Atlantic Specialty Insurance Company *(Stock company owned by the OneBeacon Insurance Group)* One Beacon Lane Canton, MA 02021	OneBeacon PROFESSIONAL INSURANCE

MANAGED CARE ERRORS AND OMISSIONS LIABILITY RENEWAL APPLICATION

THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS AND CONDITIONS, ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. CLAIM EXPENSES ARE PART OF AND NOT IN ADDITION TO THE LIMIT OF LIABILITY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES WILL BE REDUCED AND MAY BE EXHAUSTED BY CLAIM EXPENSES, AND CLAIM EXPENSES WILL BE APPLIED AGAINST THE RETENTION. WE WILL HAVE NO OBLIGATION TO PAY JUDGMENTS, SETTLEMENTS OR CLAIM EXPENSES ONCE THE APPLICABLE LIMIT OF LIABILITY IS EXHAUSTED.

APPLICATION INSTRUCTIONS: Whenever used in this Application the term "you" means the entity or individual identified in response to Question 1 of PART I TELL US WHO YOU ARE ("Applicant") and all other entities and individuals proposed for this insurance.

PART I. TELL US WHO YOU ARE

1. Name of Applicant: UT Physicians
2. Address: 6410 Fannin Suite 1500
   City: Houston State: TX ZIP: 77030
   Website: www.UTPhysicians.com Telephone: 832-325-7325
3. Risk Manager or Contact person and title: Catherine R. Thompson
   Email address: Catherine.R.Thompson@uth.tmc.edu Telephone: 713-500-3268
4. Have you changed tax status? ☐ Yes ☒ No
   Please explain: _____
5. Are there any **new** State(s) where you operate: N/A
6. Are there any **new** operations that should be considered for coverage? ☐ Yes ☒ No
   If so, describe: _____

If you are seeking coverage for any ***new*** entities (e.g., subsidiaries, joint ventures, or partnerships), list each entity below and **include all exposure data**. If needed, list additional entities on a separate attachment. (Please note that coverage for these entities is not automatically included. The policy, if issued, will determine actual coverage.)

Name & Address	Relationship	Description of Operations	Tax Status	Percent Owned
N/A				

PART II: GIVE US YOUR NUMBERS

A. ENROLLMENT:

Note: Wherever used, "enrollees" means covered lives, not just covered employees and not member months.

ENROLLMENT TYPE	ENROLLEES LAST 12 MONTHS As of / /	ENROLLEES ESTIMATE NEXT 12 MONTHS As of / /
HMO		
PPO		
Indemnity		
POS		
ASO		
IPA		
Medicaid		
Medicare		
Vision, Dental, PBM, STD, LTD or Other Carve-Out		
Other		
TOTAL ENROLLEES		

B. REVENUE:

	LAST 12 MONTHS As of / /	ESTIMATE NEXT 12 MONTHS As of / /
Total Revenue (all operations)		
PPO Revenue		
Utilization Review / Case Management Revenue		
MSO Revenue		
PHO Revenue		
IPA Revenue		
Carve-Out Revenue		
TPA/Claims Administration Revenue		

C. NUMBER OF HEALTH CARE PROVIDERS:

Provider type	LAST 12 MONTHS As of / /	ESTIMATE NEXT 12 MONTHS As of / /
Contracted Physicians		
Employed Physicians		

D. MANAGED CARE ACTIVITIES:

Please check the managed care activities or services which you perform or subcontract. If you plan on offering any of these services over the next 12 months, please include those as well. (Note: not all checked services may be covered):

Activity or Service	You Perform or Subcontract	You Perform for Others for a Fee
Credentialing or peer review of health care providers	☒	☐
Utilization review	☐	☐
Drafting practice guidelines/Critical Pathways	☒	☐
Case management	☐	☐
Disease management	☐	☐
Handling and adjusting of enrollees' health care benefit claims	☐	☐
Application or enrollment processing for enrollees of health care plans	☐	☐
Billing/other processing of enrollees' claims under health care plans	☐	☐
Advertising, marketing, or selling health care plans/products	☐	☐
Establishing health care provider networks to provide managed care	☐	☐
Actuarial services for health care plans	☐	☐
Assisting customers in securing reinsurance	☐	☐
Services for automobile liability or disability	☐	☐
Third party administration (TPA) services	☐	☐
Employee Assistance Program (EAP)	☐	☐
Nurse call line	☐	☐
OTHER (DESCRIBE):	☐	☐
	☐	☐
	☐	☐

IF YOU ARE AN **IPA, PHO** OR **MEDICAL GROUP** OR **CLINIC** AND **DO NOT** HAVE CLAIM HANDLING OR UTILIZATION REVIEW RESPONSIBILITIES SKIP PART III D.E. & F.

PART III. TELL US HOW YOU DO IT

A. GENERAL OPERATIONS:

1. Over the past 12 months, has your license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? ☐ Yes ☒ No ☐ NA
   If "Yes," please explain:

2. Are any of your operations subcontracted outside of the United States? ☐ Yes ☒ No ☐ NA
   If "Yes," please describe:

3. Have you filed for bankruptcy, bankruptcy protection, been appointed a liquidator, conservator or supervision order? ☐ Yes ☒ No ☐ NA

B. HEALTHCARE REFORM:

1. Have you ever provided customer rebates based on Medical Loss Ratio obligations? ☐ Yes ☐ No ☒ NA
   If "yes," how often? :

2. Do you have written policies and procedures surrounding the disbursement of Medical Loss Ratio rebates? ☐ Yes ☐ No ☒ NA
3. Do you publish your Medical Loss Ratio calculation process? ☐ Yes ☐ No ☒ NA
4. Have you ever been sanctioned, fined, investigated or sued for non-compliance related to your Medical Loss Ratio requirements? ☐ Yes ☐ No ☒ NA

5. Do you have an individual that is responsible for compliance with health care reform? ☐ Yes ☐ No ☒ NA
6. Have you ever been sanctioned, fined, investigated or sued for Medicare/Medicaid fraud? ☐ Yes ☐ No ☒ NA
   If "Yes", please explain: _____
7. Have you made changes to your policies and procedures to comply with all healthcare reform acts? ☐ Yes ☐ No ☒ NA
8. Do you offer quality incentives to providers? ☐ Yes ☐ No ☒ NA
9. Do you disclose and explain the provider incentives to members? ☐ Yes ☐ No ☒ NA
   If "yes", please provide details re: how and where the information is disclosed:

10. Do you have or plan to form a Medical Home facility? ☐ Yes ☐ No ☒ NA
    If "yes", please provide details:

C. CREDENTIALING:

1. Have there been any changes to your written credentialing procedures ? ☐ Yes ☒ No ☐ NA
2. Do you require and verify that all contracted health care providers maintain medical malpractice insurance with minimum limits of $1,000,000/$3,000,000? ☒ Yes ☐ No ☐ NA
   If "No," what minimum limits are required? _____
3. Do you perform on-site visits of contracted health care providers? ☒ Yes ☐ No ☐ NA
   If "Yes," how often? _____
4. Do you disclose your reimbursement policies for non-par providers on your website? ☐ Yes ☒ No ☐ NA
   If "No," please explain: _____
5. Do your subscribers have access to non-par provider rates? ☐ Yes ☒ No ☐ NA
   If "No," please explain: _____
6. Do you have a provider tiering program? ☐ Yes ☒ No ☐ NA
   If "Yes," please provide details on tiering criteria and appeal process:

D. UTILIZATION REVIEW:

SKIP THIS SECTION if you are an IPA or Medical Group/Clini c and do not provide this service.

1. Have there been any changes to your written policies and procedures for utilization review, including for denials and appeals? ☐ Yes ☒ No ☐ NA
2. Do your written Utilization Review Procedures:
   a) Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers? ☐ Yes ☒ No ☐ NA
   b) Utilize same specialty reviewers for benefit/coverage denials? ☐ Yes ☒ No ☐ NA
   c) Adhere to government mandated external review requirements in the states where you operate? ☐ Yes ☒ No ☐ NA
   d) Utilize the external review process in states where it is not mandated? ☐ Yes ☒ No ☐ NA

E. CLAIM HANDLING:

KIP THIS SECTION if you are an IPA or Medical Group/Clini c and do not provide this service.

1. Do you utilize profit sharing, risk sharing, or other financial incentives in compensation arrangements with claim handlers or adjusters? ☐ Yes ☒ No ☐ NA

PART IV: TELL US WHAT YOU HAVE

Limits of Liability desired: (Each Claim/ Aggregate)

☒ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$2,000,000
☐ $3,000,000/$3,000,000 ☐ $5,000,000/$5,000,000 ☐ $10,000,000/$10,000,000
☐ $15,000,000/$15,000,000 ☐ $20,000,000/$20,000,000 ☐ Other: $retro 9/30/94

Retention Desired:

☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000
☒ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $500,000
☐ $1,000,000 ☐ $2,500,000 ☐ Other: $_____

Please provide details of insurance/self-insurance/reinsurance currently in force (if none, please state):

Type of Coverage	Insurance Carrier(s)	Limits	Deductible/ Retention	Premium	Policy Period	If Claims Made, Retroactive Date
Managed Care Errors & Omissions						
Medical Malpractice*	Pls	See	attached	sheets.		
D&O*						
EPL*						
Fiduciary*						
Stop Loss*						
Insolvency*						
Crime*						
Network Security & Privacy *						
Other						

*Would you be interested in proposals for these coverages? If yes, please complete the appropriate section below:

OPTIONAL COVERAGES

For an option containing D&O and/or EPL, please fill out the following:

1. a. Stock ownership of the Applicant:
   Total number of authorized common shares: N/A
   Total number of outstanding common shares: _____
   Total number of common shareholders: _____
   Total number of common shares owned by Applicant's directors and officers: _____
   b. As an attachment to this Application, please provide the names and number of shares for all persons or entities that presently own or control, or have stated the intention to acquire, of record or beneficially, more than 5% of Applicant's outstanding stock.

c. Have there been any changes in Applicant's board of directors or senior management within the past 3 years for reasons other than death or retirement? ☒ Yes ☐ No ☐ NA
If "Yes," please explain:
Board members changes every two years.

d. Number of your: Full-time employees: 521
Part-time employees: 84

e. Within the past 36 months, have you or do you expect to:
(1) Merge, acquire, or consolidate with another entity? ☐ Yes ☐ No ☒ NA
(2) Sell, distribute, or divest of any assets or stock? ☐ Yes ☐ No ☒ NA
(3) Register for a public offering or private placement of securities? ☐ Yes ☐ No ☒ NA
(4) Form any joint venture? ☐ Yes ☐ No ☒ NA
(5) Enter into any new business activities or services? ☐ Yes ☐ No ☒ NA
If "Yes" to any of the above, please explain and describe the essential terms of each such transaction. (If needed, use an attachment to this Application):

For an option containing Network Security and Privacy please fill out the following: N/A

1. Do you employ a Chief Information/Security Officer? ☐ Yes ☐ No ☐ NA
2. Do you have a corporate-wide privacy policy? ☐ Yes ☐ No ☐ NA
3. Have your privacy policies been reviewed and approved by an attorney? ☐ Yes ☐ No ☐ NA
4. How often are your policies reviewed and updated? _____
5. Do you have restricted employee access to private information? ☐ Yes ☐ No ☐ NA
6. Do you have internal training for employees concerning the handling of data security and private, personal and sensitive information? ☐ Yes ☐ No ☐ NA
7. In the past twenty-four (24) months, have you undergone an internal or external privacy audit? ☐ Yes ☐ No ☐ NA
   If "Yes", have all recommendations been implemented? ☐ Yes ☐ No ☐ NA
   If "No", please explain: _____
8. Do you collect, receive, process, transmit, or maintain private, sensitive, or personal information as part of your business activities? ☐ Yes ☐ No ☐ NA
   a. Is any of this information regulated by HIPAA, GLB, the Data Protection Act or any other law or regulation protecting private, sensitive, or personal information? ☐ Yes ☐ No ☐ NA
   b Do you have written procedures in place to comply with laws governing the handling or disclosure of such information, including any Red Flag Rules? ☐ Yes ☐ No ☐ NA
   c. Do you share private, sensitive, or personal information gathered from customers with third parties? ☐ Yes ☐ No ☐ NA
9. Do you have a vendor approval process? ☐ Yes ☐ No ☐ NA
10. Do you require that contracts with outside companies and vendors require they defend and indemnify you in the event there is any loss arising out of the release or disclosure of private, sensitive, or personal information due to the outside company's or vendor's negligence? ☐ Yes ☐ No ☐ NA
11. Do you have a written and tested:
    a. Disaster recovery plan? ☐ Yes ☐ No ☐ NA
    b. Business continuity plan? ☐ Yes ☐ No ☐ NA
    c. Computer security policy? ☐ Yes ☐ No ☐ NA
    d. Procedure to change default credentials? ☐ Yes ☐ No ☐ NA
12. Do you store sensitive data on laptops or web servers? ☐ Yes ☐ No ☐ NA
    a. If "Yes", is all data that is both "at-rest" and "in-transit" encrypted? ☐ Yes ☐ No ☐ NA
    a. If "No", please describe any offsetting measures:
    _____
13. Do you use security and firewall technology? ☐ Yes ☐ No ☐ NA
14. Is it your policy to up-grade all security software as new releases/improvements become available? ☐ Yes ☐ No ☐ NA

15. Do you use anti-virus software? ☐ Yes ☐ No ☐ NA
    a. Is anti-virus software installed on all of your computer systems, including laptops, personal computers, and networks? ☐ Yes ☐ No ☐ NA
16. Do you use intrusion detection software to detect unauthorized access to internal networks and computer systems? ☐ Yes ☐ No ☐ NA
17. Do you have a formal documented user and password procedure in place? ☐ Yes ☐ No ☐ NA
18. Do you limit access to network servers and hardware? ☐ Yes ☐ No ☐ NA
19. Do you provide remote access to your network? ☐ Yes ☐ No ☐ NA
    a. Is remote access restricted to Virtual Private Networks (VPNs)? ☐ Yes ☐ No ☐ NA
20. How often is private/personal/sensitive/valuable information archived?_____
    a. How long is the information stored? _____
    b. Is the information stored in an off-premises secondary site? ☐ Yes ☐ No ☐ NA
21. Do you terminate all associated computer access and user accounts when an employee leaves the company? ☐ Yes ☐ No ☐ NA
22. Are your internal networks and computer systems subject to third party audit and monitoring? ☐ Yes ☐ No ☐ NA
    a. If "Yes," when was the last audit?_____
    b. Have all improvements and recommendations been implemented? ☐ Yes ☐ No ☐ NA
    c. If "No", please explain:_____

PART V. WHAT ELSE WE NEED

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application:

1. Currently valued loss runs for years you may have been insured elsewhere and including losses you may be handling within a self insured retention;

2. Your most current audited or accountant-prepared financial statements with notes.

If you want a D&O/EPL quote, in addition to 1 & 2 above, please include the names, occupations, and business affiliations of all your directors and officers.

If you are requesting Limits higher than those on your current policy, please answer the following:

Are you or any entity or individual proposed for coverage, aware of any act, error or omission, or course of conduct which you have reason to believe may or could reasonably be forseen to give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No
If yes, please provide details:

PART VI. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.
NOTICE TO ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

NOTICE TO LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

PART VIII: DECLARATIONS AND SIGNATURES

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, af ter reasonable inquiry, th e statements in this Application and any attachments or information submitted with this Application (togeth er referred to as the "A pplication") are true and complete. The information in this Application is materi al to the risk accepted by us. If a policy is issued i t will be in r eliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the mate rials submitted with it sh all become p art of the p olicy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connecti on with this Application. Our acceptan ce of this Ap plication or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwritin g purposes only and does not constitute notice to us un der any policy of a Claim or potential Claim.

If the information in thi s Application materially ch anges prior to the effecti ve date of the policy, you must notif y us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

APPLICANT UT Physicians		
BY *(CEO, CFO or President)*	TITLE CCO	DATE 4/19/16

NOTE: This Application must be signed by the CEO, CFO and/or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

PRODUCED BY *(Insurance Agent)*	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*	
EMAIL ADDRESS:	

SUBMITTED BY *(Insurance Agency)*	INSURANCE AGENCY TAXPAYER ID	AGENT LICENSE # or SURPLUS LINES #.
ADDRESS *(No., Street, City, State, and ZIP Code)*		

NOTE: For New Hampshire Applicants, producer's name and signature are required.

Submit

Atlantic Specialty Insurance Company One Beacon Lane Canton, MA 02021 *(hereinafter referred to as "We" or "Us")*	OneBeacon PROFESSIONAL INSURANCE™

Policy Number: MCR-8775-16

DECLARATIONS

MANAGED CARE ERRORS AND OMISSIONS LIABILITY POLICY

THIS POLICY APPLIES ONLY TO CLAIMS FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. CLAIM EXPENSES ARE PART OF AND NOT IN ADDITION TO THE LIMIT OF LIABILITY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES WILL BE REDUCED AND MAY BE EXHAUSTED BY CLAIM EXPENSES, AND CLAIM EXPENSES WILL BE APPLIED AGAINST THE RETENTION. WE WILL HAVE NO OBLIGATION TO PAY JUDGMENTS, SETTLEMENTS OR CLAIM EXPENSES ONCE THE APPLICABLE LIMIT OF LIABILITY IS EXHAUSTED. PLEASE READ THE ENTIRE POLICY CAREFULLY.

ITEM 1. **NAMED INSURED:** Name and Principal Address: UT Physicians 6410 Fannin St Ste 1500 Houston, TX 77030	ITEM 2. **POLICY PERIOD:** (a) Inception Date: June 30, 2016 (b) Expiration Date: June 30, 2017 Both dates at 12:01 a.m. at the Principal Address of the first **Named Insured** in ITEM 1.

ITEM 3. **LIMITS OF LIABILITY**	
(A) Each **Claim** Limit of Liability	$1,000,000
(B) Policy Aggregate Limit of Liability	$1,000,000

ITEM 4. **RETENTION**	
(A) Each **Claim**	$100,000
ITEM 5. **RETROACTIVE DATE:** September 30, 1994	
ITEM 6. **PREMIUM**	
ITEM 7. **EXTENDED REPORTING PERIOD:**	

"Full Annual Premium" means the amount set forth in ITEM 6 PREMIUM above, including any premium adjustments made during the Policy Period.

ITEM 8. **ALL NOTICES REQUIRED TO BE GIVEN TO US UNDER THE YOUR REPORTING OBLIGATIONS SECTION OF THIS POLICY MUST BE ADDRESSED TO:**

Chief Claims Officer
OneBeacon Professional Insurance
199 Scott Swamp Road
Farmington, CT 06032
- or-
OBPIClaims@onebeacon.com

ALL OTHER NOTICES REQUIRED TO BE GIVEN TO US UNDER THIS POLICY MUST BE ADDRESSED TO:

OneBeacon Professional Insurance
199 Scott Swamp Road
Farmington, CT 06032

ITEM 9. **POLICY FORM AND ENDORSEMENTS ATTACHED AT ISSUANCE:**

HPF 41001 04 11	
HPE-410TX-05-11	Texas Amendatory
HPE-41001-04-11	Additional Named Insured
HPE-41007-04-11	Delete Vicarious Liability For Medical Services
HPE-41008-05-15	Amend Other Insurance
HPE-41012-04-11	Amend Section IV(B)For Settlement Percentage
HPE-41036-02-12	Amend Section II Government Regulatory Exclusion (J) With Sublimits

These Declarations, the completed signed **Application**, and the Policy (including all endorsements thereto) shall constitute the entire agreement between **you** and **us**.

Atlantic Specialty Insurance Company
By:

T. M. Hill

Its Authorized Representative

July 14, 2016
Date

ENDORSEMENT NO. 1
TEXAS AMENDATORY ENDORSEMENT

This Endorsement, effective at 12:01 a.m. on June 30, 2016, forms part of

Policy No.	MCR-8775-16
Issued to	UT Physicians
Issued by	Atlantic Specialty Insurance Company

In consideration of the premium charged:

(1) Section VIII GENERAL CONDITIONS (E) (1) of this Policy is amended to add the following:

> Notice of cancellation by **us** will be delivered or mailed to the first **Named Insured** at the address shown in the Declarations and shall state the reason for cancellation.

(2) Section VIII GENERAL CONDITIONS (E) (3) is amended to add the following after the second sentence:

> Notice of nonrenewal by **us** may also be delivered to the first **Named Insured**. Such notice shall be forwarded to the first **Named Insured's** address stated in the Declarations or last known to **us** and shall state the reason for nonrenewal. If notice of nonrenewal by **us** is not given at least sixty (60) days prior to the Expiration Date stated in the Declarations, this Policy will continue in force until the sixty-first (61st) day after the date on which such notice is mailed or delivered, with such continuation conditioned on receipt by **us** of the premium for such extension when due, which shall be calculated by pro rating the premium for the expiring **Policy Period**.

(3) Section VIII GENERAL CONDITIONS (E) is amended further to add the following:

> (4) **We** may not cancel or refuse to renew this Policy based solely on the fact that one or more of **you** is an elected official.

(4) Section VIII GENERAL CONDITIONS (F) (2) is amended to add the following after the first sentence thereof:

> The periods of time stated in the Declarations shall include the option to purchase a one (1) year Additional Extended Reporting Period.

To the extent required for compliance with the regulatory requirements of this state, this Amendatory Endorsement shall supersede and take precedence over any provisions of this Policy or any endorsement to this Policy, whenever added, that are inconsistent with or contrary to the provisions of this Amendatory Endorsement.

All other terms, conditions and limitations of this Policy shall remain unchanged.

ENDORSEMENT NO. 2
ADDITIONAL NAMED INSURED ENDORSEMENT

This Endorsement, which is effective at 12:01 a.m. on June 30, 2016, forms part of:

Policy No.	MCR-8775-16
Issued to	UT Physicians
Issued by	Atlantic Specialty Insurance Company

In consideration of the premium charged, the term "**Named Insured**" as defined in Section III DEFINITIONS of this Policy, is amended to include the entity(ies) scheduled below. With respect to such entity(ies) and the **Insured Persons** thereof, the applicable Retroactive Date shall be the Retroactive Date set forth opposite the name of each such entity, and ITEM 5 of the Declarations shall be deemed amended accordingly.

Entity	Retroactive Date
UT Physicians fka Uni Care Plus	September 30, 1994
UT Physicians fka University Care Plus	April 7, 1995

Additional Premium charged for this Endorsement: N/A

All other terms, conditions and limitations of this Policy shall remain unchanged.

ENDORSEMENT NO. 3
DELETE VICARIOUS LIABILITY FOR MEDICAL SERVICES ENDORSEMENT

This Endorsement, which is effective at 12:01 a.m. on June 30, 2016, forms part of:

Policy No.	MCR-8775-16
Issued to	UT Physicians
Issued by	Atlantic Specialty Insurance Company

In consideration of the premium charged:

(1) Section I WHAT THIS POLICY COVERS is amended to delete the following therefrom:

(D) **Vicarious Liability** for an act, error, or omission, or series of acts, errors, or omissions, by a person or entity other than **you** in rendering, or failing to render, **Medical Services**;

(2) Section II WHAT THIS POLICY EXCLUDES (B) is amended to read in its entirety as follows:

(B) for any actual or alleged act, error, or omission in rendering, or failing to render, any **Medical Services**; provided that this Exclusion shall not apply to any **Claim** alleging, under statute, rule, regulation or common law, that the performance of any **Managed Care Activity** by **you** constitutes the rendering of **Medical Services**;

(3) Section III DEFINITIONS (J) of this Policy is amended to read in its entirety as follows:

(J) **Medical Services** means health or medical care or treatment provided or prescribed to any person, including but not limited to any of the following: medical, surgical, dental, psychiatric, mental health, chiropractic, osteopathic, nursing, or other professional health or medical care; the use, prescription, furnishing, or dispensing of medications, drugs, blood, blood products, or medical, surgical, dental, or psychiatric supplies, equipment, or appliances in connection with such care; the furnishing of food or beverages in connection with such care; the providing of counseling or other social services in connection with such care; or the handling of, or the performance of post-mortem examinations on, human bodies.

All other terms, conditions and limitations of this Policy shall remain unchanged.

ENDORSEMENT NO. 4
AMEND OTHER INSURANCE ENDORSEMENT

This Endorsement, which is effective at 12:01 a.m. on June 30, 2016, forms part of:

Policy Number:	MCR-8775-16
Issued To:	UT Physicians
Issued By:	Atlantic Specialty Insurance Company

In consideration of the premium charged, Section VIII GENERAL CONDITIONS (C) of this Policy is amended to read in its entirety as follows:

The coverage provided under this Policy shall be specifically excess of, and will not contribute with:

(1) Medical Malpractice Policy No. HN005259 issued by National Fire & Marine Insurance Company, or any renewal or replacement thereof, including any and all insurance or self-insurance written as excess over such policy(ies), renewal(s) or replacement(s);

(2) any other insurance or self-insurance, regardless of whether the other insurance or self-insurance is collectible or is stated as primary, *pro rata*, contributory, excess, contingent, or otherwise, unless the other insurance or self-insurance is specifically written as excess of this Policy; or

(3) any defense, hold harmless, or indemnification that **you** are entitled to from any person or entity other than one of **you.**

All other terms, conditions and limitations of this Policy shall remain unchanged.

ENDORSEMENT NO. 5
AMEND SECTION IV (B) FOR SETTLEMENT PERCENTAGE ENDORSEMENT

This Endorsement, which is effective at 12:01 a.m. on June 30, 2016, forms part of:

Policy No.	MCR-8775-16
Issued to	UT Physicians
Issued by	Atlantic Specialty Insurance Company

In consideration of the premium charged, the second sentence of Section IV HOW CLAIMS WILL BE HANDLED (B) is amended to read in its entirety as follows:

If **you** refuse to consent to a settlement acceptable to the claimant in accordance with **our** recommendation, then, subject to **our** applicable Limits of Liability stated in the Declarations, **our** liability for such **Claim** will not exceed:

(1) the amount for which the **Claim** could have been settled plus **Claim Expenses** up to the date **you** refused to settle such **Claim** (the "Settlement Amount"); plus

(2) Eighty percent (80%) of any **Damages** or **Claim Expenses** in excess of the Settlement Amount incurred in connection with the **Claim.** The remaining Twenty percent (20%) of **Damages** and **Claim Expenses** in excess of the Settlement Amount will be carried by **you** at **your** own risk and will be uninsured.

All other terms, conditions and limitations of this Policy shall remain unchanged.

ENDORSEMENT NO. 6
AMEND SECTION II GOVERNMENT REGULATORY EXCLUSION (J) WITH SUBLIMITS ENDORSEMENT

This Endorsement, which is effective at 12:01 a.m. on June 30, 2016, forms part of:

Policy Number:	MCR-8775-16
Issued To:	UT Physicians
Issued By:	Atlantic Specialty Insurance Company

In consideration of the premium charged:

(1) Section II WHAT THIS POLICY EXCLUDES J. of this Policy is amended to read in its entirety as follows:

(J) based upon or arising out of any **Claim** brought or maintained by, or on behalf of, or in the name or right of, or for the benefit of any local, state, federal, or foreign administrative, governmental, or regulatory agency, body, entity, or tribunal, including but not limited to any type of legal or equitable action or proceeding such agency, body, entity, or tribunal is entitled to bring as a regulator, receiver, trustee, liquidator, rehabilitator, or administrator; provided that this Exclusion will not apply to:

(1) any **Claim** brought by a local, state, federal, or foreign administrative, governmental, or regulatory agency, body, entity, or tribunal (a "Governmental Claim"):

(a) for **Antitrust Activity** by **you** or on **your** behalf in the performance of the **Managed Care Activity** provided by **you** or on **your** behalf;

(b) for disciplinary proceedings initiated by a local or state administrative, governmental, or regulatory agency, body, entity, or tribunal against **you** as medical director of the **Named Insured** in connection with **Utilization Review;**

(c) for an individual enrollee benefit dispute under a Medicare, Medicaid, or other health plan sponsored by the federal or state (including the District of Columbia) government;

(d) where the administrative, governmental, or regulatory agency, body, entity, or tribunal is the payor for the **Managed Care Activity** provided by **you** or on **your** behalf; or

(e) for a violation of the Health Insurance Portability and Accountability Act or any similar federal, state, or local law regulating the privacy of personally identifiable health information (hereinafter, a "HIPAA Violation") by **you** or on **your** behalf in the performance of a **Managed Care Activity;** or

(2) **Claim Expenses** as a result of any Governmental Claim, other than a Governmental Claim described in paragraph (J)(1) of this endorsement;

(2) Section III DEFINITIONS (F)(1) is amended to read in its entirety as follows:

(1) any fine, penalty, forfeiture, sanction, tax, fee, liquidated damages, or amount imposed by statute, rule, regulation, or other law; provided that **Damages** will include fines or penalties which **you** are legally obligated to pay as a result of a **Claim** for **Antitrust Activity** or a **Claim** for a "HIPAA Violation", if such fine or penalty is insurable under the **Law Most Favorable to Insurability**;

(3) **Our** maximum limit of liability for all **Damages** and all **Claim Expenses** from each **Claim** or **Related Claims** for any "HIPAA Violation" shall be $1,000,000, which amount shall be part of, and not in addition to, the Each Claim Limit of Liability stated in ITEM 3(A) of the Declarations. **Our** maximum limit of liability for all **Damages** and all **Claim Expenses** from all **Claims** and all **Related Claims** for "HIPAA Violations" shall be $1,000,000, which amount shall be part of, and not in addition to, the Policy Aggregate Limit of Liability stated in ITEM 3(B) of the Declarations.

(4) **Our** maximum limit of liability for all **Claim Expenses** from each **Claim** or **Related Claims** for any Governmental Claim other than a Governmental Claim described in paragraph (J)(1) of this endorsement, shall be $1,000,000, which amount shall be part of, and not in addition to, the Each Claim Limit of Liability stated in ITEM 3(A) of the Declarations. **Our** maximum limit of liability for all **Claim Expenses** from all **Claims** and all **Related Claims** for Governmental Claims other than Governmental Claims described in paragraph (J)(1) of this endorsement shall be $1,000,000, which amount shall be part of, and not in addition to, the Policy Aggregate Limit of Liability stated in ITEM 3(B) of the Declarations.

All other terms, conditions and limitations of this Policy shall remain unchanged.

ENDORSEMENT NO. 7
AMEND DECLARATION FOR ADMINISTRATIVE CHANGES ENDORSEMENT

This Endorsement, which is effective at 12:01 a.m. on June 30, 2016, forms part of:

Policy Number: MCR-8775-16
Issued To: UT Physicians
Issued By: Atlantic Specialty Insurance Company

In consideration of the premium charged, the following item(s) on the Declarations to this Policy:

[ ] Policy Number

[ ] ITEM 1. First Named Insured (Name)

[X] ITEM 1. First Named Insured (Principal Address)

[ ] ITEM 2(a) Inception Date

[ ] ITEM 2(b) Expiration Date

[ ] ITEM 5. Retroactive Date

[ ] ITEM 7. Extended Reporting Period

[ ] ITEM 9. Policy Form and Endorsements Attached at Issuance

is amended as follows:

6431 Fannin, JJL 475
Houston, TX 77030

Premium change for the above amendment(s): $0.00

[X] No change [ ] Additional Premium $ [ ] Return Premium $

All other terms, conditions and limitations of this Policy shall remain unchanged.