CLAIMS MADE AND REPORTED

Professional and Limited Office Premises Liability Insurance Policy

Ophthalmic Mutual Insurance Company

(A Risk Retention Group)

OMIC

OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)

January 1, 2012

NOTICE

THIS POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

THIS IS A NON-ASSESSABLE CLAIMS MADE AND REPORTED POLICY

1. This policy is not effective unless **Declarations** are issued as part of the policy.

2. This policy covers only **Claims** that arise from **professional services incidents** occurring on or after the applicable **retroactive date** shown in the **Declarations** and that are first made against the **Insured** and first reported in writing by the **Insured** to the Ophthalmic Mutual Insurance Company (a Risk Retention Group) (**OMIC**) during the applicable **policy period** or **extended reporting period**, if any. No coverage is afforded for **Claims** first made against the **Insured** and first reported to **OMIC** after the termination of this insurance except as provided in Section X. Extended Reporting Period of the policy.

3. **OMIC** pays the cost of defending **Claims** (**Claim expenses**) in addition to your limits of liability.

4. The insurance provided by this policy is contained in multiple coverage agreements. The "per **Claim**" and "aggregate" limits of liability under this policy are not cumulative even if coverage for a **Claim** is available under more than one Coverage Agreement.

5. No coverage is provided or obligation undertaken except as expressly stated in this policy. Various provisions in this policy restrict coverage. Please read the policy carefully to determine your rights and duties. Discuss the coverage with your attorney, insurance advisor, or risk management consultant.

6. Give immediate written notice of **Claims** or **potential Claims** to:

   OMIC
   Claims Department
   655 Beach Street
   San Francisco, CA 94109-1336

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SECTION I. DEFINITIONS

This Section defines various terms used in the policy. These terms are indicated throughout the policy in bold print. Terms in bold, italicized print are defined in subsequent Sections of the policy.

1. **Apparent partnership** means an association between two or more health care providers or **professional entities** in which the health care providers or **professional entities** appear to the public to be in partnership even though they have not legally formed a partnership or corporation and one is neither the employer nor **employee** or independent contractor of the other. The following are examples of activities that could give rise to an **apparent partnership**: participating in a profit-sharing plan; sharing a common business name, employees, telephone numbers, prescription pads, or letterhead; using common billing; referring to each other as partners; advertising together; or seeing each other's patients on a regular basis.

2. **Claim** means a written notice or demand received by the **Insured** for money or services, including the institution of a lawsuit or arbitration proceedings against the **Insured**, resulting from a **professional services incident**.

3. **Claim expenses** means fees charged by defense counsel retained by **OMIC** and all other fees, costs, and expenses resulting from the investigation, adjustment, defense, and appeal of a **Claim** or ***disciplinary proceeding*** if incurred by **OMIC**, including fees charged by expert witnesses and other litigation consultants.

4. **Damages** means money required to be paid as compensation to others as a result of a **Claim** to which this insurance applies. **Damages** includes prejudgment interest. **Damages** also includes the legal expenses of a person making a **Claim**, and interest based on such expenses, but only if an **Insured** is legally required to pay such expenses and interest. **Damages** does not include **Claim expenses**; post-judgment interest; punitive damages, exemplary damages, treble damages, or any other increase in damages resulting from multiplication of compensatory damages; fines or penalties; or the return, reimbursement, or restitution of governmental payments, fees, costs, or expenses for services rendered by the **Insured**.

5. **Declarations** means the document that validates the coverage available under this policy and includes Amended **Declarations**. It specifies the policy number, the **policy period**, and the **Insured(s)** covered under the policy. It also specifies the **retroactive date,** the nature of the coverage, the limits of liability, and the premium applicable to each **Insured**.

6. **Direct patient treatment** means the provision of health care services to a patient, including making diagnoses, providing medical or surgical treatment, prescribing or dispensing drugs or medical supplies or devices, rendering opinions to a patient, giving advice to a patient, or referring a patient to, or consulting about a patient with, another **physician** or health care provider.

7. **Employee** means an individual retained to provide services for the employer, including an at-will employee, employee under contract, leased employee, or volunteer employee, and excludes an independent contractor.

8. **Endorsement** means the document that forms a part of this policy and modifies or further specifies the coverage provided under this policy. If the terms of the **endorsement** are inconsistent with the terms of this policy, the terms of the **endorsement** apply. Any **endorsement** listed in Section XI. Part I – Endorsements Applied Manually is effective only if it is listed in the **Declarations** as applicable to a particular **Insured**. Any **endorsement** listed in Section XI. Part II – Endorsements Applied Automatically is effective automatically if the **Insured** meets the criteria for applicability in the **endorsement**.

9. **Eye bank services** means the provision of medical services at or on behalf of an eye bank, including the procurement, processing, testing, storage, and distribution of donor ocular tissue.

10. **Extended reporting period** means the time after the end of the **policy period** during which **Claims** arising out of **professional services incidents** that occurred on or after the **retroactive date** and prior to the end of the **policy period** may be reported.

11. **Good Samaritan** means any person who, in good faith, renders emergency medical care to an injured person at the scene of an accident or emergency without expecting to receive compensation from the injured person for such service.

12. **Insured** means any person or entity described as an **Insured** under Coverage Agreements A, B, C, D, or E.

13. **Injury** means physical injury, including mutilation or disfigurement of a cadaver or wrongful removal of tissue; sickness; disease; death; or mental or emotional injury or anguish if arising out of any of the foregoing.

14. **Locum tenens** means an ophthalmologist hired on a temporary basis to furnish **direct patient treatment** on behalf of, and only in the absence of, the **Insured** ophthalmologist.

15. **Office premises** means that part of any premises that the **Insured** owns, or leases or occupies with control over the maintenance of the leased or occupied premises, for the purpose of providing **direct patient treatment**. This does not include any parking lots, sidewalks, elevators, escalators, or common or public hallways or stairways.

16. **Outpatient surgical facility** means an in-office surgical suite that is used by **physician(s)** in addition to the owner-ophthalmologist(s) and his or her **employee(s)**, an ambulatory surgery center, and a refractive surgery center.

17. **Original effective date** means the coverage effective date applicable to an **Insured** from the earliest policy issued by **OMIC** to such **Insured**, which policy is followed by a continuous and unbroken period in which **OMIC** provided coverage to that **Insured**.

18. **Original inception date** means the policy effective date from the earliest policy issued by **OMIC** to a **Policyholder**, which policy is followed by a continuous and unbroken period in which **OMIC** provided coverage to that **Policyholder**.

19. **Permanent total disability** means the **Insured** is permanently prevented by sickness or accidental bodily injury from performing the material and substantial duties of an ophthalmologist.

20. **Physician** means a medical doctor (MD) or a doctor of osteopathy (DO).

21. **Policy period** means the period of time during which insurance coverage is provided to an **Insured**. The **policy period** begins at 12:01 a.m. at the address shown in the **Declarations** on either the effective date shown in the **Declarations** or the date an **Insured** is added to the policy, whichever is later. Coverage continues until 12:01 a.m. at the address shown in the **Declarations** on the expiration date shown in the **Declarations** or any earlier date of termination of the policy or the **Insured's** coverage under the policy.

    With respect to **slot** occupants, the **policy period** that applies to each **slot** occupant begins at 12:01 a.m. at the address shown in the **Declarations** on either the effective date shown in the

Declarations or the date the **slot** occupant first occupies such **slot**, whichever is later. Coverage continues until 12:01 a.m. at the address shown in the **Declarations** on the expiration date shown in the **Declarations**, the date of termination of the policy or the **slot's** coverage under the policy, or the date the **slot** occupant vacates the **slot**, whichever occurs first.

With respect to non-physician **employee Insureds** not specifically named in the **Declarations**, the **policy period** begins at 12:01 a.m. at the address shown in the **Declarations** on either the effective date shown in the **Declarations** or the date the **employee** first becomes continuously employed by the **Insured**, whichever is later. Coverage continues until 12:01 a.m. at the address shown in the **Declarations** on the expiration date shown in the **Declarations**, the date of termination of the policy or the employing **Insured's** coverage under the policy, or the termination date of the **Insured employee's** employment, whichever occurs first.

22. **Policyholder** means the **Insured** person or entity first listed under "Policyholder and Mailing Address" in the **Declarations**.

23. **Pollutants** mean any solid, liquid, gaseous, or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, or chemicals, or any waste materials to be disposed of, discarded, recycled, reconditioned, or reclaimed.

24. **Potential Claim** means a **professional services incident** that may reasonably be expected to result in an actual **Claim** against the **Insured**. Oral notices or demands for money or services, records requests, adverse outcomes resulting from **direct patient treatment,** and other signs that the patient is dissatisfied with treatment are all indicators of **potential Claims**.

25. **Premises maintenance** means the **Insured's** ownership, maintenance, or use of the **office premises** in which the **Insured** provides **direct patient treatment**.

26. **Professional committee activities** means service of an **Insured** while acting within the scope of his or her duties as a member of, participant in, or person charged with the duty of executing the directives of, a formal accreditation, utilization review, credentialing, quality assurance, peer review, or similar professional board or committee.

27. **Professional entity** means a medical partnership (including a limited liability partnership), a medical corporation (including a sole shareholder corporation), a limited liability company, a professional association, an **outpatient surgical facility**, an eye bank, a management services organization, an optical shop, and a medical spa.

28. **Professional services incident** means any act, error, or omission that is neither intended nor expected in the provision of, or the failure to provide, **direct patient treatment**, **eye bank services**, **professional committee activities**, or **premises maintenance**.

    Any such act, error, or omission together with all related acts, errors, or omissions will be considered one **professional services incident** and will be deemed to have occurred at the time of the earliest of such acts, errors, or omissions.

29. **Property damage** means physical damage to or destruction of personal, tangible property, and does not include the loss of use thereof.

30. **Retirement** means the total and permanent discontinuance of the clinical practice of medicine for compensation, whether private or public. An **Insured** is not deemed retired if the

Insured receives any remuneration for providing clinical professional services. Performance of any compensated or uncompensated non-clinical activities or performance of any uncompensated clinical activities will not affect an **Insured's** retired status.

31. **Retroactive date** means the date shown in the **Declarations** beginning at 12:01 a.m. at the address shown in the **Declarations** on or after which **professional services incidents** must first occur to be covered under this policy.

    With respect to **slot** coverage**,** the **retroactive date** shown in the **Declarations** is the **retroactive date** applicable to the **slot** position. The **retroactive date** that applies to each **slot occupant** is the date he or she first occupied such **slot** or the **retroactive date** of the **slot** position, whichever is later.

    With respect to non-physician **employee Insureds** not specifically named in the **Declarations**, the **retroactive date** is the date the **employee** first became continuously employed by the **Insured** ophthalmologist or **professional entity** or the **retroactive date** of the employing **Insured**, whichever is later.

32. **Sexual misconduct or activity** means making sexually offensive or suggestive statements; engaging in sexually offensive or suggestive conduct or contact; sexual relations; sexual intimacy; sexual molestation; sexual harassment; sexual exploitation; sexual assault; sexual battery; soliciting sexual relations; sexual abuse; and any act punishable as a sexually-related crime.

33. **Slot** means an ophthalmology residency or fellowship training position. Under a **slot**, coverage applies to the position rather than to an individual. If an ophthalmologist leaves the position, another ophthalmologist may fill the **slot**. Only one ophthalmologist at a time can fill a **slot**.

SECTION II. COVERAGE AGREEMENTS

OMIC, in consideration of payment of the premium, in reliance upon the statements made in the application(s) for insurance under this policy, and subject to all the terms, conditions, exclusions, restrictions, and definitions of this policy, agrees with the **Insured** as follows in Coverage Agreements A, B, C, D, and E.

COVERAGE AGREEMENT A: PROFESSIONAL LIABILITY COVERAGE FOR OPHTHALMOLOGISTS

PART I – WHO IS COVERED

Each of the following is an **Insured** under Coverage Agreement A:

1. Any ophthalmologist named in the **Declarations** whose class is identified as Ophthalmology, except in the ophthalmologist's capacity as a member, officer, director, partner, or shareholder of a **professional entity**;

2. Any ophthalmologist **slot** occupant named in the **Declarations** whose class is identified as **Slot**, or any former occupant of such **slot**, but only with respect to **direct patient treatment** performed:

    a. while an occupant of such **slot**; and

    b. within the scope of his or her licensure and authorized duties as a resident or fellow. No coverage will apply for moonlighting activities performed by a **slot** occupant or for

other activities not directly associated with the **slot** occupant's residency or fellowship training; and

3. Any ophthalmologist **locum tenens** named in the **Declarations** whose class is identified as **Locum tenens**, but only while acting within his or her duties for, and only in the absence of, the **Insured** ophthalmologist.

PART II – WHAT IS COVERED

OMIC shall defend the **Insured** and pay on behalf of the **Insured**, subject to Section IV. Limits of Liability, all amounts that the **Insured** becomes legally obligated to pay as **damages** because of a **Claim** that results from **injury** to a patient because of a **professional services incident** arising from **direct patient treatment** provided by the **Insured** or by any person acting under the supervision, direction, or control of the **Insured** at the time of the **professional services incident**, so long as that person was acting within the scope of his or her licensure, training, and professional liability insurance coverage, if applicable.

The **Claim** will be covered only if:

1. The **professional services incident** upon which the **Claim** is based occurred on or after the applicable **retroactive date** and prior to the end of the applicable **policy period**; and

2. The **Claim** is first made against the **Insured** and the **Insured** first reports that **Claim** in writing to **OMIC** during the applicable **policy period** or **extended reporting period**.

PART III – EXCLUSIONS: COVERAGE AGREEMENT A

In addition to the exclusions listed in Section III. Common Exclusions – Applicable to All Coverage Agreements, the following exclusions also apply to Coverage Agreement A.

A. No Defense or Payment of Damages or Supplementary Payments

OMIC will neither defend an **Insured** nor pay **damages** or supplementary payments because of a **Claim** that arises out of any of the following:

1. **Scope of Practice.** **Direct patient treatment** by the **Insured** that is not within the ordinary and customary scope of practice of ophthalmologists; OMIC considers ophthalmic or non-ophthalmic **direct patient treatment** provided as a "**Good Samaritan**" or in a bona fide emergency to be within the ordinary and customary scope of practice of ophthalmologists;

2. **Entity Affiliation Liability.** An **injury** arising out of **direct patient treatment** by another person or entity for whose acts, errors, or omissions the **Insured** may be held liable as a member, partner, officer, director, shareholder, or employee of any **professional entity**;

3. **Specific Procedures.** The performance of any of the following procedures (which may be within the ordinary and customary scope of practice of ophthalmologists), unless specifically covered by **endorsement**: (a) harvest of an extensor tendon from the foot, (b) harvest of a rib graft, (c) micropigmentation of the breast, (d) placement of arch bars on teeth, (e) rhinoplasty, (f) genioplasty, (g) mentoplasty, (h) full facelifts for cosmetic purposes, (i) liposuction, (j) refractive surgery, and (k) any lipodissolve, mesotherapy, or similar procedure, or related care or treatment, unless performed as part of an investigational drug trial under an American IRB-approved protocol; or

4. **Specific Procedures – Not to Treat Eye Conditions/Diseases.** The performance of any of the following procedures (which may be within the ordinary and customary scope of practice of ophthalmologists), unless performed to treat an ophthalmic condition or disease: (a) endoscopic sinus surgery, (b) facial reanimation, (c) harvest of a bone graft, (d) harvest of ear cartilage, and (e) septoplasty.

COVERAGE AGREEMENT B: PROFESSIONAL LIABILITY COVERAGE FOR EMPLOYEES

PART I – WHO IS COVERED

Each of the following is an **Insured** under Coverage Agreement B:

1. Any non-physician **employee**, except an optometrist or certified registered nurse anesthetist, of an **Insured** ophthalmologist or **professional entity** that is named in the **Declarations**, but only while acting within the scope of his or her training, licensure, and employment by and for the direct benefit of the **Insured** ophthalmologist or **professional entity** at the time of the **professional services incident**;

2. Any optometrist named in the **Declarations** whose designation is identified as Optometrist, but only while acting within the scope of his or her training, licensure, and employment by the **Insured** ophthalmologist or **professional entity** at the time of the **professional services incident**, and except in the optometrist's capacity as a member, officer, director, partner, or shareholder of a **professional entity**; and

3. Any certified registered nurse anesthetist named in the **Declarations** whose designation is identified as CRNA, but only while acting within the scope of his or her training, licensure, and employment by and for the direct benefit of the **Insured** ophthalmologist or **professional entity** at the time of the **professional services incident**.

PART II – WHAT IS COVERED

OMIC will defend the **Insured** and pay on behalf of the **Insured**, subject to Section IV. Limits of Liability, all amounts that the **Insured** becomes legally obligated to pay as **damages** because of a **Claim** that results from **injury** to a patient because of a **professional services incident** arising from **direct patient treatment** provided by the **Insured** or by any other person acting under the supervision, direction, or control of the **Insured** at the time of the **professional services incident**, so long as that person was acting within the scope of his or her licensure, training, and professional liability insurance coverage, if applicable.

The **Claim** will be covered only if:

1. The **professional services incident** upon which the **Claim** is based occurred on or after the applicable **retroactive date** and prior to the end of the applicable **policy period**; and

2. The **Claim** is first made against the **Insured** and the **Insured** first reports that **Claim** in writing to **OMIC** during the applicable **policy period** or **extended reporting period**.

PART III – EXCLUSIONS: COVERAGE AGREEMENT B

In addition to the exclusions listed in Section III. Common Exclusions – Applicable to All Coverage Agreements, the following exclusions also apply to Coverage Agreement B.

A. No Defense or Payment of Damages or Supplementary Payments

OMIC will neither defend an **Insured** nor pay **damages** or supplementary payments because of a **Claim** that arises out of any of the following:

1. **Entity Affiliation Liability.** An **injury** arising out of **direct patient treatment** by another person or entity for whose acts, errors, or omissions the **Insured** may be held liable as a member, partner, officer, director, shareholder, or employee of any **professional entity**.

COVERAGE AGREEMENT C: PROFESSIONAL LIABILITY COVERAGE FOR PROFESSIONAL ENTITIES

PART I – WHO IS COVERED

Each of the following is an **Insured** under Coverage Agreement C:

1. Any **professional entity** named in the **Declarations** whose structure is identified as Medical Entity, Sole shareholder corporation, **Outpatient Surgical Facility**, **Eye Bank**, Optical Shop, or Medical Spa;

2. Any **professional entity** named in the **Declarations** whose structure is identified as MSO, but only with respect to its vicarious liability arising out of the performance of **direct patient treatment** rendered or which should have been rendered by any other **Insured** under this policy; and

3. Any person or entity affiliated with an **Insured professional entity** that is named in the **Declarations**, but only in his, her, or its capacity as a member, officer, director, partner, or shareholder of the **professional entity** and excluding any **direct patient treatment** provided by that person or entity.

PART II – WHAT IS COVERED

OMIC shall defend the **Insured** and pay on behalf of the **Insured**, subject to Section IV. Limits of Liability, all amounts that the **Insured** becomes legally obligated to pay as **damages** because of a **Claim** that results from:

1. **Injury** to a patient because of a **professional services incident** arising from:

   a. **direct patient treatment** provided by the **Insured professional entity**; or

   b. **direct patient treatment** provided by any person for whose acts, errors, or omissions the **Insured** is legally responsible, so long as that person was acting within the scope of his or her licensure, training, and professional liability insurance coverage, if applicable. If the **Claim** results from a **professional services incident** involving **direct patient treatment** provided by a health care provider not insured under this policy, such health care provider must maintain professional liability insurance with a carrier acceptable to **OMIC** during the term of his or her volunteer or paid employment by, contractual relationship with, or utilization of the facility of, the **Insured**. Should the health care provider fail to maintain such insurance, **OMIC** will neither defend the **Insured** nor pay supplementary payments or **damages** resulting from the **Insured's** vicarious liability for the acts, errors, or omissions of the health care provider; and

2. A **professional services incident** arising from **professional committee activities** by an **Insured** defined in Part I, 3., performed for the **Insured professional entity**.

The **Claim** will be covered only if:

1. The **professional services incident** upon which the **Claim** is based occurred on or after the applicable **retroactive date** and prior to the end of the applicable **policy period**; and

2. The **Claim** is first made against the **Insured** and the **Insured** first reports that **Claim** in writing to **OMIC** during the applicable **policy period** or **extended reporting period**.

PART III – EXCLUSIONS: COVERAGE AGREEMENT C

In addition to the exclusions listed in Section III. Common Exclusions – Applicable to All Coverage Agreements, the following exclusions also apply to Coverage Agreement C.

A. No Defense or Payment of Damages or Supplementary Payments

OMIC will neither defend an **Insured** nor pay **damages** or supplementary payments because of a **Claim** that arises out of any of the following:

1. **Outpatient Surgical Facilities.** An **Insured's** failure to comply with any of the requirements agreed to by the **Insured outpatient surgical facility** in its **outpatient surgical facility** application, or any exceptions to the requirements granted in writing by **OMIC**.

2. **Medical Spas.** An **Insured's** failure to comply with any of the requirements agreed to by the **Insured** medical spa in its medical spa application, or any exceptions to the requirements granted in writing by **OMIC**.

B. Conditional Defense – No Payment of Damages or Supplementary Payments

OMIC shall defend an **Insured** because of a **Claim** otherwise covered by this policy that arises out of, but is not solely limited to, any of the following; however, under no circumstances will **OMIC** pay any **damages** or supplementary payments except **Claim expenses** resulting from either settlement or judgment attributed to any of the following:

1. **Wrongful Acts.** Allegations of any of the following resulting from the **Insured's** good faith **professional committee activities**: false arrest, detention, or imprisonment; malicious prosecution or abuse of process; libel, slander, or defamation of character; intentional invasion of privacy; or discrimination, harassment, or the violation of a person's civil rights; or

2. **Anticompetitive Activities.** Conduct, resulting from the **Insured's** good faith **professional committee activities**, alleged to be (a) anticompetitive or in restraint of trade, including interference with a contract, interference with a prospective advantage, unfair competition, unfair trade and business practices, and misappropriation of trade secrets, or (b) in violation of any state or federal antitrust, unfair trade practice, or other similar laws.

COVERAGE AGREEMENT D: PROFESSIONAL COMMITTEE ACTIVITIES COVERAGE FOR OPHTHALMOLOGISTS

PART I – WHO IS COVERED

Each of the following is an **Insured** under Coverage Agreement D:

1. Any ophthalmologist named in the **Declarations** whose class is identified as Ophthalmology, except in the ophthalmologist's capacity as a member, officer, director, partner, or shareholder of a **professional entity**.

PART II – WHAT IS COVERED

OMIC shall defend the **Insured** and pay on behalf of the **Insured**, subject to Section IV. Limits of Liability, all amounts that the **Insured** becomes legally obligated to pay as **damages** because of a **Claim** that results from a **professional services incident** arising from the **Insured's professional committee activities** performed for (a) a state licensed health care facility or clinic that is not the **professional entity** with which the **Insured** is affiliated as a member, officer, director, partner, or shareholder or (b) a professional association or society.

The **Claim** will be covered only if:

1. The **professional services incident** upon which the **Claim** is based occurred on or after the applicable **retroactive date** and prior to the end of the applicable **policy period**; and

2. The **Claim** is first made against the **Insured** and the **Insured** first reports that **Claim** in writing to **OMIC** during the applicable **policy period** or **extended reporting period**.

PART III – EXCLUSIONS: COVERAGE AGREEMENT D

In addition to the exclusions listed in Section III. Common Exclusions – Applicable to All Coverage Agreements, the following exclusions also apply to Coverage Agreement D.

A. Conditional Defense – No Payment of Damages or Supplementary Payments

OMIC shall defend an **Insured** because of a **Claim** otherwise covered by this policy that arises out of, but is not solely limited to, any of the following; however, under no circumstances will **OMIC** pay any **damages** or supplementary payments except **Claim expenses** resulting from either settlement or judgment attributed to any of the following:

1. **Wrongful Acts.** Allegations of any of the following resulting from the **Insured's** good faith **professional committee activities**: false arrest, detention, or imprisonment; malicious prosecution or abuse of process; libel, slander, or defamation of character; intentional invasion of privacy; or discrimination, harassment, or the violation of a person's civil rights; or

2. **Anticompetitive Activities.** Conduct, resulting from the **Insured's** good faith **professional committee activities**, alleged to be (a) anticompetitive or in restraint of trade, including interference with a contract, interference with a prospective advantage, unfair competition, unfair trade and business practices, and misappropriation of trade secrets, or (b) in violation of any state or federal antitrust, unfair trade practice, or other similar laws.

COVERAGE AGREEMENT E: LIMITED OFFICE PREMISES LIABILITY COVERAGE

PART I – WHO IS COVERED

Each of the following is an **Insured** under Coverage Agreement E:

1. Any ophthalmologist named in the **Declarations** whose class is identified as Ophthalmology;

2. Any **professional entity** named in the **Declarations** whose structure is identified as Medical Entity, Sole shareholder corporation, **Outpatient Surgical Facility**, **Eye Bank**, Optical Shop, or Medical Spa;

3. Any **professional entity** named in the **Declarations** whose structure is identified as MSO, but only with respect to its vicarious liability arising out of the performance of **premises maintenance** rendered or which should have been rendered by any other **Insured** under this policy; and

4. Any person or entity affiliated with an **Insured professional entity** that is named in the **Declarations**, but only in his, her, or its capacity as a member, officer, director, partner, or shareholder of the **professional entity**.

PART II – WHAT IS COVERED

OMIC shall defend the **Insured** and pay on behalf of the **Insured**, subject to Section IV. Limits of Liability, all amounts that the **Insured** becomes legally obligated to pay as **damages** because of a **Claim** that results from **injury** to a patient or **property damage** to a patient's personal, tangible property either of which are caused by a **professional services incident** resulting solely from **premises maintenance** performed by the **Insured** or anyone for whom the **Insured** is legally responsible.

The **Claim** will be covered only if:

1. The **professional services incident** upon which the **Claim** is based occurred on or after the applicable **retroactive date** and prior to the end of the applicable **policy period**; and

2. The **Claim** is first made against the **Insured** and the **Insured** first reports that **Claim** in writing to **OMIC** during the applicable **policy period** or **extended reporting period**.

This Coverage Agreement E does not constitute and is not meant to replace commercial general liability coverage or other fire and property coverage for the **Insured's office premises**.

SECTION III. COMMON EXCLUSIONS – APPLICABLE TO ALL COVERAGE AGREEMENTS

The following exclusions apply to all Coverage Agreements of this policy.

A. No Defense or Payment of Damages or Supplementary Payments

OMIC will neither defend an **Insured** nor pay **damages** or supplementary payments because of a **Claim** that arises out of any of the following:

1. **Known Prior Acts or Claims.** A **Claim**, **potential Claim,** or other circumstance likely to give rise to a **Claim**, that was known or should have been known to the **Insured** prior to the **Insured's original effective date**, whether it was reported to or covered by a previous insurance carrier or other risk-assuming entity;

2. **Licensure.** A **professional services incident** involving **direct patient treatment** by a health care provider that (a) the health care provider does not hold the required license, certification, or accreditation to provide; (b) occurs while the health care provider's license, certification, or accreditation to practice medicine or provide health care services has been suspended, revoked, voluntarily surrendered, or otherwise is not in effect; (c) constitutes a violation of any restriction imposed upon such license, certification, or accreditation; or (d) falls outside the scope of such license, certification, or accreditation;

3. **Licensure – Controlled Substances.** A **professional services incident**, involving the dispensing of controlled substances during the course of **direct patient treatment** by a health care provider, that occurs while the health care provider's license or registration to dispense such controlled substances has been suspended, restricted, revoked, voluntarily surrendered, or otherwise is not in effect;

4. **Workers' Benefits Laws.** An obligation for which the **Insured** may be held liable under any workers' compensation, unemployment compensation, or disability benefits law or any similar law;

5. **Employee Injury. Injury** to or **property damage** incurred by (a) any **employee** or independent contractor of the **Insured** arising in the course of his or her work for the **Insured** or (b) any non-employed medical personnel arising in the course of his or her work under the supervision, control, or direction of the **Insured**;

6. **Other Insurance Policies.** Allegations covered under a regulatory protection policy not issued by OMIC or allegations covered under any workers' compensation, employer's liability, employment practices liability, directors and officer liability, errors and omissions liability, billing errors, fraud and abuse liability, consultant liability, or automobile, fire, or commercial general liability policy (see Section VIII. 12. Other Insurance for more information);

7. **Billing Errors.** Except as provided under Section VII. Additional Benefits, B. Broad Regulatory Protection, allegations of errors, omissions, fraud or abuse by the Insured in billing for **direct patient treatment**;

8. **Contractual Liability.** Liability of others assumed by the **Insured** under any written or oral contract or agreement, unless:

    a. coverage for such liability would be provided to the **Insured** under this policy in the absence of such contract or agreement; or

    b. the **Insured** assumed such liability under a hold harmless or indemnification agreement in a written contract between the **Insured** and a hospital, health maintenance organization, private or governmental health insurer, preferred provider organization, or similar managed care or health care provider organization ("organization") and the liability results solely from a **professional services incident** arising from **direct patient treatment** by the **Insured** and is otherwise covered under this policy. Such organization is not an **Insured** under this policy and **OMIC** will have no duty to defend such organization. All **Claims** asserted directly by the injured party against the **Insured** and all **Claims** asserted by the organization against the **Insured** for indemnification arising out of the same **professional services incident** will constitute a single **Claim** for purposes of the limits of liability. Any payments made under this exception to the exclusion, including reasonable **Claim expenses**, are included within the limits of liability applicable to the **Insured** and will only be paid after all payments which **OMIC** is obligated to make on behalf of the **Insured** for direct liability arising out of the **Claim** have been finally determined and made. Such payments made on behalf of the organization may be considered payment of **damages** attributable to the **Insured** for national and state reporting purposes;

9. **Wrongful Acts.** Allegations of any of the following: false arrest, detention, or imprisonment; malicious prosecution or abuse of process; libel, slander, or defamation of character; intentional invasion of privacy; or discrimination, harassment, or the violation of a person's civil rights; but this exclusion does not affect the right and duty of **OMIC** to defend a **Claim** against the **Insured** that would be covered under Coverage Agreements C and D of this policy resulting from the **Insured's** good faith **professional committee activities**;

10. **Anticompetitive Activities.** Conduct alleged to be (a) anticompetitive or in restraint of trade, including interference with a contract, interference with a prospective advantage, unfair competition, unfair trade and business practices, and misappropriation of trade secrets, or (b) in violation of any state or federal antitrust, unfair trade practice, or other similar laws; but this exclusion does not affect the right and duty of **OMIC** to defend a **Claim** against the **Insured** that would be covered under Coverage Agreements C and D of this policy resulting from the **Insured's** good faith **professional committee activities**;

11. **Products.** The designing, producing, manufacturing, assembling, distributing, marketing, or selling of any medical device or other product, including the making of warranties or representations with respect to the fitness, quality, durability, performance, or use of the product and the providing of or failure to provide warnings or instructions with the product, by the **Insured**, by any entity in which the **Insured** has a financial interest, or by others trading under an **Insured's** name, including any contractor of the **Insured**;

12. **Government Work.** Employment of the **Insured** by a governmental entity, unless **OMIC** gives the **Insured** prior written confirmation of coverage for such employment. Volunteer work and work as an independent contractor are not considered employment under this exclusion;

13. **Medical Director.** Allegations against the **Insured** as a proprietor, superintendent, executive officer, administrative officer, medical staff officer, medical director, or board member of a hospital, sanitarium, clinic with bed and board facilities, HMO, laboratory, or other medically related enterprise, including as a medical director, supervising physician, or prescribing physician of a medical spa, not named in the **Declarations**;

14. **Consulting Liability.** A **Claim** arising out of services performed by the **Insured** as a paid consultant, including providing expert witness testimony or independent medical examinations, when such **Claim** is made by anyone other than the **Insured's** patient (for example, when the **Claim** is made by the person who hired the **Insured** or by the opposing party);

15. **Clinical Studies.** Clinical research or trials by the **Insured** that are not conducted under and in accordance with an American IRB-approved protocol;

16. **Postoperative Care.** A **professional services incident** occurring postoperatively unless the following conditions are satisfied:

    a. the **Insured** operating ophthalmologist or an on-call or **locum tenens** ophthalmologist performs the patient's postoperative care throughout the patient's recovery period;

    b. the **Insured** operating ophthalmologist (i) refers the patient to a licensed ophthalmologist or other licensed **physician** as appropriate and (ii) obtains the patient's informed consent for planned comanagement prior to surgery; or

c. the **Insured** operating ophthalmologist (i) arranges for a portion of the outpatient postoperative care to be rendered by a non-physician provider who is clinically competent and lawfully able to provide that care and (ii) obtains the patient's written informed consent for planned comanagement prior to surgery. Such delegated postoperative care must be provided under the **Insured** operating ophthalmologist's supervision;

17. **Communicable Disease.** The **Insured's** knowing transmission to another of, or exposure of another to, Hepatitis B, HIV/AIDS, or any other communicable disease. "Knowing" is defined as the **Insured** being aware that he or she is infected with the virus or disease, or, based upon medical symptoms, the **Insured** reasonably should have known he or she was infected. This exclusion does not apply if the **Insured** has complied with the then-current Centers for Disease Control and Prevention guidelines for infection control;

18. **ROP Remote Screening.** Any remote screening, in the absence of a live examination by a qualified ophthalmologist, for retinopathy of prematurity, unless specifically covered by endorsement;

19. **Motor Vehicles.** The **Insured's** ownership, maintenance, or operation of any motor vehicles;

20. **Other Premises.** The maintenance of any premises owned, leased, or occupied by the **Insured** that is not the **office premises** of the **Insured**;

21. **Construction.** New construction, property repair, or demolition operations performed by or under contract with the **Insured**;

22. **Earth Movement.** Earth movement, including earthquake, landslide, and mudflow; the sinking, rising, and shifting of earth; and volcanic eruption;

23. **War.** War, whether or not declared, or any act or condition incident to war;

24. **Pollutants.** The discharge, dispersal, release, or escape of **pollutants** by the **Insured** or by any person or organization for whom the **Insured** is legally responsible; or any loss, cost, or expense arising out of any governmental direction or request that the **Insured** test for, monitor, clean up, remove, contain, treat, detoxify, or neutralize **pollutants**; or

25. **Nuclear Energy Exclusion.** Allegations for which insurance is or can be available to the **Insured** under a nuclear energy liability policy or that result from the hazardous properties of nuclear materials for which financial protection would be required under the Atomic Energy Act of 1954 (as amended) or for which the **Insured** would be entitled to indemnity from the United States government pursuant to the Atomic Energy Act of 1954 (as amended).

26. **Weight Loss Treatments.** The performance of weight loss treatments, including but not limited to the use of appetite suppressants, hypnosis, and the injection of Vitamin B-12, HCG, and lipotropics.

B. Conditional Defense – No Payment of Damages or Supplementary Payments

OMIC will defend an **Insured** because of a **Claim** otherwise covered by this policy that arises out of, but is not solely limited to, any of the following; however, under no circumstances will

OMIC pay any **damages** or supplementary payments except **Claim expenses** resulting from either settlement or judgment attributed to any of the following:

1. **Intentional Acts.** An act, error, or omission intended or expected to cause **injury** or **property damage** committed by the **Insured** or at the direction of the **Insured**, including any of the following: intentional infliction of emotional distress; assault or battery, except that a technical battery based on lack of informed consent is not excluded; false, misleading, or deceptive advertising and marketing; or any other dishonest, fraudulent, malicious, or knowingly wrongful acts, errors, or omissions.

2. **Criminal Acts.** An act, error, or omission that is also a violation of a statute, ordinance, or regulation imposing criminal penalties;

3. **Sexual Misconduct or Activity.** Allegations of **sexual misconduct or activity**, even if such conduct is consensual or arises under the guise of **direct patient treatment**, or abandonment of, or failure to properly refer for treatment, the person subject to the **sexual misconduct or activity**;

4. **Substance Abuse.** An act, error, or omission (a) committed while the **Insured** is under the influence of alcohol, drugs, or other substances that adversely affect the **Insured**'s professional ability or judgment or (b) that results from substance abuse;

5. **Guarantee.** A guarantee by the **Insured** of the result of any **direct patient treatment**; or

6. **Apparent Partnership.** Allegations of vicarious liability on the part of the **Insured** for the acts, errors, or omissions of others based upon an **apparent partnership** between the **Insured** and another health care provider or **professional entity**.

C. Allegations Involving Non-Covered Damages

OMIC will not (1) pay any judgments for money legally required to be paid as compensation other than **damages** ("non-covered damages," which includes punitive and exemplary damages) or (2) contribute any amount in settlement for such non-covered damages. However, **OMIC** shall defend an **Insured** against a **Claim** for non-covered damages as long as they are alleged to have resulted from a **Claim** otherwise covered by this policy. If **OMIC** settles all **damages** except non-covered damages arising from such **Claim**, **OMIC's** duty to defend will end.

D. Failure to Meet Conditions

OMIC will neither defend an **Insured** nor pay **damages** or supplementary payments because of any **Claim** otherwise covered under this policy if the **Insured** fails to comply with any of the conditions listed in Section VIII. General Conditions, Rules, and Duties.

E. Disciplinary Proceedings

OMIC will neither defend an **Insured** nor pay any fines, sanctions, penalties, or supplementary payments that result from an investigation, disciplinary proceeding, or action for review of the **Insured's** practice by any governmental or private licensing, quality of care, or similar review board, except as may otherwise be defended as outlined in Section VII. Additional Benefits.

SECTION IV. LIMITS OF LIABILITY

Except as otherwise provided in this policy, the amount of insurance coverage available to pay **damages** for **Claims** covered by this policy made under Coverage Agreements A, B, C, and D will be as shown in the **Declarations** or any **endorsement** applicable to the **Insured**.

The amount of insurance coverage available to pay **damages** for **Claims** covered by this policy made under Coverage Agreement E will be $50,000 per **Claim**/$150,000 in the aggregate for all **Claims** made during the policy period.

For the purpose of determining the limit of liability, (1) any **Claim**, together with all related **Claims** arising out of any one **professional services incident** or any series of related **professional services incidents** or (2) all related **Claims** joined together in a class action suit or otherwise, will be considered one **Claim** under this policy and will be deemed to have been reported as of the date the first such **Claim** was reported.

The limit of liability that applies to a **Claim** is the limit that is in effect as of the date such **Claim** is reported in writing to **OMIC**.

The most **OMIC** will pay per **Insured,** for all **damages** because of any one **Claim**, will not exceed the limit of liability applicable "per **Claim**," regardless of the number of **injuries** or claimants.

The most **OMIC** will pay per **Insured** for all **Claims** reported to **OMIC** during the **policy period** will not exceed the limit of liability stated as "aggregate," regardless of the number of **injuries** or claimants. The aggregate applicable to each **slot** will be applied to all ophthalmologists who have occupied such **slot** and who have **Claims** made against them and reported to **OMIC** within the **policy period**.

The "per **Claim**" and "aggregate" limits of liability under this policy are not cumulative even if (1) related **Claims** or **professional services incidents** span more than one **policy period** or (2) coverage for a **Claim** is available under more than one Coverage Agreement.

The limits of liability apply separately to each **policy period**. If **OMIC** extends the **policy period** for an additional period of less than twelve months, the additional period will be deemed part of the preceding period and only one set of liability limits will apply.

The limits of liability apply separately to each **Insured** listed in the **Declarations** unless the "Primary limits of liability" indicate that the limits are "Shared." Unless otherwise indicated in the **Declarations** or any **endorsement**, the limits of liability are shared:

1. Among all **Insured** non-physician **employees** and the **Insured** ophthalmologist or **professional entity** employer;

2. Among all **Insured locum tenens** and the **Insured** ophthalmologist employer whom the **locum tenens** is replacing;

3. Among all **Insured professional entities** and the **Policyholder**; and

4. Between an **Insured** sole shareholder corporation **professional entity** and the **Insured** sole shareholder.

SECTION V. DEFENSE OF A CLAIM

OMIC has the right to investigate any **professional services incident** at any time and in any manner that **OMIC** deems appropriate. **OMIC** has the right and duty to defend each covered **Claim** brought against the **Insured** even if groundless, false, or fraudulent. **OMIC** has the right to select defense counsel for any covered **Claim** and to negotiate, evaluate, and control the defense of such **Claim**. **OMIC** will not be liable for **Claim expenses** incurred by an **Insured** without **OMIC's** written consent or incurred before **OMIC's** receipt of written notice of a **Claim**.

Defense counsel's primary duty will be to the **Insured**. If **OMIC** notifies the **Insured** at any time during the defense of the **Claim** that (1) **OMIC** denies coverage as to certain allegations, (2) **OMIC** denies coverage of punitive or other non-covered damages, or (3) the **Claim** is for an amount in excess of the applicable limits of liability, the **Insured** is entitled to retain counsel of the **Insured's** choice, at the sole expense of the **Insured**, to participate in the defense of the matters that are the subject of such notice. If **OMIC** is required by law to pay for such independent counsel, the attorney's fees and expenses **OMIC** will pay are limited to the rates **OMIC** usually pays to counsel it has retained in the ordinary course of business for the defense of similar **Claims** in the same community.

If an arbitration or mediation proceeding is brought against the **Insured** with respect to a **Claim**, **OMIC** has the right to exercise all of the **Insured's** rights in the choice of arbitrators or mediators and the conduct of the proceedings.

If a **Claim** is asserted against more than one **Insured**, **OMIC** may retain the same legal counsel to defend all **Insureds** consistent with counsel's ethical duties to avoid conflicts of interest.

When the applicable limit of liability has been exhausted, **OMIC** (1) has the right to withdraw from and tender to the **Insured** any further defense of the **Claim** and (2) will not be obligated to pay any further **damages** or supplementary payments. If this happens, **OMIC** shall (1) notify the **Insured** so that the **Insured** can arrange to take over control of the defense of the **Claim** and payment of **Claim expenses** and (2) assist in the transfer of control to the **Insured** for such defense.

SECTION VI. SUPPLEMENTARY PAYMENTS

The following supplementary payments are in addition to the applicable limit of liability. These supplementary payments end when the limit of liability is exhausted. For any covered **Claim**, **OMIC** shall pay:

1. All **Claim expenses** incurred by **OMIC** and all costs levied against the **Insured** related to the **Claim** and approved by **OMIC**;

2. All interest on the amount of any judgment that is within the applicable limit of liability that accrues after entry of the judgment and before **OMIC** has paid or deposited in court that part of the judgment which does not exceed the limit of liability ("post-judgment interest"). In no event will prejudgment interest be considered supplemental;

3. Premiums on appeals bonds authorized by **OMIC**, but only for that portion of a judgment that does not exceed the applicable limit of liability, and premiums on bonds to release attachments for an amount not in excess of the applicable limit of liability, but **OMIC** will have no obligation to apply for or furnish any such bonds;

4. Reasonable expenses, other than loss of earnings, incurred by the **Insured** at **OMIC's** request in the investigation or defense of the **Claim**; and

5. At the **Insured's** request, loss of earnings of the **Insured** as a result of the **Insured's** attendance, as requested by **OMIC**, at any court proceeding, trial, mediation, or arbitration involving the **Claim**, not to exceed the sum of $500 for each day and $250 for each half-day. A "day" of attendance means attendance for more than three hours. A "half-day" of attendance means attendance for three hours or fewer. Attendance at the **Insured's** own deposition, or the deposition of others, is not a "court proceeding" and does not qualify for these supplementary payments.

SECTION VII. ADDITIONAL BENEFITS

A. Disciplinary Proceeding Protection

OMIC shall defend and pay **Claim expenses** for any **Insured** ophthalmologist named in the **Declarations** whose class is identified as Ophthalmology against any investigation, disciplinary proceeding, or action for review (hereinafter "***disciplinary proceeding***") of the **Insured's** practice by any federal, state, or local regulatory agency arising from a complaint or report by a patient to such agency of an **injury** to that patient resulting from a **professional services incident** involving **direct patient treatment** provided by the **Insured**. However, **OMIC** will have no liability for fines, sanctions, penalties, or other financial awards resulting from the ***disciplinary proceeding***.

This Benefit will only be provided if:

1. The **professional services incident** upon which the ***disciplinary proceeding*** is based occurred on or after the applicable **retroactive date** and prior to the end of the applicable **policy period**; and

2. The ***disciplinary proceeding*** is first made against the **Insured** and the **Insured** provides timely written notice of the ***disciplinary proceeding*** to **OMIC** during the applicable **policy period** or **extended reporting period**.

This coverage does not apply to any ***disciplinary proceeding*** that arises out of a **professional services incident** that is not covered under this policy, or would be specifically excluded if brought as a **Claim** under this policy.

The most **OMIC** will pay per **Insured** for **Claim expenses** for any one ***disciplinary proceeding*** is $25,000. The most **OMIC** will pay per **Insured** for **Claim expenses** for all such ***disciplinary proceedings*** during the **policy period** or the **extended reporting period** will be $75,000.

The Additional Benefit pertaining to any ***disciplinary proceedings*** or ***regulatory proceedings*** arising out of the same events is afforded either under Subsection A. or B., not both, and one limit applies.

B. Broad Regulatory Protection

OMIC shall reimburse any **Insured** ophthalmologist or **professional entity** named in the **Declarations** for (1) any ***legal expenses*** incurred as a result of a ***regulatory proceeding instituted*** against the **Insured** during the **policy period**; (2) any ***audit expenses*** incurred in the course of a ***shadow audit*** related to a ***billing errors proceeding instituted*** against the **Insured** during the **policy period**; and (3) ***fines or penalties*** imposed against the **Insured** as a result of a ***billing errors proceeding***, ***EMTALA proceeding***, ***HIPAA proceeding***, or ***STARK proceeding instituted*** against the **Insured** during the **policy period**.

This Benefit will only be provided if the **Insured** provides timely written notice of the ***regulatory proceeding*** to **OMIC** during the applicable **policy period** or within sixty days after the expiration of the **policy period**.

Definitions. This Section defines various terms used in this Subsection VII.B. These terms are indicated throughout the Subsection in bold, italicized print. Refer to Section I. Definitions of the policy for terms that are shown in bold, but not defined below. If a term is defined below and in Section I. Definitions of the policy, the definition below applies to this Subsection VII.B.

1. ***Audit expenses*** means the fees for the services of a qualified audit professional and associated expenses incurred by the **Insured** in the course of a ***shadow audit***.
2. ***Billing errors proceeding*** means (a) a civil investigation or proceeding ***instituted*** against the **Insured** by a qui tam plaintiff under the federal False Claims Act, by a government entity, or by a commercial payer alleging presentation of erroneous billings by the **Insured** to a government health benefit payer or commercial payer from which the **Insured** seeks or has received payment or reimbursement for medical service or items or (b) an investigation or proceeding ***instituted*** against the **Insured** because of the **Insured's *voluntary self disclosure*** to any government entity.
3. ***Covered licensing proceeding*** means a proceeding ***instituted*** against the **Insured** by a state licensing authority that arises out of the practice of ophthalmology but that does not include a **professional services incident** involving **direct patient treatment**.
4. ***DEA proceeding*** means a proceeding ***instituted*** against the **Insured** by the Drug Enforcement Agency ("DEA"), for the purpose of adversely affecting the **Insured's** ability to prescribe drugs pursuant to a license issued by the DEA.
5. ***EMTALA proceeding*** means a proceeding ***instituted*** against the **Insured** by a government entity alleging one or more violations of the Emergency Medical Treatment and Active Labor Act ("EMTALA").
6. ***Fines or penalties*** means administrative fines or penalties the **Insured** is required to pay as a result of a covered ***billing errors proceeding***, ***EMTALA proceeding***, ***HIPAA proceeding***, or ***STARK proceeding*** (but not a ***DEA proceeding*** or ***covered licensing proceeding***).
7. ***HIPAA proceeding*** means a proceeding ***instituted*** against the **Insured** by a government entity alleging violation of the Health Insurance Portability and Accountability Act ("HIPAA") privacy and security regulations.
8. ***Instituted*** means the time formal written notice of a ***regulatory proceeding*** is received by the **Insured**. All related proceedings comprising a ***regulatory proceeding*** shall be deemed to have been ***instituted*** at the time the earliest of such proceedings was ***instituted***.
9. ***Legal expenses*** means an attorney's fees for legal services rendered in defense of a ***regulatory proceeding***, associated expenses, and related, **OMIC** pre-approved consultant fees other than ***audit expenses***. ***Legal expenses*** do not include costs associated with the adoption and implementation of any corporate integrity agreement or compliance or similar program negotiated as part of a settlement with or by order of a government entity.
10. ***Regulatory proceeding*** means a ***billing errors proceeding***, ***DEA proceeding***, ***EMTALA proceeding***, ***HIPAA proceeding***, ***covered licensing proceeding***, or ***STARK proceeding instituted*** against the **Insured** during the **policy period** that results in ***legal expenses***, ***audit expenses***, or ***fines*** *or* ***penalties*** (where applicable). All related and consolidated proceedings, and proceedings arising out of the same facts, events, or circumstances, including appeals and post-trial proceedings, shall be considered one ***regulatory proceeding***.
11. ***Shadow audit*** means an audit performed by a qualified professional, which examines the same billing records and related documents as those subject to an ongoing ***billing errors proceeding***, with the intent of providing the **Insured** with a private expert opinion.
12. ***STARK proceeding*** means a proceeding ***instituted*** against the **Insured** by a government entity alleging violation of any federal, state, or local anti-kickback or self-referral laws.
13. ***Voluntary self disclosure*** means the **Insured** discloses information to a government entity, without prior solicitation by the entity of such information, which information may serve as grounds for a ***billing errors proceeding*** against the **Insured**. Such information

must have become known to the **Insured** fortuitously and subsequent to the initial effective date of the policy.

Exclusions. These exclusions are applicable to this Subsection VII.B.:

1. This Benefit does not apply to ***regulatory proceedings*** that arise from any circumstances, events, or causes that (1) are underlying in any litigation, government investigation or proceeding, other notice pending, or any judicial decree or judgment entered; (2) are the subject of notice to an insurer under any other insurance policy; or (3) any **Insured** or any of his/her/its supervisory level employees knew or had a reasonable basis to know might result in a ***regulatory proceeding***, prior to the **Insured's original effective date**.
2. No benefits shall be reimbursable for ***legal expenses***, ***audit expenses***, or ***fines or penalties***:
   a. arising out of any matter that any **Insured** has acted with another to institute, except for ***voluntary self disclosure***;
   b. arising out of any matter brought against an **Insured** by any other **Insured**, except if brought by a qui tam plaintiff or under the federal False Claims Act;
   c. incurred in defense of a criminal proceeding. Criminal proceeding shall mean a governmental action for the enforcement of criminal laws, including those offenses for which conviction could result in criminal fines and/or incarceration;
   d. arising out of any liability of any **Insured** assumed under any contract or agreement, except if the **Insured** would have been liable in the absence of such contract or agreement and the ***legal expenses, audit expenses,*** *or* ***fines or penalties*** would have otherwise been covered by this benefit;
   e. arising out of a ***billing errors proceeding*** involving billing errors for medical services or items provided or prescribed by someone other than an **Insured**; and
   f. incurred in the course of a ***shadow audit*** not previously approved by **OMIC**, which approval will not be unreasonably withheld.
3. This Benefit does not apply to:
   a. restitution of fees, reimbursements, profits, charges, or benefit payments received by the **Insured** from a government health benefit payer, commercial payer, or patient that the **Insured** was not legally entitled to by reason of billing error;
   b. damages, including compensatory damages, punitive damages, exemplary damages, or additional damages resulting from the multiplication of compensatory damages, or any amounts which are deemed uninsurable by law;
   c. remuneration, salaries, fees, or overhead of any **Insured**; and
   d. the costs associated with the adoption and implementation of any corporate integrity agreement, compliance program, or similar provision regarding the operations of the **Insured**'s business negotiated as part of a settlement with or by order of a government entity.

Choice of Counsel and Co-Payment. **OMIC** does not assume any duty to defend under this Additional Benefit. The **Insured** shall have complete freedom of choice of counsel. Upon receiving notice from an **Insured** of a ***regulatory proceeding***, **OMIC** will provide the **Insured** with the name(s) of panel counsel. If the **Insured** retains panel counsel for the ***regulatory proceeding***, **OMIC** will, subject to the other provisions of this policy, reimburse 100% of covered ***legal expenses***, ***audit expenses***, and ***fines and penalties*** (where applicable). If the **Insured** retains non-panel counsel for the ***regulatory proceeding***, **OMIC** will reimburse 75% of covered ***legal expenses***, ***audit expenses*** and ***fines or penalties*** (where applicable), and the **Insured** must make a copayment of 25%. Rates for non-panel counsel will be limited to a maximum of $300 per hour. All counsel, panel or non-panel, must comply with **OMIC's** reasonable parameters.

Coverage Limit. The most **OMIC** will reimburse per **Insured** for ***legal expenses***, ***audit expenses***, and ***fines or penalties*** for any one ***regulatory proceeding*** and in the aggregate for all ***regulatory proceedings instituted*** during a **policy period** is $50,000.

The Additional Benefit pertaining to any ***disciplinary proceedings*** or ***regulatory proceedings*** arising out of the same event(s) is afforded either under Subsection A. or B., not both, and only one limit applies. The Additional Benefit pertaining to any ***HIPAA proceedings*** or ***privacy wrongful acts*** arising out of the same event(s) is afforded either under Subsection B. or C., not both, and only one limit applies (Subsection C. limits are a sub-limit of Subsection B. limits, regardless). OMIC has the sole discretion to determine which coverage provision applies in any event.

C. e-MD™ Network Security & Privacy Coverage, Patient Notification and Credit Monitoring Costs Coverage, and Data Recovery Costs Coverage

This Section VII.C. provides three different coverages. Section VII.C.1. covers ***network security wrongful acts*** and ***privacy wrongful acts*** committed or alleged to be committed by an **Insured**. Section VII.C.2. covers ***patient notification and credit monitoring costs*** resulting from ***privacy wrongful acts*** committed or alleged to be committed by an **Insured**. Section VII.C.3. covers ***data recovery costs*** resulting from a ***data interference act*** committed by someone other than an **Insured**.

1. Network Security & Privacy Coverage

OMIC shall pay on behalf of any **Insured** ophthalmologist or **professional entity** named in the **Declarations** the ***loss*** and ***legal expenses*** such **Insured** becomes legally obligated to pay as a result of a ***claim*** for a ***network security wrongful act*** or ***privacy wrongful act*** first made against such **Insured** during the **policy period**. **OMIC** shall have the right and duty to defend any ***claim*** even if the allegations of the ***claim*** are groundless, false, or fraudulent. **OMIC** shall have the right to appoint defense counsel and to investigate any ***claim*** as **OMIC** deems necessary.

This Benefit will only be provided if:

1. The ***network security wrongful act*** or ***privacy wrongful act*** actually or allegedly takes place on or after the applicable **retroactive date** and prior to the end of the applicable **policy period**; and
2. The **Insured** provides timely written notice of the ***claim*** to OMIC during the applicable **policy period** or within sixty days after the expiration of the **policy period**.

2. Patient Notification and Credit Monitoring Costs Coverage

OMIC shall pay on behalf of any **Insured** ophthalmologist or **professional entity** named in the **Declarations** the ***patient notification and credit monitoring costs*** incurred during the applicable **policy period** as a result of a ***privacy wrongful act***, but only if such ***patient notification and credit monitoring costs*** are incurred with **OMIC's** prior written consent. **OMIC** will not unreasonably withhold consent.

This Benefit will only be provided if:

1. The ***privacy wrongful act*** actually or allegedly takes place on or after the applicable retroactive date and prior to the end of the applicable **policy period**; and
2. The **Insured** provides timely written notice of the ***privacy wrongful act*** to **OMIC** during the applicable **policy period**.

3. Data Recovery Costs Coverage

OMIC shall pay on behalf of any **Insured** ophthalmologist or **professional entity** named in the **Declarations** the ***data recovery costs*** incurred during the applicable **policy period** as a result of a ***data interference act***, but only if such ***data recovery costs*** are incurred with **OMIC's** prior written consent. **OMIC** will not unreasonably withhold consent.

This Benefit will only be provided if:

1. The ***data interference act*** actually or allegedly takes place on or after the applicable retroactive date and prior to the end of the applicable **policy period**;
2. The **Insured** provides timely written notice of the ***data interference act*** to **OMIC** during the applicable **policy period**.

In the event that ***data*** belonging to an **Insured** has been compromised, damaged, lost, erased, eradicated, altered, corrupted, or tainted by reason of a ***data interference act***, the **Insured** shall, as soon as practicable following notification to **OMIC**, provide a written statement to **OMIC** detailing:

1. the harm or damage known to have resulted from the ***data interference act***;
2. the circumstances under which the **Insured** first discovered the ***data interference act***;
3. the proposed plan for remediation and/or recovery of said ***data***, including the name and identity of the professional or consultant proposed for carrying out the remediation and/or recovery;
4. the proposed or estimated costs of the remediation and/or recovery; and
5. the proposed date and time for both commencing and completing such remediation and/or recovery.

No ***data recovery costs*** shall be incurred without **OMIC's** prior written consent, and **OMIC** shall not be responsible to pay any ***data recovery costs*** that were not so approved. Notwithstanding the foregoing, an **Insured** may incur ***data recovery costs*** without **OMIC's** prior written consent if the circumstances are such that there is no practical or reasonable opportunity to obtain **OMIC's** prior written consent and the exigencies then and there existing require immediate action to mitigate the potential for damages or harm to an **Insured** or to third parties.

Definitions. This Section defines various terms used in this Subsection VII.C. These terms are indicated throughout the subsection in bold, italicized print. Refer to Section I. Definitions of the policy for terms that are shown in bold, but not defined below. If a term is defined below and in Section I. Definitions of the policy, the definition below applies to this Subsection VII.C.

1. ***Claim*** *means:*
   a. any written demand for monetary damages or other non-monetary relief against an **Insured**;
   b. any civil proceeding or arbitration proceeding against an **Insured**, commenced by the service of a complaint or similar pleading or notification;
   c. any written request to toll or waive a statute of limitations relating to a potential ***claim*** against an **Insured**, including any appeal therefrom; or
   d. any proceedings instituted against an **Insured** by a government entity, commenced by letter notification, complaint, or order of investigation, the subject matter of which is a ***privacy wrongful act*** committed by an **Insured**.

   A ***claim*** will be deemed to be first made or instituted when any of the foregoing is first received by an **Insured**. More than one ***claim*** arising out of the same ***network security wrongful act***, the same ***privacy wrongful act***, the same ***data interference act*** or related ***network security wrongful acts***, ***privacy wrongful acts*** or ***data interference acts*** shall be deemed one ***claim***, and such ***claim*** shall be deemed to be first made on the date the earliest of such ***claims*** is first made. ***Network security wrongful acts***, ***privacy wrongful acts,*** or ***data interference acts*** will be deemed related if they are logically or causally connected by any common fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events, or transactions.
2. ***Data*** means any and all information stored, recorded, appearing, or present in or on the **Insured's** computer systems, electronic communication systems, devices, and telephony,

including, but not limited to, information stored, recorded, appearing, or present in or on the **Insured's** electronic and computer databases, the Internet, intranet, extranet, and related websites, facsimiles, and electronic mail.

3. ***Data interference act*** means any act by a party other than an **Insured** that occurs during the **policy period** and is carried out without an **Insured's** consent or knowledge, whether intentional, malicious, reckless, or negligent, which act causes harm or damage to the ***data*** maintained by an **Insured**, including but not limited to interference with, or intrusion or incursion into, any of the **Insured's** computer systems, electronic communication systems, devices, and telephony, including, but not limited to, the **Insured's** electronic and computer databases, the Internet, intranet, extranet, and related websites, facsimiles, and electronic mail.
4. ***Data recovery costs*** means all reasonable and necessary sums incurred by an **Insured**, with **OMIC's** prior written consent, to recover and/or replace ***data*** that is compromised, damaged, lost, erased, eradicated, altered, corrupted, or tainted by reason of a ***data interference act***, including but not limited to the costs associated with the repair or replacement of any software that is compromised, damaged, lost, erased, eradicated, altered, corrupted, or tainted by reason of a ***data interference act***.
   Data recovery costs shall not include: 1) the costs of repairing or replacing any hardware, equipment or wiring; 2) wages, salaries or other compensation or income of any **Insured**; or 3) the costs of recovering or replacing data for any third party or any data that was not within the care, custody or control of the **Insured**.
5. ***Legal expenses*** mean reasonable and necessary fees, costs, and expenses incurred in the investigation, defense, and appeal of any covered ***claim***; but ***legal expenses*** shall not include any wages, salaries, or other compensation or income of any **Insured**.
6. ***Loss*** means money an **Insured** is legally obligated to pay as a result of a ***claim***. ***Loss*** includes damages and judgments; prejudgment and post-judgment interest awarded against an **Insured** on that part of any judgment paid or to be paid by **OMIC**; legal fees and costs awarded pursuant to such judgments; settlements negotiated with **OMIC's** prior consent; and administrative fines or penalties assessed against an **Insured** by a government entity as a result of a ***privacy wrongful act***.
   Loss does not include (1) taxes; (2) any amount for which the **Insured** is absolved from legal responsibility to make payment to any third party; (3) amounts owed under, or assumed by, any contract; (4) any return, withdrawal, restitution, or reduction of professional fees, profits, or other charges; (5) punitive or exemplary damages or the multiple portion of any multiplied damages; (6) criminal fines or penalties; or (7) any matters that are uninsurable under applicable law.
7. ***Network security wrongful act*** means an actual or alleged act, error, or omission by an **Insured**, including an unauthorized act by an employee, which results in the unauthorized access or unauthorized use of the **Insured's** computer system, the consequences of which include, but are not limited to:
   a. the failure to prevent unauthorized access to, use of, or tampering with a third party's computer systems;
   b. the inability of an authorized third party to gain access to the **Insured's** services;
   c. the failure to prevent denial or disruption of Internet service to an authorized third party;
   d. the failure to prevent identity theft or credit/debit card fraud; or
   e. the inadvertent transmission of harmful or corrupt software code, including but not limited to computer viruses, Trojan horses, worms, logic bombs, spyware, or spiderware.
8. ***Patient notification and credit monitoring costs*** means all reasonable and necessary expenses incurred by an **Insured**, with **OMIC's** prior written consent, in notifying patients of any actual or potential ***privacy wrongful act***, including, but not limited to:
   a. legal expenses;
   b. computer forensic and investigation fees;

c. public relations expenses;
d. postage expenses;
e. related advertising expenses; and
f. the costs of credit monitoring services provided to affected individuals for a period of up to 12 months from the date of enrollment in such services.

9. ***Privacy wrongful act*** means any of the below, whether actual or alleged, but only if committed or allegedly committed by an **Insured**:
   a. breach of confidence or invasion, infringement, interference, or violation of any rights to privacy including, but not limited to, breach of the **Insured's** privacy statement, breach of a person's right of publicity, false light, intrusion upon a person's seclusion, public disclosure of a person's private information, or intrusion or misappropriation of a person's name or likeness for commercial gain; or
   b. any breach or violation of US federal, state, or local statutes and regulations associated with the control and use of personally identifiable financial or medical information, including but not limited to:
      i. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) ("HIPAA"), including Title II which requires protection of confidentiality and security of electronic protected health information, and the rules and regulations promulgated thereunder as they currently exist and as amended, including related state medical privacy laws as they currently exist and as amended;
      ii. Gramm-Leach-Bliley Act of 1999 (G-L-B), also known as the Financial Services Modernization Act of 1999**,** including sections concerning security protection and standards for customer or patient records maintained by financial services companies, and the rules and regulations promulgated thereunder as they currently exist and as amended;
      iii. State Attorneys General and Federal Trade Commission enforcement actions regarding the security and privacy of consumer information;
      iv. Governmental privacy protection regulations or laws, as they currently exist now or in the future, which require commercial Internet sites or on-line services that collect personal information or medical information (as defined by such laws or acts) to post privacy policies and adopt specific privacy controls or to notify those impacted by identity or data thief, abuse or misuse;
      v. Federal and state consumer credit reporting laws, such as the federal Fair Credit Reporting Act (FCRA); and
      vi. The Health Information Technology for Economic and Clinical Health Act ("HITECH ACT"), Title XIII of the American Recovery and Reinvestment Act ("ARRA") of 2009.

Exclusions. These exclusions are applicable to this Subsection VII.C.:

1. This Benefit does not apply to any ***claim***, any ***patient notification and credit monitoring costs***, or any ***data recovery costs***:
   a. based on, resulting from, arising out of, attributable to, or in any way involving:
      i. any facts, circumstances, events, causes or situations that (1) are underlying in any litigation, government investigation or proceeding, other notice pending, or any judicial decree or judgment entered; (2) are the subject of notice to an insurer under any other insurance policy; or (3) any **Insured** or any of his/her/its supervisory level employees knew or had a reasonable basis to know might result in a ***claim*** prior to the **Insured's original effective date**;

ii. (a) any breach of contract, warranty, or guarantee; or (b) liability of others assumed by an **Insured** under any contract or agreement. This exclusion 1.a.ii. shall not apply to the extent the **Insured** would have been liable in the absence of a contract or agreement;

iii. any business, joint venture, or enterprise other than the health care practice of the **Insured**;

iv. any **Insured** gaining in fact any profit, remuneration, or financial advantage to which such **Insured** was not legally entitled;

v. any deliberately dishonest, malicious, or fraudulent act or omission or any willful violation of law by any **Insured**, if judgment or other final adjudication adverse to the **Insured** establishes such an act, omission, or willful violation; however, this exclusion 1.a.v. shall not apply to any **Insured** that did not commit, participate in, or have knowledge of any such act, omission or violation of law described in this exclusion;

vi. any actual or alleged violation of the False Claims Act, or any similar federal or state law, rule, or regulation concerning billing errors or fraudulent billing practices or abuse;

vii. any actual or alleged price fixing, restraint of trade, or violation of any securities or anti-trust laws;

viii. any actual or alleged Violation of any of United States of America's economic or trade sanctions, including but not limited to, sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC");

b. based on, resulting from, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:

i. any actual or alleged electrical failure, including any electrical power interruption, surge, brownout, or blackout;

ii. any actual or alleged malfunction or defect of any hardware, equipment, or component;

iii. any **Insured's** actual or alleged failure to render professional services;

iv. loss of business income arising from the interruption, suspension, or degradation of the **Insured's** own computer network;

v. (a) any ***network security wrongful act***, ***privacy wrongful act***, or ***data interference act*** actually or allegedly occurring prior to the applicable **retroactive date**; or (b) any other ***network security wrongful act***, ***privacy wrongful act***, or ***data interference act*** actually or allegedly occurring on or subsequent to the applicable retroactive date which, together with a ***network security wrongful act***, ***privacy wrongful act***, or ***data interference act*** actually or allegedly occurring prior to such date would constitute related ***network security wrongful acts***, ***privacy wrongful acts***, or ***data interference acts***. For purposes of this exclusion 1.b.v., ***network security wrongful acts***, ***privacy wrongful acts***, or ***data interference acts*** will be deemed related if they are logically or causally connected by any common fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events, or transactions.

2. This benefit does not apply to any ***claim*** brought by or on behalf of:

a. any **Insured** against another **Insured**;

b. any entity owned, in whole or in part, by any **Insured**;

c. any entity directly or indirectly controlled, operated, or managed by any **Insured**;

d. any entity that is a parent, affiliate, or subsidiary of any entity in which any **Insured** is a partner; or

e. any person who is a partner or joint venturer in any entity in which any **Insured** is also a partner or joint venturer.

This exclusion 2. shall not apply to an otherwise covered ***claim*** by an employee of an **Insured** alleging a ***privacy wrongful act***.

Notice of a Potential ***Claim***. If, during the **policy period**, any **Insured** first becomes aware of a specific ***network security wrongful act***, ***privacy wrongful act***, or ***data interference act*** which could give rise to a ***claim*** under this Subsection VII.C., and if the **Insured**, during the **policy period**, provides **OMIC** with written notice as soon as practicable of:

1. the specific ***network security wrongful act***, ***privacy wrongful act***, or ***data interference act;***
2. the nature of the alleged or potential damages;
3. the identity of the potential claimants and any **Insured** involved;
4. the manner in which the **Insured** first became aware of the circumstances; and
5. the consequences which have resulted or may result from the ***network security wrongful act***, ***privacy wrongful act***, or ***data interference act***,

then any ***claim*** subsequently arising from such circumstances will be deemed first made on the date such notice was given to **OMIC**.

Coverage Limit. The most **OMIC** will pay per **Insured** for ***legal expenses***, ***loss***, ***patient notification and credit monitoring costs***, ***and data recovery costs*** combined is $50,000 for a **policy period**. Any payment under this Section VII.C. is a sub-limit of, and reduces the benefits payable under, Section VII.B. Broad Regulatory Protection.

The Additional Benefit pertaining to any ***HIPAA proceedings*** or ***privacy wrongful acts*** arising out of the same event(s) is afforded either under Subsection B. or C., not both, and only one limit applies (Subsection C. limits are a sub-limit of Subsection B. limits, regardless). OMIC has the sole discretion to determine which coverage provision applies in any event.

SECTION VIII. GENERAL CONDITIONS, RULES, AND DUTIES

If any **Insured** fails to comply with any obligations under this policy, **OMIC's** obligations to such **Insured** under this policy terminate, including any obligation to defend or continue any litigation or to pay any **damages** or supplementary payments.

1. Policyholder

The **Policyholder** shall act on behalf of all **Insureds** under this policy with respect to giving and receiving notice regarding this policy. This may include changes in premium, termination of the policy, accepting any **endorsement** issued to form a part of this policy, and receiving premium refunds. The **Policyholder** is also responsible for notifying **OMIC** of any changes of which it is aware that might affect the insurance under this policy.

2. Application

The **Insured** represents and agrees that the statements made in any application(s), supplemental questionnaire(s), and any other documents submitted to **OMIC** for the purpose of obtaining, retaining, or modifying this insurance are the **Insured's** true and complete agreements and representations and that this policy is issued in reliance upon the truth and completeness of such representations.

The **Insured** shall immediately inform **OMIC**, in writing, of any changes in such representations that may occur during the **policy period**. If the **Insured** fails to notify **OMIC** of material changes within thirty days following the change, **OMIC** has the right to deny coverage of a **Claim** related to the change or cancel this policy or the insurance provided by this policy with respect to such **Insured**.

If the **Insured** or the **Insured's** representative conceals or misrepresents, either negligently or intentionally, any material fact or circumstance concerning this insurance, including the **Insured's** training, experience, **Claims** history, prior **potential Claims**, or the nature or scope of the **Insured's** practice, **OMIC** has the right to deny coverage of a **Claim** related to the concealment or misrepresentation or cancel this policy or the insurance provided by this policy with respect to such **Insured**.

Any application(s), supplemental questionnaire(s), and any other documents submitted to **OMIC** for the purpose of obtaining, retaining, or modifying this insurance, together with this policy, the **Declarations**, and any **endorsements**, constitute the contract of insurance between **OMIC** and the **Insured**.

3. Reporting Health, Licensing, and Privileges Occurrences

Each **Insured** shall notify **OMIC**, in writing, within thirty days after the occurrence of any one or more of the following:

a. such **Insured** is undergoing treatment or is advised by a treating health care provider, peer review committee, hospital credentialing committee, or licensing agency to undergo treatment for alcohol, drug, or other substance abuse, or for psychiatric illness;

b. such **Insured** suffers an illness or physical injury which impairs, or is likely to impair, such **Insured's** ability to practice ophthalmology for thirty days or more;

c. such **Insured** is convicted of, or pleads guilty or no contest to, a felony or misdemeanor, including driving under the influence (DUI) or driving while intoxicated (DWI), other than minor traffic offenses;

d. such **Insured's** license, certification, or accreditation to practice medicine, dispense drugs, or provide health care services is investigated, revoked, suspended, surrendered, or restricted in any respect, or any licensing agency, peer review committee, professional standards review committee, or credentialing committee takes any action against the **Insured**; or

e. such **Insured's** privilege to practice is denied, terminated, revoked, suspended, or restricted by any licensed health care facility or employer, whether by reason of termination of employment, voluntary termination, or otherwise.

4. Policy Changes

The **Insured** must contact **OMIC** in writing to request a change in policy terms. Notice given to or knowledge possessed by **OMIC** does not affect a waiver of or change to any part of this policy or prevent **OMIC** from asserting any right under the terms of this policy. The terms of this policy are waived or changed only by **endorsement** or Amended **Declarations** issued to form a part of this policy and signed by a duly authorized **OMIC** representative, except that, in the event that **OMIC** adopts any revision to this policy that would broaden coverage without payment of additional premium, the broadened coverage will automatically apply to this policy effective on the date **OMIC** authorizes the change.

5. Declarations

This policy is not effective unless **Declarations** are issued as part of the policy. The coverage afforded by this policy is subject to the conditions and limitations set forth in the **Declarations**.

6. Certificates of Insurance

At the **Insured's** request, **OMIC** may, but is not required to, provide certification of the **Insured's** coverage with **OMIC** ("certificates of insurance") to third parties. It is the **Insured's** responsibility to inform recipients of certificates of insurance of any changes in, or cancellation of, coverage under this policy. Neither the issuance of certificates of insurance by **OMIC** nor the contents of any such certificate will extend or modify coverage or in any other way affect this policy.

7. Premium

a. Insurance under this policy is provided in return for, and expressly conditioned on, timely payment by the **Insured** of a premium established by **OMIC**.

b. All premiums for this policy are computed in accordance with **OMIC's** rules, rates, and rating plans. The **Insured** shall maintain records of such information as is necessary for premium computation and shall send copies of such records to **OMIC** at such times during and after the **policy period** as **OMIC** may require.

c. All **OMIC** premiums, assessments that **OMIC** collects on behalf of state patient compensation or excess liability funds, and any applicable premium taxes and service charges for this policy are payable on or before the due date on the premium notice. Premiums may be paid either in full or, at **OMIC's** discretion, in installments. State patient compensation or excess liability fund assessments and any applicable premium taxes are due in full at policy issuance. There is no grace period for payment. Any amount due, whether full or installment, not paid on or before the due date, will be in default. **OMIC** applies payments received from **Insureds** in the following order: state patient compensation or excess liability fund assessments, premium taxes, **OMIC** premiums, and service charges.

d. Any overpayment will be refunded directly to the **Policyholder**, regardless of who made the payment.

8. Reporting Claims and Potential Claims

In order for this policy to cover a **Claim** against an **Insured**:

a. the **Insured** must immediately give written notice of any **Claim** that has been made against the **Insured**, or any **potential Claim**, to **OMIC**, Claims Department, 655 Beach Street, San Francisco, CA 94109-1336. Informing any other OMIC department of a **Claim** is not deemed notice of a **Claim** for coverage purposes.

b. the notice of the **Claim** or **potential Claim** must include the following information, as applicable:

   i. the **Insured** involved;
   ii. the extent and type of **Claim** received or anticipated;
   iii. the date, time, and place of the **professional services incident**;
   iv. the facts and circumstances of the **professional services incident**;
   v. the **injury** or **property damage**, including the names, addresses, and ages of the claimants or persons injured; and
   vi. the names of witnesses, including other treating health care providers.

Written notice of a **Claim** or **potential Claim** received by **OMIC's** Claims Department from the **Insured** during the **policy period** or within five days after the end of the **policy period** will be deemed a **Claim** reported during the **policy period**.

There may be no coverage if a delay in reporting a **Claim** or **potential Claim** results in prejudice to **OMIC** or to the **Insured's** defense. For example, there is prejudice if the **Insured** fails to report a lawsuit to **OMIC** until after a default judgment is entered against the **Insured** in court.

Claims and **potential Claims** reported to **OMIC's** Risk Management Department are kept confidential and are not shared with the Underwriting or Claims Departments without the **Insured's** permission and are therefore not considered reported to **OMIC** for coverage purposes. In order to report a **Claim** or **potential Claim**, the **Insured** must notify **OMIC's** Claims Department as explained above.

9. Cooperation

In order for this policy to cover a **Claim** against an **Insured**, the **Insured** and each of the **Insured's employees**, members, partners, directors, officers, and shareholders must fully cooperate with **OMIC**, **OMIC's** authorized representatives, and defense counsel appointed by **OMIC** in their investigation and defense of the **Claim**.

a. The **Insured** shall promptly forward to **OMIC** every demand, notice, summons, or other process or legal documents received by the **Insured** or the **Insured's** representative in connection with the **Claim**.

b. Upon **OMIC's** request, the **Insured** and each of the **Insured's employees**, members, partners, directors, officers, and shareholders, as necessary, must:

   i. authorize **OMIC** to obtain medical records and other information;
   ii. meet with **OMIC** representatives and defense counsel;
   iii. submit to an examination under oath;
   iv. attend hearings, conferences, depositions, trials, mediations, and arbitrations;
   v. assist **OMIC** in securing and giving evidence and obtaining the attendance of witnesses at the above proceedings; and
   vi. assist **OMIC** in its effort to reach a settlement.

c. The **Insured** must not admit liability and must not take any action with regard to a **Claim**, including voluntarily making any payment, assuming any obligation, or incurring any expense, without **OMIC's** prior written consent.

d. The **Insured** must not create, alter, modify, or destroy medical records with the intent to defraud or deceive or otherwise misrepresent or conceal facts pertinent to any **professional services incident** or **Claim**. This does not preclude coverage where a proper correction or addendum to a medical record has been made, the original entry remains legible, and the correction or addendum is dated and initialed by the **Insured**.

e. If the **Claim** involves both covered and non-covered allegations, at **OMIC's** request, the **Insured** must cooperate in securing (i) a bifurcation of the hearing, arbitration, or trial as to covered and non-covered **Claims** and **damages** and (ii) a special verdict form that segregates covered **Claims** from non-covered **Claims**, as well as covered and non-covered **damages**.

10. Subrogation

The **Insured** must preserve for and transfer to **OMIC** any right the **Insured** may have to recover all or part of any payment **OMIC** has made under this policy. If the **Insured** takes action against a third party concerning a loss for which sums were paid under this policy on the **Insured's** behalf, **OMIC** will have a lien against such sums recovered by the **Insured** to the extent that such sums were paid by **OMIC**. The **Insured** shall execute and deliver any instruments and papers and do whatever else **OMIC** may request to secure such rights. The **Insured** shall not do anything after any loss to prejudice such rights.

11. Consent to Settle

OMIC will not settle any **Claim** without the consent of the **Insured**. If the **Insured** is a **professional entity**, a duly authorized representative of the **Insured** may give his or her consent on behalf of the **professional entity**. **OMIC** bases all recommendations to settle a **Claim** on careful consideration of all circumstances surrounding the **Insured's** potential liability. The **Insured** shall give careful consideration to any settlement recommendation by **OMIC**. **OMIC**, however, is not obligated to recommend settlement of any **Claim**.

12. Other Insurance

a. Except as provided in paragraphs b. through f. below or as otherwise provided in this policy, the **Declarations**, or any **endorsement** to this policy, the insurance provided under this policy is primary. If an **Insured** has other insurance, risk transfer funds, or another source of indemnification ("other insurance") applicable to a **Claim**, **OMIC** will not be liable under this policy for a greater proportion of the **damages** than the amount due if all the insurers contribute equal amounts until each has paid its applicable limit in full or the full amount of the **damages** is paid, whichever comes first ("contribution by equal shares"), regardless of whether the other insurance states that it will be primary, excess, or contingent to another policy, unless such other insurance was specifically purchased to apply in excess of this policy.

b. With respect to **employees** insured under Coverage Agreement B, the insurance provided by this policy is excess over any other valid and collectible insurance, risk transfer funds, or source of indemnification available to such **Insured employees** for **Claims** covered under this policy.

c. With respect to **Claims** arising from **professional committee activities** covered under Coverage Agreement D, the insurance provided by this policy is excess over any other valid and collectible insurance, risk transfer funds, or source of indemnification available for such **Claims**.

d. With respect to **Claims** arising from **professional services incidents** covered under Coverage Agreement E, this policy will not apply if there is any other valid and collectible insurance, risk transfer funds, or source of indemnification available for such **Claims**.

e. With respect to the Additional Benefits provided to **Insureds** under Section VII. Additional Benefits, this coverage shall be excess over any other valid and collectible insurance, risk transfer funds, or source of indemnification available to the Insured, unless such insurance specifically applies as excess insurance over the maximum benefit provided under this policy.

f. With respect to **Claims** that are covered under a state patient compensation fund or excess liability fund ("fund"), the **Insured's** primary limit of liability is decreased to the minimum amount required for the fund to respond to the **Claim**. If the **Insured's** limit is not exhausted at the point the fund responds, the remainder of the **Insured's** limit will apply on an excess basis after the fund limit is exhausted. If the fund does not cover a **Claim**, the **Insured's** limit of liability for that **Claim** will apply uninterrupted on a primary basis.

13. Allocation

OMIC has the right to allocate **damages** or supplementary payments among claimants, **Insureds**, and policies as **OMIC** deems appropriate.

14. Appeal of Judgment

OMIC has the right but not the duty to appeal any judgment rendered against the **Insured**.

15. Assignment of Interest

The **Insured** must not assign or transfer the **Insured's** interest under this policy without the prior written consent of **OMIC**.

16. Death or Incompetence

If the **Insured** dies or is adjudged incompetent, this insurance will cover the **Insured's** heirs, assigns, and legal representative as the **Insured** with respect to liability incurred by the **Insured** before his or her death or incompetence and otherwise covered by this policy.

17. Bankruptcy or Insolvency

Bankruptcy or insolvency of the **Insured** or the **Insured's** estate does not relieve **OMIC** or the **Insured** of their respective obligations under this policy.

18. Action Against OMIC

No action may be taken against **OMIC** to recover under this policy until:

a. the **Insured** has complied with all of the applicable terms and conditions of this policy; and

b. the amount of damages the **Insured** is legally obligated to pay has been determined either by judgment against the **Insured** after actual trial or by written agreement of the **Insured**, the claimant, and **OMIC**.

No person or organization has any right under this policy to include **OMIC** in any legal action against the **Insured** to determine the **Insured's** liability, nor may the **Insured** or the **Insured's** legal representative bring **OMIC** into such an action.

Any recovery under this policy is limited to the extent of the protection provided under this policy and the limits of liability.

Any action against **OMIC** must be brought in the state of Vermont or the state where the policy was delivered to the **Insured**.

19. Service of Lawsuit

If any state law applicable to **OMIC** so requires, **OMIC** designates the Superintendent, Commissioner, or Director of Insurance or other specified officer, as its true and lawful attorney, upon whom may be served any lawful process in an action, lawsuit, or proceeding instituted by or on behalf of the **Insured** arising out of this contract of insurance.

20. Arbitration

OMIC and the **Insured** agree that any dispute between the **Insured** and **OMIC** arising out of the policy that cannot be settled through direct discussions will be submitted exclusively to final and binding arbitration. **OMIC** and the **Insured** agree not to proceed against the other seeking equitable or declaratory relief or damages through a civil action in state or federal court. Each party specifically acknowledges waiving its right to trial by jury. In construing this agreement, the commercial intention of the parties in entering into this contract shall be considered. Any arbitration award rendered will be final and not subject to appeal. The award will be binding on each of the parties to this agreement and judgment may be entered in any court of competent jurisdiction.

Any such dispute will be submitted to and settled by arbitration in any jurisdiction that is convenient for the **Insured** and agreed to by the parties. The **Insured** or **OMIC** 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. If the **Insured** or **OMIC** demands arbitration, all claims, either known or which reasonably should have been known at the time, that arise out of the same transaction, occurrence, or series of transactions or occurrences, as alleged in the demand for arbitration, must be asserted or will be deemed waived and forever barred.

Unless the parties agree otherwise, the arbitration will be conducted by three arbitrators and pursuant to the arbitration rules and procedures of the alternative dispute resolution service provider, JAMS, Inc., The Resolution Experts, ("JAMS"), except that any provision in this Arbitration Clause supersedes any JAMS rule or procedure. Within thirty days of the initiation of arbitration proceedings, the **Insured** and **OMIC** each will select one arbitrator who may serve in a non-neutral capacity. When the first two arbitrators are selected, they will select a third arbitrator within thirty days. The third arbitrator will be neutral and will act as the chairperson of the panel with the responsibility of and authority accorded to JAMS. The decision and award of a majority of the panel will be the arbitration award. The arbitrators may grant any remedy or relief that they deem just and equitable except that they will have no authority to award punitive or other damages not measured by the prevailing party's actual damages.

Each party to arbitration shall pay its own arbitration costs and expenses. Each party shall pay the fees of its selected arbitrator. Each party shall share equally in the fees of the neutral arbitrator and any other arbitration fees or costs.

This insurance contract touches interstate commerce, so any challenges to arbitrability will be governed by federal law. If any provision or any part of this Arbitration Clause is for any reason invalid, unenforceable, or in conflict with Title 9 of the U.S. Code (the Federal Arbitration Act) or any other applicable public policy or law, that provision or part will be conformed to applicable public policy or law and the remainder of this Arbitration Clause will not be affected.

All parties shall treat the dispute as a private matter and shall not make the dispute public. All parties shall maintain the confidential nature of the arbitration proceeding and the award.

21. Choice of Law

The laws of the state of Vermont will govern this policy, including the meaning, interpretation, or operation of any term, condition, definition, or provision of this policy.

22. Policy Territory

Coverage is provided for the **Insured** only for **professional services incidents** that occur while the **Insured's** principal professional office and practice are maintained in the state(s) declared in the application applicable when the **professional services incident** occurred. Coverage is provided only for **Claims** brought against the **Insured** in the fifty United States and Washington, D.C.

23. Inspection and Audit

OMIC, or any inspection organization acting on **OMIC's** behalf, has the right but not the duty to inspect the **Insured's office premises** and operations and examine and audit the **Insured's** books and records that are relevant to this insurance at any time during normal business hours while this policy is in force and for three years after termination of this policy. In making such inspections, **OMIC** will not determine or warrant that the **Insured's office premises** or operations are safe, or that they conform to any laws, codes, standards, or regulations.

24. Non-Assessable

This policy is non-assessable. This means that **OMIC** cannot collect more money from the **Insured** to recoup losses and expenses that exceed **OMIC's** premium income than the initial premium charged for a **policy period**. However, the premium itself may increase during the **policy period** as described in Section IX. B. Premium Increase.

25. Headings

The descriptions in the headings and sub-headings of this policy are solely for convenience and form no part of the terms and conditions of coverage.

26. Compliance with Applicable Law

OMIC and the **Insured** agree that all policy terms shall be construed and administered in a manner consistent with applicable federal and state law. Further, should either a federal or state court invalidate any provision of the policy, all remaining provisions of the policy shall remain binding and in full force.

SECTION IX. TERMINATION AND CHANGES IN PREMIUM

A. Termination

An **Insured's** coverage under this policy terminates upon cancellation of the policy, cancellation of the **Insured's** coverage under this policy, or upon the end of the **policy period** shown in the **Declarations**, whichever occurs first. The reporting period terminates either five days after the termination of the **Insured's** coverage under this policy or at the end

of the **extended reporting period** specified in the **extended reporting period endorsement**, if any, whichever occurs later.

If the coverage under Agreements A, B, or D of this policy of an **Insured** member of an **Insured professional entity** terminates, the member will continue to have coverage under Coverage Agreements C and E, but only in his or her capacity as a member, officer, director, partner, or shareholder of the **professional entity**, as long as the policy remains in force, but he or she will not have coverage for any **Claims** under any other Coverage Agreement of this policy.

1. Cancellation

This policy or an **Insured's** coverage under this policy may be cancelled only as provided here. Nonrenewal of this policy is not cancellation.

a. **Death, Disability, or Incompetency.** Insurance coverage for an **Insured** under this policy is automatically cancelled upon the death, **permanent total disability**, or judicial determination of incompetency of the **Insured**.

b. **Cancellation by the Insured.** The **Policyholder** may cancel this policy and the **Policyholder** or any **Insured** may cancel that **Insured's** coverage under this policy at any time by giving **OMIC** written notice prior to the desired date of cancellation stating when thereafter the cancellation will be effective.

c. **Cancellation by OMIC. OMIC** may cancel this policy by giving the **Policyholder** a notice of cancellation, or an **Insured's** coverage under this policy by giving the **Policyholder** or **Insured** a notice of cancellation, stating the reason(s) for cancellation and when the cancellation will be effective.

(i) If the policy or an **Insured's** coverage under the policy has been in effect for fewer than sixty days from the **original inception date** or the **Insured's original effective date**, respectively, **OMIC** may cancel this policy or the **Insured's** coverage under this policy for any reason, with no prior notice.

(ii) If the policy or an **Insured's** coverage under the policy has been in effect for sixty days or more from the **original inception date** or the **Insured's original effective date**, respectively, **OMIC** may cancel this policy or the **Insured's** coverage under this policy for nonpayment of premium, surplus contribution, or other payment, with at least fifteen days' notice prior to such date of cancellation.

(iii) If the policy or an **Insured's** coverage under the policy has been in effect for sixty days or more from the **original inception date** or the **Insured's original effective date**, respectively, **OMIC** may cancel this policy or the **Insured's** coverage under this policy with at least sixty days' notice prior to such date of cancellation, only for one or more of the following reasons: (a) fraud or material misrepresentation, concealment, or omission by the **Insured** affecting this policy or in the presentation of a **Claim** made under this policy; (b) material increase in hazard insured against; (c) material breach of any term or condition of the policy by the **Insured**; or (d) the **Insured** no longer satisfies the eligibility criteria for membership in **OMIC** as set forth in **OMIC's** Bylaws.

d. **Premium Adjustment.** If the policy is cancelled, **OMIC** shall return any unearned premium to the **Policyholder**. If the **Policyholder** or an **Insured** cancels, unearned premium will be computed, at **OMIC's** discretion, either in accordance with the customary short rate table and procedure or on a pro rata basis from the date of cancellation. If cancellation is for death, disability, or incompetency, or if **OMIC** cancels, unearned premium will be computed on a pro rata basis from the date of cancellation. **OMIC** may adjust the **Insured's** premium either at the time of cancellation or as soon as practicable after cancellation becomes effective, but **OMIC's** refunding of unearned premium to the **Policyholder** is not a condition of cancellation.

2. Nonrenewal

OMIC, the **Policyholder**, and the **Insured** do not have any obligation to renew this policy or any **Insured's** coverage under this policy. If **OMIC** elects to nonrenew, it shall give the **Insured** a notice of nonrenewal stating the reason(s) for nonrenewal at least sixty days prior to the policy expiration date. If notice is given less than sixty days before expiration, coverage will remain in effect until sixty days after notice is given. **OMIC** will consider an **Insured's** nonpayment of renewal premium notice to **OMIC** of the **Insured's** intent to nonrenew. Renewal of the policy will not prevent **OMIC** from later cancelling the policy on grounds that existed before or after the effective date of the renewal.

B. Premium Increase

In the event of a change in the practice or activities of any **Insured** which, in **OMIC's** opinion, materially alters the risk or affects the hazard insured against, **OMIC** has the right, as a condition of continued coverage, to impose and obtain additional premium consistent with **OMIC's** rating plans applicable to such practices or activities. **OMIC** may also charge an additional premium, in accordance with **OMIC's** rating plans, if coverage or limits changes are selected by the **Insured**. Upon renewal of the policy, **OMIC** may increase the premium for any reason by giving notice of the renewal premium to the **Insured** at least sixty days prior to renewal.

C. Notice

Notice under Section IX. Termination and Changes in Premium by **OMIC** or by the **Policyholder** or **Insured** must be provided in writing. The mailing or delivery of notice by **OMIC** to the **Policyholder** or **Insured** using a traceable method will be sufficient proof of notice. The mailing or delivery of notice by the **Policyholder** or **Insured** to **OMIC** at 655 Beach Street, San Francisco, CA, 94109, will be sufficient proof of notice.

SECTION X. EXTENDED REPORTING PERIOD

In the event of the termination of the policy or an **Insured's** coverage under this policy, any **Insured** ophthalmologist whose class is identified as Ophthalmology, any **slot**, and any **professional entity Policyholder** has the right, upon the payment of additional premium computed in accordance with **OMIC's** rules, rates, and rating plans applicable on the effective date of such termination, to have issued an **endorsement** providing an **extended reporting period** of at least one year in which **Claims** otherwise covered by this policy may be reported. This right must be exercised by payment of the **extended reporting period endorsement** premium no later than sixty days after termination of the policy. The earned policy premium through the date of termination must be paid before the **extended reporting period endorsement** will be issued. The premium for the **extended reporting period endorsement** is fully earned as of the effective date of such **endorsement**, and

the premium is non-refundable to the **Insured**, or the estate or legal representative of the **Insured**, under any circumstances, including the **Insured's** subsequent death, **permanent total disability**, or judicial determination of incompetency.

A separate set of liability limits, equal to the policy limits, applies under the **extended reporting period**. The "aggregate" limit of liability does not apply on an annual basis; it applies to the entire **extended reporting period**, even if paid for and provided by **endorsement** on an annual basis.

In the event that the **Insured** fails to purchase an **extended reporting period endorsement** within the required sixty days, coverage will not be provided for any **Claims** the former **Insured** reports to **OMIC** more than five days after the termination of the policy or the **Insured's** coverage under the policy.

If the coverage under this policy of any **Insured** non-physician **employee** or **locum tenens** terminates, such **employee** or **locum tenens** will continue to be covered for **Claims** based on **professional services incidents** that occurred while such **employee** or **locum tenens** was employed by the **Insured** ophthalmologist or **professional entity**, even if any such **Claim** is not reported until after the **employee** or **locum tenens** is no longer employed, so long as such **Claim** is first made against the **employee** or **locum tenens** and first reported to **OMIC** within the **policy period** or **extended reporting period** applicable to the employer **Insured**. Limits of liability for such a **Claim** will be shared with the employer **Insured**.

If the coverage under this policy of any **Insured professional entity** that shares limits with another **Insured** terminates by reason of the dissolution or other termination of activity of the **professional entity**, the **professional entity** will continue to be covered for **Claims** based on **professional services incidents** that occurred while such **professional entity** was active, even if any such **Claim** is not reported until after the **professional entity** ceases activity, so long as such **Claim** is first made against the **professional entity** and first reported to **OMIC** within the **policy period** or **extended reporting period** applicable to the **Insured** with which the **professional entity** shares limits.

1. Retirement Premium Waiver

In the event of the termination of this policy or an **Insured** ophthalmologist's coverage under this policy upon the **retirement** of the **Insured**, the premium for the **extended reporting period endorsement** for such **Insured** will be waived in its entirety if the **Insured** has been continuously insured by **OMIC** for at least five years.

The **extended reporting period endorsement** will be provided as soon as (a) **OMIC** receives a signed affidavit confirming the **Insured's retirement** and (b) the earned policy premium through the date of termination has been paid.

2. Death, Disability, or Incompetency Premium Waiver

In the event of the termination of this policy or an **Insured** ophthalmologist's coverage under this policy upon the death, **permanent total disability**, or judicial determination of incompetency of the **Insured**, the premium for the **extended reporting period endorsement** for such **Insured** will be waived in its entirety.

The **extended reporting period endorsement** will be provided as soon as (a) **OMIC** receives written notice of the **Insured's** death, **permanent total disability**, or incompetency and (b) the earned policy premium through the date of termination has been paid.

3. One Premium Waiver Per Lifetime

The provision for waiver of **extended reporting period** premium applies only once per lifetime. In the event that an **Insured** who has received a waiver of such premium later resumes practice such that he or she does not meet the definition of **permanent total disability** or **retirement**, **OMIC** may collect a premium for the **extended reporting period endorsement** issued. This premium will be computed in accordance with **OMIC's** rules, rates, and rating plans applicable as of the effective date of the **extended reporting period**.

SECTION XI. ENDORSEMENTS

If the terms of any **endorsement** are inconsistent with the terms of the policy, the terms of the **endorsement** apply. There may be **endorsements** other than those listed in this Section that also apply to the policy. Unless otherwise specified in an **endorsement**, the terms of an **endorsement** in effect at the time of a **professional services incident** govern the **Insured's** coverage for any **Claim** based on that **professional services incident**.

PART I – ENDORSEMENTS APPLIED MANUALLY

The following **endorsements** are effective only if they are listed by number in the **Declarations** as applicable to a particular **Insured**. They may be added or deleted by subsequent Amended **Declarations** or **endorsements** issued by **OMIC**.

OMC123A – Part-time Coverage: 20 Hours or Fewer per Week

The **Insured** represents and agrees that the **Insured** is and will remain during the **policy period** engaged in **direct patient treatment** for which coverage is provided under this policy for an average of not more than twenty hours per week. The **Insured** may be insured elsewhere for any additional practice activity. In reliance upon the **Insured's** written representations and in consideration of the reduced premium for which this policy is provided, **OMIC** and the **Insured** agree that the insurance afforded by this policy applies only to **Claims** arising out of the **Insured's** limited practice activity.

OMC123B – Part-time Coverage: 10 Hours or Fewer per Week

The **Insured** represents and agrees that the **Insured** is and will remain during the **policy period** engaged in **direct patient treatment** for which coverage is provided under this policy for an average of not more than ten hours per week. The **Insured** may be insured elsewhere for any additional practice activity. In reliance upon the **Insured's** written representations and in consideration of the reduced premium for which this policy is provided, **OMIC** and the **Insured** agree that the insurance afforded by this policy applies only to **Claims** arising out of the **Insured's** limited practice activity.

OMC132A – Modification of Exclusion – Radial and Astigmatic Keratotomy (RK/AK)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to radial and astigmatic keratotomy (RK/AK) performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132B – Modification of Exclusion – Photorefractive Keratectomy (PRK)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to photorefractive keratectomy (PRK) and approved variations of PRK performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132C – Modification of Exclusion – Laser Assisted In Situ Keratomileusis (LASIK)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to laser assisted in situ keratomileusis (LASIK) and approved variations of LASIK performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132D – Modification of Exclusion – Automated Lamellar Keratoplasty (ALK)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to automated lamellar keratoplasty (ALK) performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132E – Modification of Exclusion – Epikeratophakia

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to epikeratophakia performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132F – Modification of Exclusion – Liposuction

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (i) does not apply with respect to liposuction procedures performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132G – Modification of Exclusion – Full Facelifts for Cosmetic Purposes

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (h) does not apply with respect to full facelifts for cosmetic purposes performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132H – Modification of Exclusion – Intrastromal Corneal Ring Segments (Intacs)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to refractive surgery using intrastromal corneal ring segments (Intacs) performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132I – Modification of Exclusion – Refractive Lens Exchange (RLE)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to refractive lens exchange (RLE) performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132J – Modification of Exclusion – Phakic Implants

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to refractive surgery using phakic implants performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132K – Modification of Exclusion – Laser Thermal Keratoplasty (LTK)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to laser thermal keratoplasty (LTK) performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132L – Modification of Exclusion – Conductive Keratoplasty (CK)

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (j) does not apply with respect to conductive keratoplasty (CK) performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC132M – Modification of Exclusion – Rhinoplasty

OMIC and the **Insured** agree that the policy is amended as follows:

Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures (e) does not apply with respect to rhinoplasty performed within **OMIC's** underwriting requirements or any exceptions to the requirements granted in writing by **OMIC**.

OMC136 – Modification of Exclusion – Retinopathy of Prematurity (ROP)

OMIC and the **Insured** agree that the following provision is added under Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments, 3. Specific Procedures: any care, treatment, or services, including screening, for retinopathy of prematurity.

OMC145 – Suspension of Coverage

OMIC and the **Insured** agree that coverage under this policy is suspended. No coverage will be provided for any **Claims** that arise from **professional services incidents** that occur while the **Insured's** coverage under this policy is suspended.

OMC147 – Excess Liability Coverage over Louisiana PCF

OMIC and the **Insured** agree that this policy provides excess coverage for ultimate net losses in excess of the **Insured's** combined limits of liability of $500,000 per **Claim** ($100,000 limit from **OMIC** for primary coverage and $400,000 limit from the Louisiana Patient's Compensation Fund for first excess coverage). "Ultimate net loss" means the sum actually paid or payable due to a **Claim** for which the **Insured** is liable either by a settlement to which **OMIC** has agreed or a final judgment.

OMC165 – OSF Limit of Liability for Anesthesia Related Claims

OMIC and the **Insured** agree that the limit of liability available to the **Insured** for any anesthesia-related **Claim** is reduced to the "per **Claim**" limit carried by the anesthesia provider who administered services during the patient's treatment that led to the **Claim** (or, if more than one anesthesia provider was involved, the limit of liability is reduced to the lowest "per **Claim**" limit carried by any of the anesthesia providers).

PART II – ENDORSEMENTS APPLIED AUTOMATICALLY

The following **endorsements** are effective and applicable to a particular **Insured** if the **Insured** meets the criteria for applicability in the **endorsement**.

OMC121A – Coverage Classification Endorsement – Ophthalmology – Surgery Class 2

*This **endorsement** incorporates endorsements OMC121B and OMC122 and automatically applies to all **Insureds** whose class is identified in the **Declarations** as Ophthalmology – Surgery Class 2.*

OMIC and the **Insured** agree that the policy is amended as follows:

The following exclusion is added to Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments:

the performance of any surgical procedures, except for the following surgical procedures permitted in Surgery Class 2: laser capsulotomy, laser iridotomy, laser iridectomy, laser iridoplasty, laser punctal closure, punctal closure with cautery, laser trabeculoplasty, wedge resection for suspected non-cancerous tumors, suture tarsorrhaphy, marginal adhesion tarsorrhaphy without incision into the tarsus, laser ablation of corneal lesions, temporal artery biopsy, skin rejuvenation/tightening using non-invasive, non-ablative techniques, blue light acne treatment (with or without use of photodynamic therapy), non-invasive cellulite reduction, periocular injections, periorbital injections, peribulbar injections, retrobulbar injections, and sub-Tenons injections; and the additional surgical procedures permitted in Surgery Class 1 as described in OMC121B. Coverage applies only to the surgical procedures listed above; assisting in surgery; and non-surgical ophthalmology as described in OMC122.

OMC121B – Coverage Classification Endorsement – Ophthalmology – Surgery Class 1

*This **endorsement** incorporates endorsement OMC122 and automatically applies to all **Insureds** whose class is identified in the **Declarations** as Ophthalmology – Surgery Class 1.*

OMIC and the **Insured** agree that the policy is amended as follows:

The following exclusion is added to Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments:

the performance of any surgical assisting or surgical procedures, except for the following surgical procedures permitted in Surgery Class 1: removal of sutures, fluorescein angiography, tear duct probing or irrigation done under local anesthetic, repair of minor lid lacerations limited to the skin and/or muscle, repair of minor conjunctival lacerations, biopsy of lid tumors, biopsy of the conjunctiva, removal of cysts and other non-cancerous skin lesions and tumors, removal of corneal epithelium, incision and drainage, implantation of eye jewelry, laser hair removal, electrical epilation, photo-epilation, hair removal using radio frequency/light energies, intramuscular injections, intravenous injections, subconjunctival injections, injection of Botox or collagen and other fillers, stromal puncture, micropigmentation, superficial chemical peels limited to the epidermis, microdermabrasion, removal of papillomas and chalazions, cryotherapy of the lid, and non-incisional entropion or ectropion repair. Coverage applies only to the surgical procedures listed above and non-surgical ophthalmology as described in OMC122.

OMC122 – Coverage Classification Endorsement – Ophthalmology – No Surgery

*This **endorsement** automatically applies to all **Insureds** whose class is identified in the **Declarations** as Ophthalmology – No Surgery.*

OMIC and the **Insured** agree that the policy is amended as follows:

The following exclusion is added to Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments:

the performance of any surgical assisting or surgical procedures. Coverage applies only to non-surgical ophthalmology, which includes the diagnosis and non-surgical treatment of diseases (other than screening for or treating retinopathy of prematurity), prescription of glasses or contact lenses, mechanical epilation, punctal closure with plugs, and removal of superficial foreign bodies from the cornea and conjunctiva.

OMC157 – Pennsylvania Amendatory Endorsement

*This **endorsement** automatically applies to all **Insureds** who participate in the Medical Care Availability and Reduction of Error Fund (Mcare) under the provisions of Act 13 of 2002. In the event that a similar provision is already contained in another **endorsement** under Section XI. Part II – Endorsements Applied Automatically, the provisions of this **endorsement** will take precedence.*

OMIC and the **Insured** agree that the policy is amended as follows:

Under Section II. Coverage Agreement A, Part I – Who Is Covered 3. (**locum tenens**) is deleted in its entirety.

Under Section II. Coverage Agreement C, Part I – Who Is Covered 2. (MSOs) is deleted in its entirety.

Section IV. Limits of Liability is amended as follows: After "Unless otherwise indicated in the **Declarations** or any **endorsement**, the limits of liability are shared:" 1. through 4. are deleted and replaced by:

1. Among all **Insured** non-physician **employees**, who will share a separate limit of liability equivalent to the limits shown in the **Declarations** as applicable to the **Insured** ophthalmologist or **professional entity** employer.

Section X. Extended Reporting Period is amended as follows: The last sentence of paragraph 4 is deleted and replaced by: "Limits of liability for such a **Claim** will be shared with all **Insured** non-physician **employees**."

OMC158 – Nebraska Amendatory Endorsement

*This **endorsement** automatically applies to all **Insureds** who participate in the Nebraska Excess Liability Fund under the provisions of the Nebraska Hospital - Medical Liability Act. In the event that a similar provision is already contained in another **endorsement** under Section XI. Part II – Endorsements Applied Automatically, the provisions of this **endorsement** will take precedence.*

OMIC and the **Insured** agree that the policy is amended as follows:

Under Section II. Coverage Agreement A, Part I – Who Is Covered 2. (**slots**) and 3. (**locum tenens**) are deleted in their entirety.

Under Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments 3. Specific Procedures and 4. Specific Procedures – Not to Treat Eye Conditions/Diseases are deleted in their entirety.

Under Section II. Coverage Agreement B, Part I – Who Is Covered 3. (CRNAs) is deleted in its entirety.

Under Section II. Coverage Agreement C, Part I – Who Is Covered 2. (MSOs) is deleted in its entirety.

Section II. Coverage Agreement E: Limited Office Premises Liability Coverage is deleted in its entirety.

Under Section III. Common Exclusions – Applicable to All Coverage Agreements, A. No Defense or Payment of **Damages** or Supplementary Payments 1. Known Prior Acts or **Claims**; 12. Government Work; 13. Medical Director; 15. Clinical Studies; 16. Postoperative Care; 18. ROP Remote Screening; and 26. Weight Loss Treatments are deleted in their entirety.

Section IV. Limits of Liability is amended as follows: After "Unless otherwise indicated in the **Declarations** or any **endorsement**, the limits of liability are shared:" 1. through 4. are deleted and replaced by:

1. Among all **Insured** non-physician **employees**, who will share a separate limit of liability equivalent to the limits shown in the **Declarations** as applicable to the **Insured** ophthalmologist or **professional entity** employer.

Under Section VIII. 12. Other Insurance paragraph b. is deleted.

Section VIII. 21. Choice of Law is deleted.

Section X. Extended Reporting Period is amended as follows: The last sentence of paragraph 4 is deleted and replaced by: "Limits of liability for such a **Claim** will be shared with all **Insured** non-physician **employees**."

Section XI. Part I – Endorsements Applied Manually is deleted in its entirety.

Under Section XI. Part II – Endorsements Applied Automatically, Endorsement OMC121A – Coverage Classification Endorsement – Ophthalmology – Surgery Class 2, Endorsement OMC121B – Coverage Classification Endorsement – Ophthalmology – Surgery Class 1, and Endorsement OMC122 – Coverage Classification Endorsement – Ophthalmology – No Surgery, are deleted in their entirety.

OMC159 – Indiana Amendatory Endorsement

*This **endorsement** automatically applies to all **Insureds** who participate in the Indiana Patient's Compensation Fund under the provisions of the Indiana Medical Malpractice Act. In the event that a similar provision is already contained in another **endorsement** under Section XI. Part II – Endorsements Applied Automatically, the provisions of this **endorsement** will take precedence.*

OMIC and the **Insured** agree that the policy is amended as follows:

The following is added to Section VIII. 11. Consent to Settle: However, in the event a medical review panel issues a unanimous opinion that the **Insured** failed to comply with the appropriate standard of care as charged in the **Claim**, **OMIC** has the right to settle the liability **Claim** without the **Insured's** consent.

Section IV. Limits of Liability is amended as follows: After "Unless otherwise indicated in the **Declarations** or any **endorsement**, the limits of liability are shared:" 1. Is amended as follows:

1. Among all **Insured** non-physician **employees** who are not independent ancillary providers ("IAPs"), and the **Insured** ophthalmologist or **professional entity** employer. **Insured** non-physician **employees** who are IAPs, such as nurse practitioners, physician's or surgeon's assistants, and clinical nurse specialists, will each have a separate limit of liability equivalent to the limits shown in the **Declarations** as applicable to the **Insured** ophthalmologist or **professional entity** employer, and;

OMC160 – Kansas Amendatory Endorsement

*This **endorsement** automatically applies to all **Insureds** who participate in the Kansas Health Care Stabilization Fund under the provisions of the Health Care Provider Insurance Availability Act. In the event that a similar provision is already contained in another **endorsement** under Section XI. Part II – Endorsements Applied Automatically, the provisions of this **endorsement** will take precedence.*

OMIC and the **Insured** agree that the policy is amended as follows:

Under Section II. Coverage Agreement A, Part I – Who Is Covered 2. (**slots**) and 3. (**locum tenens**) are deleted in their entirety.

Under Section II. Coverage Agreement A, Part III – Exclusions, A. No Defense or Payment of **Damages** or Supplementary Payments 3. Specific Procedures and 4. Specific Procedures – Not to Treat Eye Conditions/Diseases are deleted in their entirety.

Under Section II. Coverage Agreement C, Part I – Who Is Covered 2. (MSOs) is deleted in its entirety.

Section II. Coverage Agreement E: Limited Office Premises Liability Coverage is deleted in its entirety.

Under Section III, Common Exclusions – Applicable to All Coverage Agreements, A. No Defense or Payment of **Damages** or Supplementary Payments 12. Government Work; 15. Clinical Studies; 16. Postoperative Care; 18. ROP Remote Screening; and 26. Weight Loss Treatments are deleted in their entirety.

Section IV. Limits of Liability is amended as follows: After "Unless otherwise indicated in the **Declarations** or any **endorsement**, the limits of liability are shared:" 1. through 4. are deleted and replace by:

1. Among all **Insured** non-physician **employees**, who will share a separate limit of liability equivalent to the limits shown in the **Declarations** as applicable to the **Insured** ophthalmologist or **professional entity** employer.

Section VIII. 20. Arbitration is deleted and replaced by the following:

20. Arbitration

After a dispute between the **Insured** and **OMIC** has arisen and the dispute cannot be settled through direct discussions, the **Insured** and **OMIC** may agree, voluntarily, to have the dispute resolved by arbitration.

Section X. Extended Reporting Period is amended as follows: The last sentence of paragraph 4 is deleted and replaced by: "Limits of liability for such a **Claim** will be shared with all **Insured** non-physician **employees**."

Section XI. Part I – Endorsements Applied Manually is deleted in its entirety.

Under Section XI. Part II – Endorsements Applied Automatically, Endorsement OMC121A – Coverage Classification Endorsement – Ophthalmology – Surgery Class 2, Endorsement OMC121B – Coverage Classification Endorsement – Ophthalmology – Surgery Class 1, and Endorsement OMC122 – Coverage Classification Endorsement – Ophthalmology – No Surgery, are deleted in their entirety.

OMC161 – Eye Bank Amendatory Endorsement

*This **endorsement** automatically applies to all **Insured professional entities** whose structure is identified in the **Declarations** as Eye Bank.*

OMIC and the **Insured** agree that the policy is amended as follows:

the term "**eye bank services**" replaces the term "**direct patient treatment**" throughout the entirety of this policy; and

Section VII.C. Definitions, 8. is amended as follows:

8. ***Patient notification and credit monitoring costs*** means all reasonable and necessary expenses incurred by an **Insured**, with **OMIC's** prior written consent, in notifying donor families or tissue recipients of any actual or potential ***privacy wrongful act***, including, but not limited to: ….

OMC162 – Terrorism Insurance Coverage Endorsement

*This **endorsement** automatically applies to all **Insureds**.*

Coverage is included in the policy for otherwise insured **damages** arising out of certified acts of terrorism. The definition of an act of terrorism has been changed pursuant to the Terrorism Risk Insurance Program Reauthorization Act of 2007 to mean any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been

committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any **damages** otherwise insured under the policy caused by certified acts of terrorism may be partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States generally reimburses 85% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, **Insureds'** coverage may be reduced. The portion of **Insureds'** annual premium that is attributable to coverage for acts of terrorism is $0 and does not include any charges for the portion of loss that may be covered by the Federal Government under the Act.

The Terrorism Risk Insurance Act, as amended on December 26, 2007, and this Endorsement only affect coverage in the policy for otherwise insured **damages** relating to certified acts of terrorism. All other terms and conditions of the policy, including applicable limits and deductibles, are not affected and still apply to **Insureds'** coverage under the policy.

IN WITNESS WHEREOF, Ophthalmic Mutual Insurance Company (a Risk Retention Group) has caused this policy to be signed by its Chairman and Secretary, but it will not be valid unless **Declarations** signed by a duly authorized representative of **OMIC** are issued as part of this policy.

John W. Shore, MD
Chair of the Board
Ophthalmic Mutual Insurance Company
(a Risk Retention Group)

Tamara R. Fountain, MD
Secretary
Ophthalmic Mutual Insurance Company
(a Risk Retention Group)

OMIC

OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)

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