Healthcare Organizations Professional Liability Package Policy
Professional Liability Coverage Section – Claims Made

THE PROFESSIONAL LIABILITY COVERAGE IN THIS COVERAGE SECTION IS PROVIDED ON A CLAIMS MADE AND REPORTED BASIS. THIS COVERAGE APPLIES TO ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST AN INSURED DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD, AND REPORTED TO THE INSURER IN ACCORDANCE WITH SECTION VII.A. OF THE GENERAL TERMS AND CONDITIONS.

WITH RESPECT TO INSURING AGREEMENT I.A., DEFENSE EXPENSES ARE PAID IN ADDITION TO THE LIMITS OF LIABILITY.

In consideration of the payment of the Premium and in reliance upon all the statements made and the information contained in the **Application** and subject to the Declarations, General Terms and Conditions and all of the terms and conditions of this Coverage Section, the **Insurer** and the **Named Insured**, on behalf of all **Insureds**, agree as follows:

I. INSURING AGREEMENTS

A. PROFESSIONAL LIABILITY COVERAGE – CLAIMS MADE

The **Insurer** will pay on behalf of the **Insured**, **Loss**, in excess of the Deductible and subject to the Limits of Liability specified in the Declarations, that the **Insured** becomes legally obligated to pay as a result of a **Claim** for a **Healthcare Professional Services Wrongful Act**. The **Healthcare Professional Services Wrongful Act** must commence and take place on or after the Retroactive Date and before the end of the **Policy Period**. Such **Claim** must be first made against the **Insured** during the **Policy Period** or any applicable Extended Reporting Period, and reported to the **Insurer** in accordance with Section VII.A. of the General Terms and Conditions.

The Insurer has a right and duty to defend any such **Claim** brought against an **Insured**, and will do so even if any allegations of the **Claim** are groundless, false or fraudulent. However, the **Insurer's** obligation to defend any **Claim** or pay **Defense Expenses** on behalf of any **Insured** ends when the Limits of Liability are exhausted.

B. DAMAGE TO PATIENT'S PROPERTY

The **Insurer** will pay on behalf of the **Insured**, **Loss**, subject to the Limits of Liability specified in the Declarations, that is due to **Property Damage** to a **Patient**'s tangible property which takes place during the **Policy Period** if resulting directly from the rendering of **Medical Services** to such **Patient** during the **Policy Period**. Such property must be in the care, custody and control of the **Insured** at the time the **Property Damage** takes place.

The **Insurer** will make these payments regardless of fault.

No deductible shall apply to payments made pursuant to this Insuring Agreement. The Limits of Liability for this Insuring Agreement are in addition to Coverage Aggregate Limit of Liability.

Upon receipt of sufficient documentation and satisfactory proof of loss, as determined by the **Insurer**, the **Insurer** will pay such **Loss** on behalf of the **Insured**.

C. DISCIPLINARY PROCEEDINGS COVERAGE

The **Insurer** will pay on behalf of the **Insured**, **Defense Expenses** only, subject to the Limits of Liability specified in the Declarations, to investigate and defend a **Disciplinary Proceeding**. Such **Disciplinary Proceeding** must arise from **Medical Services** provided to **Patients**. Such **Disciplinary Proceeding** must be first commenced against the **Insured** during the **Policy Period**.

A **Disciplinary Proceeding** shall be reported to the **Insurer** as soon as practicable, but in no event later than thirty (30) days after the **Insured** first becomes aware of the **Disciplinary Proceeding**.

The **Insurer** has a right and duty to defend any such **Disciplinary Proceeding** brought against an **Insured**, and will do so even if any allegations of the **Disciplinary Proceeding** are groundless, false or fraudulent. However, the **Insurer's** obligation to defend any **Disciplinary Proceeding** or pay **Defense Expenses** on behalf of any **Insured** ends when the Limits of Liability are exhausted.

No deductible shall apply to payments made pursuant to this Insuring Agreement. The Limits of Liability for this Insuring Agreement are in addition to Coverage Aggregate Limit of Liability.

Coverage under this Insuring Agreement is not a guaranty of coverage for any **Claim** which arises out of those facts and circumstances which are the subject of the **Disciplinary Proceeding**. Coverage for such **Claim** shall be determined by the **Insurer** at the time such **Claim** is reported to the **Insurer**.

D. PUBLIC RELATIONS EVENT COVERAGE

The **Insurer** will reimburse the **Insured**, **Public Relations Event Expenses**, subject to the Limits of Liability specified in the Declarations, that the **Insured** incurs in connection with a **Public Relations Event**. Such **Public Relations Event** must first commence during the **Policy Period**.

The **Public Relations Event** shall be reported to the **Insurer** as soon as practicable, but in no event later than thirty (30) days after the **Insured** first becomes aware of the **Public Relations Event**. The **Insured** is not required to obtain prior approval of the **Insurer** before incurring any **Public Relations Event Expenses**, but must provide the **Insurer** with sufficient documentation and proof of payment on a timely basis.

Upon receipt of sufficient documentation and satisfactory proof of payment by the **Named Insured**, as determined by the **Insurer**, the **Insurer** will reimburse the **Insured** for **Public Relations Event Expenses** actually paid by the **Insured** during the **Policy Period** in connection with a **Public Relations Event**.

No deductible shall apply to payments made pursuant to this Insuring Agreement. The Limits of Liability for this Insuring Agreement are in addition to Coverage Aggregate Limit of Liability.

E. HIPAA CLAIMS COVERAGE

The **Insurer** will reimburse the **Insured**, **HIPAA Defense Expenses** only, subject to the Limits of Liability specified in the Declarations, that the **Insured** incurs in connection with a **HIPAA Claim**. Such **HIPAA Claim** must arise from **Medical Services** provided to **Patients**. Such **HIPAA Claim** must be first made against the **Insured** during the **Policy Period**.

A **HIPAA Claim** shall be reported to the **Insurer** as soon as practicable, but in no event later than thirty (30) days after the **Insured** first becomes aware of the **HIPAA Claim**. The **Insured** shall have the duty to defend a **HIPAA Claim**, and shall retain an attorney to respond to and defend such **HIPAA Claim**, subject to the prior consent of the **Insurer**, which shall not be unreasonably withheld.

No deductible shall apply to payments made pursuant to this Insuring Agreement. The Limits of Liability for this Insuring Agreement are in addition to Coverage Aggregate Limit of Liability.

F. BILLING ERRORS AND OMISSIONS COVERAGE

The **Insurer** will reimburse the **Insured**, **Billing Defense Expenses** only, subject to the Limits of Liability specified in the Declarations, that the **Insured** incurs in connection with a **Billing Error Claim**. Such **Billing Error Claim** must arise from billings for **Medical Services** provided to **Patients**. Such **Billing Error Claim** must be first made against the **Insured** during the **Policy Period**.

A **Billing Error Claim** shall be reported to the **Insurer** as soon as practicable, but in no event later than thirty (30) days after the **Insured** first becomes aware of the **Billing Error Claim**. The **Insured** shall have the duty to defend a **Billing Error Claim**, and shall retain an attorney to respond to and defend such **Billing Error Claim**, subject to the prior consent of the **Insurer**, which shall not be unreasonably withheld.

No deductible shall apply to payments made pursuant to this Insuring Agreement. The Limits of Liability for this Insuring Agreement are in addition to Coverage Aggregate Limit of Liability.

G. SUBPOENA DEFENSE COVERAGE

The **Insurer** will reimburse the **Insured**, **Subpoena Defense Expenses** only, subject to the Limits of Liability specified in the Declarations, that the **Insured** incurs as a result of a **Subpoena**. Such **Subpoena** must arise from **Medical Services** provided to **Patients**. Such **Subpoena** must be first received by the **Insured** during the **Policy Period**.

The **Named Insured** must promptly notify the **Insurer** of the receipt of any **Subpoena** received during the **Policy Period** for which the **Named Insured** is seeking coverage, but in no event later than thirty (30) days after the **Insured** first becomes aware of the **Subpoena**. The **Insured** may retain an attorney to respond to such **Subpoena** subject to the prior consent of the **Insurer**, which shall not be unreasonably withheld.

No deductible shall apply to payments made pursuant to this Insuring Agreement. The Limits of Liability for this Insuring Agreement are in addition to Coverage Aggregate Limit of Liability.

Coverage under this Insuring Agreement is not a guaranty of coverage for any **Claim** which arises out of those facts and circumstances which are the subject of the **Subpoena**. Coverage for such **Claim** shall be determined by the **Insurer** at the time such **Claim** is reported to the **Insurer**.

H. EVACUATION EXPENSE COVERAGE

The **Insurer** will reimburse the **Insured** for **Evacuation Expenses**, subject to the Limits of Liability set forth in the Declarations, actually incurred due to an **Evacuation** which first commences and takes place during the **Policy Period**.

An **Evacuation** must be reported to the **Insurer** as soon as practicable, but in no event later than thirty (30) days after the **Insured** first becomes aware of an **Evacuation**. The **Insured** is not required to obtain prior written approval or consent from the **Insurer** before incurring **Evacuation Expenses**, but must provide the **Insurer** with sufficient documentation and proof of payment on a timely basis.

Upon receipt of sufficient documentation and satisfactory proof of payment by the **Named Insured**, as determined by the **Insurer**, the **Insurer** will reimburse the **Insured** for **Evacuation Expenses** actually paid by the **Insured** during the **Policy Period** in connection with an **Evacuation**.

No deductible shall apply to payments made pursuant to this Insuring Agreement. The Limits of Liability for this Insuring Agreement are in addition to Coverage Aggregate Limit of Liability.

II. DEFINITIONS

Some bold-faced words may be defined in other parts of the Policy.

A. **Billing Defense Expenses** means reasonable fees, costs and expenses incurred by the **Insured** for an attorney to respond to and defend a **Billing Error Claim**.

Billing Defense Expenses do not include: (a) fees, costs or expense associated with the adoption or implementation of a corporate integrity agreement or other corrective actions to ensure future compliance; (b) the cost of conducting an internal assessment to determine compliance or other internal costs; (c) the return or restitution of any amounts received from a governmental or commercial payment program; (d) fines or penalties; or (e) the costs associated with exclusion from participation in any governmental or commercial payment program.

B. **Billing Error Claim** means a formal investigation, suit or regulatory action or proceeding brought against the **Insured** by:

1. A governmental or regulatory agency, including the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS);
2. A health insurer, commercial payer, or other entity that arranges payments for healthcare services; or
3. An individual, in a Qui Tam Action pursuant to the False Claims Act (FCA)(31 USC §§3729-3733 et sec), as may be amended, and any rules or regulations promulgated pursuant thereto, or any similar federal or state law;

Which arises from:

1. actual or alleged erroneous or incorrect billings or improper payments for healthcare services, for which the **Insured** has received payment or is seeking payment; or
2. the **Insured's** voluntary disclosure of information related to erroneous or incorrect billings or improper payments for healthcare services, as long as the **Insured** was not aware of such information prior to the Effective Date of this Policy.

The audit of an individual or entity by a Recovery Audit Contractor, regulatory agency or payor, or any information or documentation request, shall not constitute a **Billing Error Claim**, unless and until the **Insured** receives a formal demand letter indicating incorrect billings or improper payments for which fines and penalties may be sought.

C. **Claim**, as used in this Coverage Section, is defined as set forth in the General Terms and Conditions, provided however, that it shall also include:

1. A **Disciplinary Proceeding** for which coverage is provided under Insuring Agreement C.;
2. A **HIPAA Claim** for which coverage is provided under Insuring Agreement E.; and
3. A **Billing Error Claim** for which coverage is provided under Insuring Agreement F.

D. **Disciplinary Proceeding** means an investigation or proceeding instituted against an **Insured** by a State Medical Board, or by any other state or federal administrative agency, licensing or regulatory authority responsible for regulating an **Insured's** professional conduct, alleging unprofessional conduct or misconduct in the rendering of or failure to render **Medical Services** to **Patients**.

E. **Evacuation** means the removal of all or the majority of **Patients** from one or more of the **Insured's** covered residential facilities, in response to an actual or threatened, natural or man-made, condition or event. Such condition or event must be unforeseen or unexpected from the standpoint of the **Insured**, and presents an imminent danger of loss of life or physical harm to the **Insured's Patients**.

However, an **Evacuation** will not include any condition or event arising out of:

1. a strike or bomb threat, unless ordered by a civil authority;
2. a false fire alarm;
3. a planned evacuation;
4. a nuclear reaction, radiation, or any radioactive contamination, however caused;
5. the vacating of one or more **Patients** that is related to their medical condition;
6. the seizure or destruction of property by a civil authority, provided that it is not related to an actual or threatened, natural or man- made, condition;
7. war, including undeclared or civil war, warlike action by a military force, insurrection, rebellion or revolution.

F. **Evacuation Expenses** means reasonable costs and expenses actually incurred by the **Insured** due to an **Evacuation,** including the costs associated with the transporting and lodging of **Patients** who needed to be evacuated. However, it would not include any remuneration, salaries, overhead, fees or benefit expenses of any **Insured.**

G. **Good Samaritan Services** means first aid emergency services voluntarily provided by an **Insured** as a Good Samaritan, that are not a part of the **Insured's** employment duties or responsibilities, at the scene of an accident or emergency requiring sudden action. **Good Samaritan Services** include the actions of anyone under an **Insured's** direction or control.

H. **Healthcare Professional Services Wrongful Act** means any actual or alleged negligent act, error or omission, or series of negligent acts, errors or omissions, by an **Insured**, or a person or entity for whom an **Insured** is vicariously liable, in the performance of the following activities:

1. the rendering of or failure to render **Medical Services** to **Patients**;
2. the activities of an **Insured** as a member of a formal accreditation, standards of review or similar professional board or committee of the **Named Insured**, including executing the directives of such board or committee;
3. supervising, teaching or proctoring others at the request of the **Named Insured**;
4. reviewing the quality of **Medical Services**;
5. the performance of administrative services by an administrator or medical director (but not for direct patient care); or
6. the rendering of or failure to render **Good Samaritan Services**.

I. **HIPAA Claim** means any formal regulatory suit, action or proceeding brought by a United States governmental entity or regulatory agency, including the Department of Health and Human Services (HHS), alleging:

1. a violation of the security and privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); or
2. any other failure to maintain the confidentiality of **Patient** information regarding **Medical Services** or information obtained in the provision of **Medical Services**, or any unauthorized release or use of such information.

A **HIPAA Claim** does not include routine investigations, audits or other proceedings which take place in the ordinary course of the **Named Insured's** business.

J. **HIPAA Defense Expenses** means reasonable fees, costs and expenses incurred by the **Insured** for an attorney to respond to and defend a **HIPAA Claim**.

K. **Insured Person**, as used in this Coverage Section, is defined as set forth in the General Terms and Conditions, but shall not include the following individuals for the direct provision of **Medical Services** to **Patients**, regardless of whether such individual is also an **Employee**, unless such individual is specifically listed as an **Insured Person** in an Endorsement to this Policy:

1. Physicians;
2. Surgeons;
3. Medical Residents;
4. Medical Interns, Externs;
5. Certified Registered Nurse Anesthetists;
6. Nurse Midwives;
7. Podiatrists; or
8. Dentists.

If such individuals are specifically listed as an **Insured Person** in an Endorsement to this Policy, then **Insured Person** shall also include any **Locum Tenens** who is serving as a substitute for such individual.

L. **Locum Tenens** means any individual who is temporarily serving as a substitute healthcare provider for an **Insured Person** or a healthcare provider who is scheduled as an **Insured Person** in an Endorsement to this Policy. Coverage for a **Locum Tenens** is subject to the following:

1. Coverage shall only apply while such **Insured Person** or other healthcare provider is temporarily absent from professional practice for the **Named Insured**
2. Coverage shall only extend for a period up to sixty (60) consecutive days during the Policy Period, subject to the paragraph immediately below; and
3. Coverage shall not apply to **Medical Services** provided on or after the date such **Insured Person** or healthcare provider ceased to be employed or contracted with the **Insured Entity**.

M. **Loss**, as used in this Coverage Section, is defined as set forth in the General Terms and Conditions, provided however, that

Loss payable under this Coverage Section shall not include:

1. fines or penalties or other amounts awarded in or resulting from a **HIPAA Claim** or a **Billing Error Claim**;
2. amounts awarded in any **Disciplinary Proceeding** or the costs to comply with any decision or order in a **Disciplinary Proceeding**.

N. **Medical Services** means healthcare, medical care, or treatment provided to any individual, including without limitation any of the following: medical, dental, psychiatric, mental health, chiropractic, osteopathic, nursing, or other professional healthcare; the furnishing or dispensing of medications, drugs, blood, blood products, or medical, dental, or psychiatric supplies, equipment, or appliances in connection with such care; the furnishing of food or beverages in connection with such care; the providing of counseling or other social services in connection with such care; and the handling of, or the performance of post-mortem examinations on, human bodies.

O. **Public Relations Event** means any criminal investigation, complaint or indictment of an **Insured**, or any administrative, regulatory, disciplinary or licensure proceeding against an **Insured**, arising out of **Healthcare Professional Services Wrongful Acts**.

P. **Public Relations Event Expenses** are the reasonable fees and costs incurred by the **Insured** in the management of public relations in order to minimize reputational harm and potential loss of customers or revenue which may result from a **Public Relations Event**. Included in these expenses are fees and costs due to services provided by experts, consultants, including third-party media consultants, and attorneys, which are incurred in the investigation and management of a **Public Relations Event**.

Public Relations Event Expenses do not include fines, penalties, assessments of costs or taxes, or other damages, awards, cost or amounts arising out of any such **Public Relations Event** or other than those specifically described above.

Q. **Subpoena** means any writ issued by a court or governmental agency to compel the production of documents, notes, tapes, testimony or other information or documentation related to the rendering of or failure to render **Medical Services** to **Patients**.

R. **Subpoena Defense Expenses** means reasonable fees, costs and expenses incurred by the **Insured** for an attorney to respond to or defend a **Subpoena**.

III. EXCLUSIONS

A. No coverage shall be provided under this Coverage Section for **Loss**, including **Defense Expenses**, in connection with any **Claim** based upon, arising out of, resulting from or in connection with, in whole or in part, whether or not any other cause or event contributes concurrently or in any sequence to, any actual or alleged:

1. Prior Acts

Healthcare Professional Services Wrongful Acts which commence prior to the Retroactive Date for this Coverage Section, even if they continue or are repeated after the Retroactive Date or during the **Policy Period**;

2. Prior Notice/Prior Knowledge

Healthcare Professional Services Wrongful Acts which take place on or after the Retroactive Date for this Coverage Section, if as of the Effective Date of this Policy: (a) any **Insured** knew, had been told or should have known, of the **Healthcare Professional Services Wrongful Acts**; or (b) any **Insured** had notified a prior insurer, or administrator of any other risk transfer instrument, of any such **Healthcare Professional Services Wrongful Acts**.

For the purposes of this Exclusion, if this Policy is a renewal policy with the **Insurer** or an affiliate thereof, the reference to the "Effective Date of this Policy" shall be replaced with the Effective Date of the earliest policy issued by the **Insurer** by which the **Insurer** has continuously provided the same or similar coverage to the **Insured** as that provided by this Policy;

3. Misleading Advertising, Promises and Warranties; No Medically Proven Basis

   Misleading marketing or advertising, or the provision or distribution of false or misleading information, or making promises or guarantees, relating to any treatment, procedure or therapy, including but not limited to its safety or effectiveness, its status as approved or not approved by the U.S. Food and Drug Agency (FDA), or whether or not it has any proven medically beneficial use;

4. Licensing/Supervision

   The rendering of, or failure to render, **Medical Services** by any individual while the individual's license or certification to practice is or was not active, not in good standing, revoked or suspended; or by any individual that does not have the required supervision that is needed under law;

   For purposes of this Exclusion, the license or certification status of a person shall not be imputed to any other person;

5. Sexual Misconduct

   Sexual Misconduct;

6. Self-Referral or Kickbacks

   Illegal or unethical patient referrals, including any violation of 42 U.S.C. Section 1395nn et seq. (the Ethics in Patient Referral Act, or Stark Law), as may be amended, or any regulations promulgated pursuant there to, or any similar federal, state or local law or regulation relating to illegal or unethical patient referrals; or

   Acceptance or offering of any payment or remuneration to induce or reward patient referrals or to general business, including any violation of 42 U.S.C. Section 1320a-7b(b) et seq (the Anti-Kickback Statute) as may be amended, or any regulations promulgated pursuant there to, or any similar federal, state or local law or regulation relating to illegal or unethical kickbacks;

7. EMTALA Violations

   Any violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), as may be amended, or any regulations promulgated pursuant there to, or any similar federal, state or local law or regulation relating to illegal or unethical discrimination in the admission, acceptance, screening and treatment of patients.