company so long as this policy is in force and shall be entitled to one vote, either in person or by proxy, at meetings of members of the Company and to such dividends as may be declared payable to members by the Board of Directors of the Company. Upon cancellation or upon other termination of the policy, the physician ceases to be a member of the Company.

B. No Contingent Liability Of Members

This policy is non-assessable, and the members are not liable for any amount other than for the payment of the annual premium for the policy, or any membership requirement.

C. Annual Meeting

The annual meeting of the members of the Company will be held at such time and place as shall be designated by the Board of Directors, of which due notice will be mailed or delivered to each member at the address stated in the policy at least thirty (30) days prior thereto.

IN WITNESS WHEREOF, Medical Mutual Insurance Company of North Carolina has caused this policy to be signed by its President and its Secretary, but this policy shall not be valid unless completed by the attachment of the Declarations signed by a duly authorized representative of the Company.

Thomas Hatton McCoy, MD  H. David Bruton, MD
President     Secretary

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