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Original

No.: 691431-1

COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

BRUCE PLEASANT AND KIMBERLY PLEASANT,
a marital community,

Appellants,

vs.

REGENCE BLUESHIELD, a Washington Corporation,

Respondent.

BRIEF OF APPELLANTS
BRUCE AND KIMBERLY PLEASANT

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I. INTRODUCTION

Mr. Pleasant was admitted for a routine knee operation at a regional surgical facility in March of 2010. CP 11-12. While in the recovery room, he suffered a massive stroke, which caused extensive brain damage. CP 12:2-3. Mr. Pleasant is permanently disabled as a result of the stroke. *Id.* Following the stroke, Mr. Pleasant was rushed to the Swedish Hospital. CP 12:4-5. Mr. Pleasant was later readmitted on a different floor which provided in-patient rehabilitative services. CP 12:7-9. However, while on that floor, he also received other reasonable and necessary medical treatments. CP 125-126. There is no dispute that the treatment Mr. Pleasant received from the Swedish Hospital was reasonable and medically necessary.

Mr. Pleasant was insured pursuant to the terms and conditions of an insurance policy issued by Regence Blue Shield. At issue in this case is Regence's denial of benefits based upon exclusions and limitations in the policy of insurance. CP 1-4. Regence denied coverage for a mechanical embolectomy procedure during Mr. Pleasant's initial emergency room stay, claiming the procedure was "investigational." CP 604-606. Regence also denied coverage for reasonable and necessary

medical expenses incurred by Mr. Pleasant, based upon his geographical location within the Swedish Hospital. CP 11-20.

The Pleasants brought suit against Regence Blue Shield (“Regence”), asserting that Regence wrongfully denied benefits to the Pleasants by limiting coverage under the inpatient rehabilitative services provision despite the fact that Mr. Pleasant received treatment for other non-rehabilitative services, and that Regence breached the contract by improperly denying the Pleasant’s claims for the mechanical embolectomy procedure. CP 1-4.

In 01/13/12, the trial court entered an Order denying the Pleasants’ Motion for Partial Summary Judgment. Appendix A. The Court entered Summary Judgment in favor of Regence on the same issue on April 10, 2012.¹

Thereafter, the parties cross-moved for summary judgment on Regence’s denial of the mechanical embolectomy procedure. *Id.*

¹ Following the trial court’s January 13, 2012 Order, Regence moved for Summary Judgment on the exact same issue which was before the trial court on January 13, 2012. The trial court granted partial summary judgment on Defendants’ Summary Judgment Motion on April 10, 2012. The Pleasants failed to identify the trial court’s 04/10/12 Order in the original Notice of Appeal. Accordingly, on October 19, 2012, the Pleasants filed Appellants’ Motion to Amend Notice of Appeal and Supplement Record on Review. In the instance that the Appellants’ Motion is granted, the Pleasants will file a succinct supplemental brief to Appellants’ Opening Brief.

In its 07/13/12 Order, the trial court granted Regence's Motion for Summary Judgment finding that: (1) this matter is a contract issue; (2) Regence's denial of coverage for the Pleasants' mechanical embolectomy claims based upon its investigational status was proper based upon Regence's medical policy on mechanical embolectomy procedures; and (3) Regence is entitled to make the determination of a medical procedure's "investigational" status without the possibility of review by the Court or trier of fact. RP 23:4-25, 24:5-11, 24:14-25 and 25:1-4; see also, CP 1519-1520; Appendix B.

On August 3, 2012, the trial court denied Plaintiffs' motion for reconsideration. CP 1655; Appendix C.

II. ASSIGNMENTS OF ERROR

- A. The trial court erred in entering its 01/13/12 Order denying plaintiffs' motion for partial summary judgment and granting Regence's Motion for Summary Judgment on the issue of rehabilitative services filed 04/10/12. See, CP 602-603 and 697; Appendix A; and footnote 1.
- B. The trial court erred in granting Regence's motion for summary judgment and denying the Plaintiff's cross-motion on 07/13/12, regarding the mechanical embolectomy. CP 1519-1520; Appendix B.
- C. The trial court erred in denying plaintiffs' motion for reconsideration. CP 1655; Appendix C.

III. ISSUES RELATED TO THE ASSIGNMENTS OF ERROR

- A. Did the Court err in concluding that Mr. Pleasant's geographical location within the hospital dictated whether or not he was entitled to coverage as opposed to examining the procedures provided to determine whether or not coverage was available? (Assignment of Error A).
- B. In the alternative, did the trial court err when it did not find that the language of the insurance policy is void as against public policy? (Assignment of Error A).
- C. Did the trial court err in finding that Regence's denial of coverage for the Pleasants' mechanical embolectomy when it failed to present evidence creating a genuine issue of material fact? (Assignment of Error B).
- D. Did the Court err in allowing Regence to offer testimony of an expert witness not disclosure until **after** the discovery cutoff, **after** the deadlines for disclosing primary and expert witnesses, and over the objections the Pleasants? (Assignment of Error B).
- E. Did the trial court err in finding that Regence did not violate the Consumer Protect Act or act in bad faith because Regence failed to provide the basis of its denial as required under WAC 284-30, *et.seq.*? (Assignment of Error B).
- F. Did the trial court err in denying Plaintiffs' Motion for Reconsideration? (Assignment of Error C).
- G. Are the Pleasants entitled to an award of reasonable attorney fees and expenses pursuant to *Olympic Steamship v. Centennial Insurance*, 117 Wn.2d 37, 811 P.2d 673 (1991)?

IV. STATEMENT OF THE CASE

A. Background Facts.

This lawsuit arises out of Regence Blue Shield's denial of insurance benefits in excess of \$100,000.00. CP 11.

In March of 2010, Mr. Pleasant underwent a seemingly routine procedure to repair his damaged knee. CP 11-12. However, during the course of that procedure, Mr. Pleasant suffered a stroke which caused severe debilitating injuries. CP 12:2-3. Currently, Mr. Pleasant has been deemed 100% disabled as a result of the stroke. *Id.*

Following the stroke, Mr. Pleasant was rushed to Swedish Hospital where he received treatment. CP 12:4-5. Mr. Pleasant was discharged and admitted into a nursing facility following the initial emergency room treatment. CP 12:5-6. While at the nursing facility, Mr. Pleasant's treatment plan included specified care designed to increase his strength so that he could continue receiving treatment for his stroke injuries. CP 12:6-7.

After approximately one month, Mr. Pleasant was readmitted to a different floor at the Swedish Medical Center. CP 12:7-9. Mr.

Pleasant was readmitted to a different floor in the exact same hospital in which he had received emergency care. *Id.*

B. The Swedish Medical Center Is A Singular Hospital.

The Swedish Medical Center operates under a singular hospital license issued by the State of Washington. CP 502-520. The treatment Mr. Pleasant received was at the same hospital, just on a different floor. CP 12.

C. The Policy of Insurance.

The policy of insurance is organized in such a way that it is broken down into various articles numbered as Articles 1-8. CP 166. Rather than first setting forth the grant of coverage followed by the exclusions, the Regence Policy addresses what is excluded before addressing what is covered. *Id.* Nevertheless, it is the Pleasants' position that in order to understand the Regence Policy, it is necessary to first identify what is covered before analyzing what is excluded from coverage.

With this in mind, Article 8 of the policy of insurance provides in part:

ARTICLE 8 BENEFITS

8.2 BENEFIT PROVISIONS. The Benefits of this Article for Medically Necessary services, will be provided at the payment levels specified in the Payment Schedule

in the *Guide to Using Your Benefits*, subject to all limitations, exclusions, and provisions of this Contract.

8.5 COVERED BENEFITS. The Benefits described in this Article will be provided at the payment level specified in the Payment Schedule in the *Guide to Using Your Benefits*. All Benefits are subject to the preadmission approval provision described in this Article, and to all conditions and limitations stated in the Benefit sections below or elsewhere in this Contract, as determined by the Company. All services and supplies must be Medically Necessary as defined in Article 1, except as provided in this Article for preventive care services.

8.6 PROFESSIONAL SERVICES. The services of a provider who is not a facility that provides Inpatient services, will be provided for the diagnosis and treatment of illness, accidental injury, or physical disability including x-ray and laboratory, surgery, second opinions, injectable drugs for covered conditions in the office, home, Hospital, or skilled nursing facility, and for covered services for women's health to include gynecological care and general exams as medically appropriate and medically appropriate follow-up visits.

8.7 HOSPITAL FACILITY.

8.7.1 INPATIENT BENEFITS. When the Member is confined as an Inpatient, Benefits will be provided for services and supplies provided by a Hospital. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be Medically Necessary.

See, CP 73-76.

Article 1 of the Policy sets forth the pertinent definitions:

ARTICLE 1 DEFINITIONS

- 1.12 HOSPITAL. An accredited general Hospital that is a provider covered under this Contract.
- 1.13 INPATIENT. A person confined overnight in a Hospital or other facility as a regularly admitted bed patient to whom a charge for room and board is made in accordance with the Hospital's or facility's standard practice.
- 1.14 INPATIENT REHABILITATION ADMISSION. An inpatient admission to a Company approved facility specifically for the purpose of receiving speech, physical, or occupational therapy in an inpatient setting.

See, CP 34-36.

The limitations and exclusions are found in Article 6. The policy provides in part:

ARTICLE 6 LIMITATIONS AND EXCLUSIONS; WAITING PERIODS

6.1.11 Drugs, except as follows:

- a. Drugs will be provided for the Inpatient who is receiving the Benefits of this Contract for that confinement, unless otherwise excluded under this Contract.

6.1.24 Services and supplies that are not Medically Necessary for treatment of an illness, injury, or physical disability, including routine physical and hearing exams and related x-ray and laboratory, except as specified in Article 8.

6.1.34 Treatment for rehabilitative care, including speech therapy, physical therapy, or occupational therapy, except as specified in the Home Health, Hospice, and Rehabilitation Benefits of Article 8.

CP 64-67.

D. Regence Denied Coverage of Mr. Pleasant's Non-Rehabilitative Care Based Upon His Geographic Location.

Mr. Pleasant received treatment and prescribed medications at a "hospital" as defined by the policy of insurance. CP: 96-11 and 141:7-16. For example, Mr. Pleasant received medications called Enoxaparin² and Latanoprost³. CP 102 and 97, respectively. Additionally, Mr. Pleasant received numerous blood draws, laboratory tests, etc., for the purposes of monitoring his blood and recovery from the stroke. CP 106. He also received Visipaque injections which are radiographic contrast mediums used to enhance x-ray imaging. CP 103 and 115-116. In another instance, Mr. Pleasant received a CT scan. CP 106-108. The CT scan had nothing to do with rehabilitative care. Regence has denied the expenses associated with these medications, nearly 20 blood

² Enoxaparin is an anti-coagulant used to prevent and treat pulmonary embolisms (the effects of stroke). CP 113.

³ Latanoprost is a topical ophthalmic solution used to reduce pressure inside the eye. CP 114.

draws and associated lab work of Mr. Pleasant's blood, as well Mr. Pleasant's claims for x-rays. CP 95-111.

Despite the fact that Regence paid for these same types of medications and procedures during Mr. Pleasant's initial hospitalization, Regence has taken the position that Mr. Pleasant's geographic location within the hospital dictates whether or not he is entitled to insurance coverage. CP 12:13-15 and CP 130:1-6.

E. Regence Denied the Costs Associated with Mr. Pleasant's Mechanical Embolectomy Procedure.

As noted above, Mr. Pleasant received a mechanical embolectomy⁴ in treatment for his stroke in order to restore the flow of blood to Mr. Pleasant's brain. CP 125-126, ¶¶2-5; see also, CP 605:18.

The treatment was *medically necessary* following Mr. Pleasant's March 2010 stroke as determined by his treating medical providers:

Mr. Pleasant received treatment while at the rehabilitation center. He received certain treatment which was medically necessary regardless of the setting in which he received the treatment.

⁴ A mechanical embolectomy involves a micro-catheter being placed in the blood vessel and being directed to the area of the blood clot. CP 605:10-17. At the end of the device, there is a helical coil which is used to grasp the obstruction, allowing for the obstruction to be pulled back out through the blood vessel, thus restoring blood flow to the area affected by the stroke. *Id.*

Examples include medication, laboratory work, and a CT scan. Additionally, Mr. Pleasant underwent a procedure to remove and replace a blood filter. Again, ***these are treatments Mr. Pleasant received related to his stroke.*** The procedures, lab work and medicines were needed regardless of Mr. Pleasant's setting. In other words, Mr. Pleasant would have needed these treatments whether or not he had been admitted for in-patient rehabilitative services.

CP 125-126: ¶5 (emphasis added).

Regence's denial of the mechanical embolectomy procedure was based, in part, upon a medical policy (which was identified after the close of discovery) which was drafted by a medical policy clinician. As identified by Regence, a medical policy clinician "is the person who performs the literature review and gathers materials and does initial critical appraisal of the evidence." CP 1549:2-5. Incredibly, a medical policy clinician is not a doctor but "either a nurse or has some other advanced training, like an MPH." CP 1549:5-13. It is the medical policy clinician who conducts the research to draft an initial draft of the medical policy that is then reviewed by doctors. *Id.* This medical policy is not part of the policy of insurance.

Regence's own reviewing neurosurgeon, Dr. Maurice Collada, strongly asserts that denial of a mechanical embolectomy

procedure is “unwise, inappropriate, indefensible.” Dr. Collada states:

Folks to suggest that a technique that reconstitutes the blood supply mechanically to areas of the brain compromised due to a blocked intracerebral vessel should not be done, or should not be funded is **unwise, inappropriate, indefensible**. The studies are already fairly strong. I presume you would not refuse payment in an effort to reconstitute the flow in an occluded carotid artery by way of an endarterectomy, and yet the double blinded studies in that area are also lacking. I think that this is like asking to get more convincing double blinded studies before you jump out of a crashing airplane with a parachute. I would urge a rethinking of this policy.

CP 1564 (emphasis added).

A year later, during another review, Dr. Collada again renewed his position, calling Regence’s denial of mechanical embolectomy treatments “preposterous” and “unconscionable”:

I totally disagree with the decision to make this experimental, and not have this as an option in stroke management. I do think clear criteria, and timelines exist. I also understand why the double blind studies have been so difficult since it would be **unconscionable** to do a double blind study just as it would be **unconscionable** to do a double blind

study in the use of parachutes when jumping out of airplanes. Once you do have timelines, and criteria in place that you can study, and track, realizing reconstituting the cerebral blood flow is the goal, then it is ***preposterous*** to keep this outside of our armamentarium. ***Not having this option would hinder stroke management substantially, and be a disservice to your clients.***

CP 1565 (emphasis added).

Regence denied the mechanical embolectomy procedure on an unexplained determination that the procedure was “investigational.” CP 605:19 and CP 685-686. Astoundingly, Regence denied the mechanical embolectomy procedure, which was found to be medically necessary by Mr. Pleasant’s provider, a medical doctor, based upon a medical policy drafted by a nurse – a policy which was subsequently deemed to be “unconscionable” by one of Regence’s own internal reviewing experts. As a result of Regence’s denial, the Pleasants have been forced to pay for these expenses out of pocket. CP 2:¶1.9 – 1.10.

F. Procedural History.

The Pleasants moved for Summary Judgment seeking a finding of coverage as a matter of law. CP 11-20. On January 13, 2012, the trial court denied the Pleasants’ Motion for Summary Judgment. CP 602-603; Appx. A. Thereafter, Regence moved for Summary Judgment on the same issue which was granted by the

trial court on April 10, 2012. CP 697; see also, footnote 1. The issue of Regence's denial of the mechanical embolectomy based upon its "investigational" status remained in dispute. CP 697:11-12.

Pursuant to the case scheduling order, the deadline for identifying primary witnesses, which includes those witnesses with relevant expert knowledge, was February 21, 2012. CP 1197 and 1207. The deadline for disclosing additional witnesses was April 2, 2012. CP 1207.

Following the expiration of these deadlines, the Pleasants moved for Summary Judgment on the issue of the mechanical embolectomy. CP 604-610. The Pleasants argued that the burden of proof for establishing exclusionary provisions in the policy of insurance rested upon the insurer. CP 607-608. In response, Regence offered the Declaration of Richard Rainey, M.D. CP 789-791 and 799-800. Dr. Rainey had never previously been identified as a witness, let alone a testifying expert. CP 1199:1-16.

Nevertheless, and over the objection of the Pleasants, the trial court accepted the Declaration of Dr. Rainey. RP 25:9-12. The trial court ruled that Regence had followed the "procedure" for determining that the mechanical embolectomy procedure was "investigational" but neglected to analyze whether or not the procedure was in **fact** investigational. RP 16: 17-21, 18:2-7, 19:13-

20, 23:4-23 and 24:20-25. The trial court summarily dismissed the remaining causes of action asserted by the Pleasants. RP 25:5-8.

V. ARGUMENT AND AUTHORITY

A. Summary Judgment is Reviewed De Novo.

An appellate court reviewing a summary judgment order must engage in the same inquiry as the trial court. *Sedwick v. Gwinn*, 73 Wash.App. 879, 884, 873 P.2d 528, 531 (1994), referencing, *Marincovich v. Tarabochia*, 114 Wash.2d 271, 274, 787 P.2d 562 (1990). The appellate court reviews the facts and law with respect to summary judgment de novo. *Mountain Park Homeowners Ass'n v. Tydings*, 125 Wash.2d 337, 341, 883 P.2d 1383 (1994).

To the extent that any aspect of the Superior Court's rulings on the Pleasants' Motion for Reconsideration is before this Court, the Court reviews those rulings for abuse of discretion. *Byerly v. Madsen*, 41 Wn. App. 495, 499, 704 P.2d 1236 (1985).

A trial court abuses its discretion when it exercises it in a manifestly unreasonable manner or bases it upon untenable grounds or reasons. *Wagner Dev. v. Fidelity & Deposit*, 95 Wn. App. 896, 906, 977 P.2d 639 (1999).

B. The Pleasants Are Entitled To Coverage For All Reasonable And Necessary Medical Treatment.

As set forth above, benefits will be provided to an insured for all medically necessary services as set forth in Article 8 of the Regence Policy. See, Article 8.2 and 8.5. Additionally, the policy provides for coverage “for the diagnosis and treatment of illness, accidental injury...x-rays...laboratory work...injectable drugs...which are medically appropriate.” See, Article 8.6. The policy also provides benefits to the insured when the insured is confined as an in-patient in a hospital. See, Article 8.7.1. The policy defines a hospital as an accredited general hospital that is a provider covered under this contract. See, Article 1.12. There is no question of fact but that the Swedish Medical Center is a hospital as defined by the policy of insurance. CP 502-520.

Pursuant to the plain language of the policy, Mr. Pleasant is entitled to coverage for all services provided at the hospital unless specifically excluded elsewhere. There is no dispute of fact but that the treatment Mr. Pleasant received was medically necessary and reasonable. Therefore, all treatment is presumed covered under this policy unless specifically excluded.

C. Regence Bears the Burden of Proving Its Exclusions.

For purposes of analyzing this de novo review, the burden of proof rests squarely on Regence in establishing its exclusions and limitations.

It is well established that the burden is on an insurer to prove that a claim is not covered because of an exclusionary provision in the policy. *Brown v. Snohomish County Physicians, Corp.*, 120 Wn.2d 747, 758-59, 845 P.2d 334 (1993), citing *Burrier v. Mutual Life Ins. Co. of New York*, 63 Wn.2d 266, 270, 387 P.2d 58 (1963); *Pemco v. Rash*, 48 Wn.App. 701, 703, 740 P.2d 370 (1987). Language in an insurance policy is ambiguous if it is fairly/reasonably susceptible to more than one common sense interpretation; such an ambiguity must be liberally construed in favor of benefiting the insured. *Mutual of Enumclaw v. Cross*, 103 Wn.App. 52, 10 P.3d 440 (2000); *Robinson v. PEMCO Insurance*, 71 Wn.App. 746, 862 P.2d 614 (1993).

In Washington State, any ambiguity in the health insurance policy must be read in favor of coverage. *McCarty v. King County Medical Services Corp.* 175 P.2d 653, 26 Wn.2d 660 (1946). Exclusionary clauses are to be construed narrowly. *Cook v. Evanson*, 920 P.2d 1223 83 Wn.App.149 (1996); *McMahan and Baker Inc. v. Continental Casualty Company*, 843 P.2d 1133 68 Wn.App. 573. Exclusionary clauses are narrowly construed for the purpose of providing maximum coverage for an insured person. *George v. Farmers Insurance Company of Washington*, 23 P.3d 552, 106 Wn.App. 430 (2001); see also, *County Mutual Insurance*

Company v. McCauley, 974 P.2d 1288 95 Wn.App. 305. As a result, they are strictly construed against the insurer and will not be extended beyond the clear and unequivocal meaning. *Firemans's Fund Ins. Co. v. Puget Sound Escrow Closers, Inc.*, 96 Wn.App. 227, 979 P.2d 872 (1999); *Brown v. Snohomish County Physicians Corp.*, 822 P.2d 336, 63 Wn.App. 788 (1992), reversed on other grounds; 120 Wn.2d 747.

In this case, Regence has failed to provide any documentation in response to discovery concerning the mechanical embolectomy. Regence has failed to identify any witness who will testify concerning the alleged investigational nature of the mechanical embolectomy procedure. In short, there was a complete failure of evidence on the part of Regence concerning its denial of Mr. Pleasant's mechanical embolectomy procedure.

Moreover, because Regence bears the burden of proof in establishing the investigational status of the mechanical embolectomy procedure, Regence was required to come forward with specific evidence factually establishing the investigational status of the mechanical embolectomy procedure. Such evidence would in and of itself **create** a genuine issue of material fact regarding the investigational nature of the procedure.

D. The “In-Patient” Limit is Not Applicable for Other Treatment.

The basic exclusionary clause relied upon by Regence only limits coverage for rehabilitative care which is *specifically* for the purpose of receiving speech, physical, or occupational therapy:

SECTION 1.14

INPATIENT REHABILITATION ADMISSION: An inpatient admission to a Company approved facility specifically for the purpose of receiving speech, physical, or occupational therapy in an inpatient setting.

See, CP 36, § 1.14.

Thus, the exclusionary clause only applies if a patient is admitted specifically for rehabilitative services and only limits coverage to specific rehabilitative care, not other non-rehabilitative care services.

8.29.1 INPATIENT. The Professional, Inpatient Hospital, and Skilled Nursing Facility Benefits of this Article will be provided to an Inpatient for an Inpatient Rehabilitation Admission for physical therapy, speech therapy, and occupational therapy, to a maximum of \$4,000 per Year.

CP 87, §8.29 and §8.29.1.

Section 8.7.1, provides coverage when the insured is confined in a hospital. In this particular case, Mr. Pleasant received care at the Swedish Medical Center which by any definition is a hospital. CP 502-520.

1. **Coverage is available under the Regence Policy for all non-rehabilitative care that Mr. Pleasant received while at Swedish.**

The Pleasants assert that coverage is available for ***all non-rehabilitative care*** that Mr. Pleasant received at the Swedish Medical Center regardless of where he was located within the hospital, *i.e.*, medication expenses, x-ray expenses, lab work expenses, changing of his heart filter, etc. CP 559. While there is no controlling case law in the State of Washington, other jurisdictions have addressed this exact issue.

In the decision of *National Family Care Life Ins. Co. v. Kuykandall*, 705 SW 2d 267 (1986), the court held:

The contract clearly evinces an intent to cover the care that appellee received, regardless of the label given to the part of the hospital where he received the care.

* * *

Distinguishing the two units on the basis of label while defining only one and not the other is like comparing apples to oranges and creates an ambiguity to be

construed most strongly against the insurer.

CP 18; Appendix D.

The *Kuykandall* decision involved a nearly identical attempt by an insurer to deny coverage following a pulmonary embolus (stroke). In that case, the patient was moved from one side of the hospital to the other. This is directly analogous to moving Mr. Pleasant from one floor to the other. CP 18.

Another case, *Dobias v. Service Life Insurance Company of Omaha*, 469 N.W.2d 143 (1991), is also analogous to the instant matter. CP 18; Appendix E. The facts of *Dobias* involved a patient's move from one floor of the hospital to another. The insurer claimed that coverage was available while the patient was on one floor of the hospital but not on another. The Court flatly rejected this contention. The *Dobias* court held:

Any rehabilitative care which she received at Immanuel was incidental to the acute hospital care necessary to avoid the life-threatening complications she faced as a result of a spinal cord injury and paralysis.

* * *

A hospital by any other name, still provides acute medical care, and Pam received acute medical care at Immanuel.

CP at 18; Appx. E at 124, ¶3.

The *Dobias* court held that the insured was entitled to coverage under the policy of insurance.

At best and in the absence of any controlling Washington authority, the Regence policy provisions would be ambiguous and subject to reasonable interpretations. Plaintiffs presented two reasonable interpretations of the subject provisions thereby affirmatively establishing an ambiguity in the policy language.

2. Regence denied coverage for medications for which no exclusionary clause or language exists.

Regence has denied coverage for certain items which are covered under the policy of insurance for which there is no exclusionary or limiting language. CP 18. For example, Regence has denied all coverage for all medications received by Mr. Pleasant during his second hospitalization.

However, paragraph 6.1.11 of the Policy specifically provides coverage for drugs for the in-patient unless otherwise excluded under the contract:

ARTICLE 6 LIMITATIONS AND EXCLUSIONS; WAITING PERIODS.

6.1.11 Drugs, except as follows:

- a. Drugs will be provided for the Inpatient who is receiving the Benefits of this

Contract for that confinement, unless otherwise excluded under this Contract.

CP 64-65.

The policy contains no pertinent exclusionary language. Regence has never articulated the exclusionary language which precludes Mr. Pleasant from receiving coverage for medications while hospitalized. CP 18-19.

Pursuant to the plain language of the policy, Mr. Pleasant is entitled to coverage for all in patient benefits. At section 8.7.1, the Policy specifically provides benefits for the services and supplies provided by the hospital. Unquestionably, there were services and supplies provided by the hospital for which Mr. Pleasant is entitled to coverage. The same holds true for virtually every other expense incurred by Mr. Pleasant. As such, the trial court erred in denying the Pleasants summary judgment on the issue of coverage.

3. Mr. Pleasant's geographic location within Swedish Hospital does not dictate coverage.

Regence has taken the untenable position that the mere fact that Mr. Pleasant was on a different floor of the exact same hospital that the policy somehow excludes coverage for procedures which are clearly not rehabilitative services. CP 130:1-6 and 133-137. The only authority offered by Regence was an unpublished Nebraska decision which is not controlling law even in Nebraska, let alone Washington.

Dr. Clawson testified that Mr. Pleasant “received certain treatment which was **medically necessary** regardless of the setting in which he received the treatment.” CP 125, ¶5 (emphasis added). Such treatments are covered under the Regence Policy.

In advancing its argument, Regence requests this Court to *infer* policy language by concluding that **ANY** medications, x-rays, surgical procedures, tests, etc., an insured person receives while also receiving rehabilitation is not covered. CP 561.

Washington Courts have held that: “we will not add language to the policy that the insurer did not include.” *Fluke Corp. v. Hartford Accident*, 102 Wn.App. 237, 7 P.2d 825 (2000) citing *American National Fire Insurance Company v. V&L Trucking and Construction Co.*, 134 Wn.2d 413, 430, 951 P.2d 250 (1998).

In fact, nowhere in the Regence policy is treatment or services an insured may receive limited just because the insured is on a different floor of the same hospital. CP 561. As a result, the only fair and sensible reading of the Regence policy is that the policy limits only rehabilitative care to \$4,000.00. *Id.*

Regence cites to a Pennsylvania District Court, *Taylor v. Phoenix Mutual Life Ins. Co.*, 453 F.Supp. 372 (Penn. 1978). CP 561-562; Appendix F. *Taylor* fails to address the issues raised in the case at bar. The sole issue in *Taylor* was whether or not the treatment the insured received was at a hospital as defined by the

policy of insurance; specifically, whether or not Moss Rehabilitation Hospital was a hospital. Appx. F at 575, ¶1. In *Taylor*, the policy at issue “expressly lists eight criteria which an institution must satisfy to qualify as a “hospital” and thus qualify for policy coverage.” *Id.*, 576. In *Taylor*, the Court was asked to examine the eight criteria which defined a hospital as per the terms and conditions of that insurance contract. *Id.*

In stark contrast, the Regence policy of insurance provides no such eight criteria test for determining what constitutes a hospital. The Regence policy of insurance defines a hospital as “an accredited general Hospital that is a provider covered under this contract.” CP 35, §1.12. Pursuant to Regence’s own materials, Swedish Medical Center operates under a “single hospital license.” CP 502-520.

Regence’s reliance upon the decision of *Rew v. Beneficial Standard Life Ins. Co.*, 41 Wn.2d 577, 250 P.2d 956 (1952), is equally misplaced. Again, the only issue in the *Rew* decision was whether or not the Valley View Convalescent Home was a hospital as defined by the terms and conditions of that policy. CP 562. The *Rew* decision involved a limited “World-Wide Hospital and Surgical Expense Policy for Family Groups” which provided coverage in the event an insured was hospitalized. *Id.* However, the policy specifically excluded coverage for a convalescent or nursing home.

Id. Thus, the policy at issue in *Rew* simply didn't cover any expenses incurred while at a rest, convalescent or nursing home.

Stated another way, the *Rew* policy of insurance only covered hospital stays, surgical expenses and nothing else. The Court determined that the Valley View Convalescent Home was not a hospital.

Again, Swedish Medical Center operates under a "single hospital license." CP 502-520. There is no doubt but that the Swedish Hospital Medical Center is a hospital.

E. Regence Failed to Produce Any Evidence to Support Its Position Regarding the Mechanical Embolectomy Procedure.

Our Supreme Court has traditionally noted that a moving party under CR 56 bears the initial burden of demonstrating an absence of any genuine issue of material fact and an entitlement to judgment as a matter of law. *Schaaf v. Highfield*, 127 Wash.2d 17, 21 896 P.2d 665, 666 (1995), referencing, *Young v. Key Pharmaceuticals*, 112 Wn.2d 216, 770 P.2d 182 (1989); *LaPlante v. State*, 85 Wn.2d 154, 158, 531 P.2d 299 (1975). Thereafter, the nonmoving party must set forth specific facts evidencing a genuine issue of material fact for trial.

Washington State has specifically adopted the standard articulated by the United States Supreme Court in *Celotex Corp. v.*

Catrett, 477 U.S. 317 (1986), holding that the moving party may meet its burden of proof by “showing that there is an there is an absence of evidence to support the non-moving parties’ case.” *Howell v. Spokane and Inland Empire Blood Bank*, 117 Wn.2d, 619, 624, 818 P.2d 1056 (1991). A moving party must come forward with evidence sufficient to establish the existence element of its claim, otherwise, there can be no genuine issue of material fact since a complete failure of proof concerning an essential element necessarily renders all other facts and material. *Id.*, at 625, quoting *Celotex*, 477 U.S. at 322-23.

Pursuant to the *Celotex* standard, Regence had the burden of proof to establish the exclusion, *i.e.*, the investigational status, it claims justifies its denial of Mr. Pleasant’s mechanical embolectomy procedure.

Despite Plaintiffs’ specific requests for discovery regarding the mechanical embolectomy, Regence failed to provide any evidence justifying its conclusion that the procedure is “investigational.” CP 1204: ¶¶9. Regence relied on its Medical Policy regarding Mechanical Embolectomies to justify its denial of Mr. Pleasant’s claim. CP 699:15-20 and 7011:1-2. However, the Medical Policy relied upon by Regence is not part of the contract of insurance and was produced after the discovery cut-off pursuant to the trial court’s case scheduling order. CP 1198:13-14; CP 1207.

The trial court erred in accepting the Medical Policy as evidence.
Appx. B.

Regence failed to identify any witness who will testify concerning the alleged investigational nature of the mechanical embolectomy procedure.

The witness who was offered, Dr. Rainey, is not qualified to opine as to Regence's determination of mechanical embolectomy's investigational status to a reasonable degree of medical certainty because he has no background or training in mechanical embolectomies.⁵ CP 1548 at 10:8-10. In fact, Dr. Rainey specifically testified that he could not render an opinion as to whether mechanical embolectomies are an effective treatment for the treatment of strokes as it was outside the scope of his expertise. CP 1548 at 12:8-17.

In short, there was a complete absence of evidence on the part of Regence concerning its denial of Mr. Pleasant's mechanical embolectomy procedure.

Regence has taken the position that Regence, and Regence alone, gets to make the determination as to whether a treatment is "investigational." Regence argued:

THE COURT: Ms. Denton...again, I want to clarify that you are taking the position it's not the role

⁵ Moreover, Dr. Rainey is not qualified as an expert witness. CP 1523.

of this Court to determine whether or not that service is investigational at the time that it was denied?

MS. DENTON: I don't believe that it is the role of the Court or a jury to determine if the medical studies conducted to date are sufficient to meet the criteria of an investigational service.

RP 12:7-14.

The trial court agreed with Regence's position finding that Regence had followed the "procedure" for determining that the procedure was "investigational" but neglecting to analyze whether or not the procedure was in *fact* investigational. RP 16: 17-21, 18:2-7, 19:13-20, 23:4-23 and 24:20-25.

In so ruling, Plaintiffs were essentially denied due process with respect to a review of whether or not the procedure is in fact investigational. To hold such puts the insurer in the position where it can make any arbitrary or capricious determination and an insured is stuck with that decision without recourse.

At oral argument on the Motion for Summary Judgment, Regence took the untenable position that Regence, and Regence alone, had the authority to make the determination as to what constitutes an "investigational" procedure. This argument is flawed for a multitude of reasons.

The policy of insurance does not state, anywhere, that a mechanical embolectomy is investigational in nature. Regence befuddled the trial court by offering print outs of a web page stating

that it was the “policy of Regence” to treat mechanical embolectomies as investigational. However, the web page was not, and is not, a part of the insurance contract. As a result, it was manifest error for the court to even consider the web page as evidence, let alone assume that the web page was part of the insurance policy which controlled the contract between the two parties.

The burden of proof upon establishing the exclusion rests upon the insurer. Regence failed to present any admissible evidence which could create a question of fact precluding the possibility of summary judgment. Pursuant to the *Celotex* analysis, summary judgment should have been granted in favor of Mr. and Mrs. Pleasant.

The mechanical embolectomy is an accepted and standard procedure which has received FDA approval. CP 1532-1536. In fact, mechanical embolectomy procedures are approved for Medicaid/Medicare reimbursement. CP 688-691. Moreover, five (5) separate national medical affiliations, the American Association of Neurological Surgeons (“AANS”), the Society of NeuroInterventional Surgery, the Congress of Neurological Surgeons (“CNS”), the Society of Vascular and Interventional Neurologists, and the American Society of Neuroradiology, found that in respect to treatment for strokes, the mechanical

embolectomy procedure is a **medically necessary** option in appropriate patients with medical indications as determined by their treating physician. CP 1640-1644.

In the instant matter, Dr. David R. Clawson, one of Bruce Pleasant's medical providers who treated him while he was admitted at Swedish, testified that a mechanical embolectomy was among the treatment Mr. Pleasant received which was **medically necessary** as related to Mr. Pleasant's stroke. CP 1645-1646.

F. The Medical Policy and the Testimony of Dr. Richard Rainey Should Have Been Stricken.

The Local Rules of the Superior Court for King County ("KCLCR") requires the exclusion of evidence and testimony not disclosed in compliance with KCLR 26(k). Regence's reliance on evidence and testimony produced after the discovery cut-off is misplaced in light of KCLCR 26, which states in part:

(k) Disclosure of Primary Witnesses. Required Disclosures.

(1) Disclosure of Primary Witnesses:
Each party shall, no later than the date for disclosure designated in the Case Schedule, disclose all persons with relevant factual or expert knowledge whom the party reserves the option to call as witnesses at trial.

(2) *Disclosure of Additional Witnesses:* Each party shall, no later than the date for disclosure designated in the Case Schedule, disclose all persons whose knowledge did not appear relevant until the primary witnesses were disclosed and whom the party reserves the option to call as witnesses at trial.

(3) *Scope of Disclosure:* Disclosure of witnesses under this rule shall include the following information:

(A) All Witnesses. Name, address, and phone number.

(B) Lay Witnesses. A brief description of the witness's relevant knowledge.

(C) Experts. A summary of the expert's opinions and the basis therefore and a brief description of the expert's qualifications.

(4) *Exclusion of Testimony:* Any person not disclosed in compliance with this rule may not be called to testify at trial, unless the Court orders otherwise for good cause and subject to such conditions as justice requires.

CP 1197; KCLCR 26(f).

Pursuant to the Case Scheduling Order issued by the trial court, the discovery cut-off in this matter was June 4, 2012. CP 1198:1-3; CP 1207.

On June 14, 2012, ten (10) days after the discovery cut-off, Regence provided some documents (identified as RBS 000536-000854) to Plaintiffs. CP 1198: 13-15. These documents included the Medical Policy (RBS 000616-619) upon which Regence relies as its basis for denial of coverage for Mr. Pleasant's embolotomy procedure. CP 793-796.

In this case, Regence has failed to provide any documentation in response to discovery concerning the mechanical embolotomy. Regence has failed to identify any witness who will testify concerning the alleged investigational nature of the mechanical embolotomy procedure. In short, there is a complete failure of evidence on the part of Regence concerning its denial of Mr. Pleasant's mechanical embolotomy procedure.

In the instant case, the trial court erred in considering: (1) the Medical Policy; and (2) the testimony of Dr. Richard Rainey. Moreover, the Pleasants met their burden of proof and demonstrated through **admissible** evidence and testimony that there exist genuine issues of material fact as to each of the elements of their causes of action. The Plaintiffs met their burden of proof and Regence failed to set fourth specific facts.

G. Regence Has Violated WAC 284-30-380(1), WAC 284-30-330(13) and WAC 284-44-043.

WAC 284-30-380(1) provides in part:

The insurer must not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the specific provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer must contain a copy of the denial.

WAC 284-30-330(13) provides:

Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

Pursuant to WAC 284-44-043, Regence is obligated as follows:

(3) Every health care service contractor that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the contract and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter

must identify by name and job title the individual making the decision and fully disclose:

- (a) The basis for the denial of benefits or refusal to preauthorize services;
- (b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;
- (c) What information the appellant is required to submit with the appeal; and
- (d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health care service contractor must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

- (i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual;

- (ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and
- (iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

WAC 284-44-043.

In this case, Regence failed to provide the Pleasants with explanation, reasonable or otherwise, supporting the basis of its denial of the mechanical embolectomy procedure. CP1200. Other than simply advising Mr. Pleasant that the procedure is investigational, Regence wholly failed to provide any authority, law, or other justification, throughout the course of the original claims handling, or the course of this litigation justifying its denial of the mechanical embolectomy procedure. *Id.* Moreover, not only did Regence fail to explain its basis for denial in violation of WAC, Regence did not offer another treatment option in its place. In these circumstances, Regence has violated the Washington Administrative Code and therefore violated the Consumer

Protection Act at RCW 19.86, *et seq.* The court erred in granting summary judgment to Regence.

Washington courts have repeatedly held that whether or not an insurer acted in bad faith is a question of fact for the jury to decide. *Unigard Ins. Co. v. Mut. Of Enumclaw Ins. Co.*, 160 Wn.App. 912, 250 P. 3d 121 (2011); *Safeco Ins. Co. v. Butler*, 118 Wn.2d 383, 823 P.2d 499 (1992). In this case, there is ample evidence, aside from the actual coverage determination, for a jury to conclude that Regence acted in bad faith. First and foremost, Regence denied coverage for medications which no exclusionary clause or language exists. Second, Regence failed to provide coverage for non-rehabilitative treatment received by Mr. Pleasant. Third, Regence failed to provide coverage for the mechanical embolectomy by asserting that it is an investigational procedure when in fact it is not.

Moreover, there is ample evidence for a trier of fact to conclude that Regence acted in bad faith by failing to advise Mr. Pleasant that he could have simply checked out of the rehabilitative floor and onto another floor at the Swedish Medical Center in order to obtain coverage for the medically necessary treatment he

received. For these reasons, Mr. and Mrs. Pleasant's cause of action for bad faith should be reserved for trial.

I. The Pleasants Should Be Awarded Their Reasonable Attorney Fees and Expenses on Appeal and at the Trial Court Level.

Pursuant to *Olympic Steamship v. Centennial Insurance*, 117 Wn.2d 37, 811 P.2d 673 (1991), an insured is entitled to an award of reasonable attorney fees and expenses incurred in filing suit against its insurer to obtain the benefits due under the policy of insurance. If this Court rules in favor of the Pleasants, they should be awarded reasonable attorney fees and expenses.

VI. CONCLUSION

In light of the above, the Pleasants summarize their conclusions as follows:

- Coverage for all non-rehabilitative costs incurred by Mr. Pleasant exists regardless of his geographic location within Swedish Hospital at the time such services were incurred.
- Coverage exists for Mr. Pleasant's mechanical embolectomy procedure as Regence failed to establish the exclusionary status, *i.e.*, investigational status, of the treatment.
- Merely advising an insured that requested treatment is investigational is insufficient to justify an insurer's denial of

such treatment. As such, Regence failed to provide the Pleasants with any explanation supporting the basis of its denial of the mechanical embolectomy procedure.

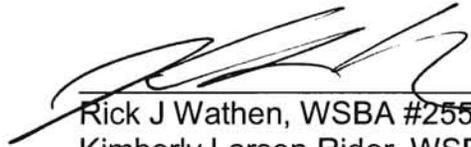
- Moreover, not only did Regence fail to explain its basis for denial in violation of WAC, Regence did not offer another treatment option in its place. In these circumstances, Regence has violated the Washington Administrative Code and therefore violated the Consumer Protection Act at RCW 19.86, *et seq*, thereby rendering *Olympic Steamship* fees.

In light of the above, the Pleasants respectfully request that the Court reverse the trial court's 01/13/12 and 07/13/12 Orders.

In the alternative, the Pleasants have established that there at least exists a question of material fact as to whether the mechanical embolectomy procedure is investigational or medically necessary, which is entitled to properly be determined before the trier of fact.

DATED THIS 22nd day of October, 2012.

COLE | WATHEN | LEID | HALL



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APPENDIX A

FILED
KING COUNTY, WASHINGTON

JAN 13 2012

SUPERIOR COURT CLERK
BY Sarah Hudson
DEPUTY

The Honorable Judge Mary Yu
Hearing Date: January 13, 2012
Hearing Time: 9:00 a.m.

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
FOR KING COUNTY

BRUCE PLEASANT and KIMBERLY
PLEASANT, a marital community

Plaintiffs,

v.

REGENCE BLUESHIELD, a Washington
corporation,

Defendant.

NO.: 11-2-06336-4 SEA

ORDER DENYING PLAINTIFFS' MOTION
FOR PARTIAL SUMMARY JUDGMENT
[PROPOSED]



This matter has come before the Court on Plaintiffs' Motion for Partial Summary Judgment. The Court has reviewed the following:

1. Plaintiffs' Motion for Partial Summary Judgment;
2. Declaration of Rick J. Wathen, with Exhibits;
3. Declaration of David R. Clawson, M.D.
4. Regence's Brief in Opposition to Plaintiffs' Motion for Summary Judgment;
5. Declaration of Stephania Denton, with Exhibits;
6. Supplemental Declaration of Stephania Denton, with Exhibit;
7. Plaintiffs' Reply in Support of Motion for Partial Summary Judgment; and

ORDER - 1
(NO. 11-2-06336-4 SEA)

LAW OFFICES OF
MILLS MEYERS SWARTLING
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SEATTLE, WASHINGTON 98104-1064
TELEPHONE (206) 382-1000
FACSIMILE (206) 386-7343

1 8. The papers and pleadings on file with this Court.

2 THE COURT ORDERS AS FOLLOWS:

3 *SD* 1. ~~Regence's motion to strike statements in plaintiffs' motion that are not~~
4 ~~supported by evidence~~ is GRANTED.

5 2. Plaintiffs' motion for partial summary judgment is DENIED.

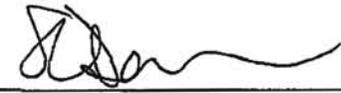
6 *SD* ~~[Regence's motion for a continuance pursuant to Civil Rule 56(f) is GRANTED.]~~

7 Signed this 13 of January, 2012.

8 
9 _____
The Honorable Judge Mary Yu

10 PRESENTED BY:

11 MILLS MEYERS SWARTLING
12 Attorneys for Defendant Regence BlueShield,

13 By: 
14 _____
Stephania Camp Denton
15 WSBA #21920

16 Copy received; notice of presentation waived:

17 COLE LETHER WATHEN LEID & HALL,
18 P.C.
19 Attorneys for Plaintiffs

20 By: 
21 _____
Rick J. Wathen
22 WSBA #25539
23 *Approved on behalf of team*

24 ORDER - 2
25 (NO. 11-2-06336-4 SEA)

26 LAW OFFICES OF
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APPENDIX B

The Honorable Judge Mary Yu
Noted for Oral Argument: July 13, 2012
Hearing Time: 10:00 a.m.

FILED
KING COUNTY, WASHINGTON

JUL 13 2012

SUPERIOR COURT CLERK
BY: Annie Johnson
DEPUTY

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
FOR KING COUNTY

BRUCE PLEASANT and KIMBERLY
PLEASANT, a marital community,

Plaintiffs,

v.

REGENCE BLUESHIELD, a Washington
corporation,

Defendant.

NO.: 11-2-06336-4 SEA

~~[PROPOSED]~~ ORDER GRANTING
REGENCE'S MOTION FOR SUMMARY
JUDGMENT ON REMAINING CLAIM

The matter has come before the Court on Regence's Motion for Summary Judgment on Remaining Claim. The Court has reviewed the following:

1. Regence's Motion for Summary Judgment on Remaining Claim;
2. Declaration of Stephania Denton, with exhibits;
3. Declaration of Richard Rainey, M.D., with exhibit;
4. Plaintiff's Motion for Summary Judgment;
5. Plaintiffs' Response in Opposition to Regence's Motion for Summary

Judgment on Remaining Claim;

6. Declaration of Rick J. Wathen, with exhibits;

[PROPOSED] ORDER GRANTING REGENCE'S MOTION FOR
SUMMARY JUDGMENT ON REMAINING CLAIM - 1
(NO.: 11-2-06336-4 SEA)

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APPENDIX C

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**IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING**

BRUCE PLEASANT and KIMBERLY
PLEASANT, a marital community,

Plaintiff,

v.

REGENCE BLUE SHIELD,

Defendants.

No. 11-2-06336-4 SEA

ORDER DENYING MOTION FOR
RECONSIDERATION

THIS MATTER came before the undersigned judge upon Plaintiff's Motion for Reconsideration. The court reviewed the Motion and being familiar with the history of the case and all records and files herein, denies the request for reconsideration.

IT IS SO ORDERED this 3rd day of August, 2012.



Judge Mary I. Yu
KING COUNTY SUPERIOR COURT

APPENDIX D



NATIONAL FAMILY CARE LIFE INSURANCE CO., Appellant v. Frank R. KUYKANDALL, JR., Appellee

No. 04-84-00459-CV

COURT OF APPEALS OF TEXAS, Fourth District, San Antonio

705 S.W.2d 267; 1986 Tex. App. LEXIS 12439

January 15, 1986

PRIOR HISTORY: [**1] Appeal from the 224th District Court of Bexar County, Trial Court No. 83-CI-20279, Honorable Carolyn Spears, Judge Presiding.

COUNSEL: Warren E. Zimmerman, Dallas, Texas, for appellant.

Tuck R. Chapin, San Antonio, Texas, for appellee.

JUDGES: Blair Reeves, Associate Justice.

OPINION BY: REEVES

OPINION

[*269] Appellant, National Family Care Life Insurance Company, seeks reversal of this case on the grounds that the hospitalization of Frank R. Kuykendall, Jr., appellee, fell within a noncompensable exception to the policy.

Appellant insured appellee, contracting to pay \$300.00 per day in the event he was hospitalized in an intensive care unit.

Appellee became ill and was first confined in the Intensive Care Unit (ICU) at the Medical Center Hospital where he was diagnosed as suffering from a pulmonary embolus. The payment of this portion of appellee's hospitalization is not contested. After three days in the Medical Center Hospital's ICU, appellee's doctor ordered his transfer to an equivalent unit at the San Antonio Community Hospital. Appellee was placed in a part of the hospital designated as the Coronary Care Unit (CCU) where he remained for 27 days. The area designated [**2] as the ICU is contiguous to the CCU.

1 Pulmonary Embolus: The obstruction of an artery in a lung by an embolus or blood clot. 3 J. E. Schmidt, M.D., *Attorney's Dictionary of Medicine*, 317 (1985).

Appellant refused to pay for the \$300.00 per diem rate, contending that confinement in the San Antonio Community Hospital fell within an exception enumerated in the insurance policy. A jury found to the contrary and the trial court granted judgment to appellee for the time he was confined to the CCU.

Appellant asserts the trial court erred in the following:

1. in entering judgment for appellee because, as a matter of law, the confinement in the CCU was expressly excluded from the contract;
2. the undisputed evidence displays that appellee was not confined in a medical care unit covered under the contract;
3. there was no evidence or insufficient evidence to support appellee's claim to medical payment coverage; and
4. in overruling appellant's objections to the jury charge and failing to submit [**3] appellant's requested issues and instructions.

The standard of review for a "no evidence" assertion requires that the court consider only evidence tending to

support the finding, viewing it in the most favorable light in support of the finding, giving effect to all reasonable inferences that may properly be drawn therefrom and disregarding all evidence which is conflicting or contrary. *Glover v. Texas General Indemnity Co.*, 619 S.W.2d 400, 401 (Tex. 1981).

The standard of review for an insufficient evidence assertion requires that the court consider and weigh all the evidence and set aside the judgment if we conclude that the finding is clearly wrong and unjust. *In re King's Estate*, 150 Tex. 662, 244 S.W.2d 660, 661 (1951).

If the insurance contract is ambiguous or uncertain, it will be construed liberally in favor of the insured and strictly against the author of the contract, the insurer. *United States Fidelity & Guaranty Co. v. Bimco Iron & Metal Corp.*, 464 S.W.2d 353, 355 (Tex. 1971); *Zimmerman v. National Home Life Assurance Co.*, 517 S.W.2d 842, 845 (Tex. Civ. App. -- Waco 1974, writ ref'd n.r.e.). Our Supreme Court in *Hardware Dealers Mutual Insurance [**4] Co. v. Berglund*, 393 S.W.2d 309, 314 (Tex. 1965) stated:

The language used in the policies must be construed according to the evident intent of the parties, to be derived from the words used, the subject matter to which they relate, and the matters naturally or usually incident thereto, and it is only when the words admit of two constructions, that one will be adopted most [sic] favorable to the insured. [Citations and emphasis omitted.]

It is undisputed that appellant's contract of insurance excepts from coverage confinement by the insured in a CCU. The contract provides, in pertinent part:

[*270] COVERED CONFINEMENT: Covered Confinement shall mean the occurrence or all of the following conditions:

1. The Covered Person is necessarily confined in a Hospital Intensive Care Unit (Hospital ICU).

EXCLUSIONS AND LIMITATIONS: This policy does not cover confinement in coronary care units, neonatal intensive care units, or step-down units

such as progressive care, sub-acute intensive care, intermediate care units, private monitored rooms, observation units or other facilities which do not meet the standards of 'Hospital ICU' as defined above.

It [**5] is also undisputed that appellee was receiving treatment in ICU at the Medical Center Hospital, and his doctor, Raymond P. Harle, ordered that he be placed in a like environment when transferred to the San Antonio Community Hospital. The doctor was evidently satisfied with the care received in the area designated CCU as his patient remained there for 27 days. Appellee's problem was diagnosed pulmonary embolus. The CCU and the ICU were side by side and Dr. Harle said the treatment in both units was comparable. He testified as follows:

Q: And did you undertake his care and treatment at that time?

A: That's correct.

Q: What did you recommend be done for him?

A: Be transferred to an equivalent unit at Community Hospital.

Q: What was that equivalent unit?

A: In this case it was the coronary care unit.

Q: And what was it specifically -- did you intend to specifically put him in a coronary care unit or looking for intensive care unit, whatever was available at the hospital?

A: At that time he had to go into intensive care unit and in other words these were back to back at Community Hospital and one is interchangeable with the other in my opinion.

[**6] The hospital staff originally billed appellee for confinement in the CCU but changed the billing to care in ICU because of the diagnosis and because appellee was not listed as a coronary patient. The cost of the care is the same in either facility.

Appellant has not defined "coronary care unit" in its insurance contract. It is apparent, however, that at the time appellant authored that portion of its contract excluding confinement in a CCU, it considered care in that

type of unit inferior to care in a "Hospital ICU." The absence of a comma following the word *facilities* indicates that the clause following it, "which do not meet the standards of ICU as described above," is a restrictive clause modifying facilities and limiting its meaning to only those facilities which do not meet the standards of ICU as described above. The use of "other" in combination with the restrictive clause indicates that all the specifically listed units are considered "facilities which do not meet the standards of ICU as described above." Appellant did not choose to define "coronary care unit" more specifically, but it did define "Hospital Intensive Care Unit" as:

'Hospital ICU' shall mean only [**7] that specifically designated facility of the hospital that provides the highest level of medical care and which is restricted to those patients who are physically, critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured, and they must be under the constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to the Hospital Intensive Care Unit.

The trial court used appellant's definition of an ICU in its special issue when asking the jury if appellee was confined and treated as a patient in an ICU at San Antonio Community Hospital. The jury answered in the affirmative.

[*271] The contract clearly evinces an intent to cover the care that appellee received, regardless of the label given to the part of the hospital where he received the care. The evidence is more than sufficient that he

received intensive care even though he was located in a portion of the hospital styled CCU.

Appellant would have us exclude [**8] the CCU from coverage on the basis of its label or its designation, but the ICU is not defined only by its label. The ICU is defined according to the standard of care available. Distinguishing the two units on the basis of label while defining only one and not the other is like comparing apples to oranges and creates an ambiguity to be construed most strongly against the insurer.

Appellant's points of error one through three are overruled.

Appellant's objection to the charge is that the following special issue comments on the weight of the evidence. The special issue asks if appellee was confined and treated as a patient in an Intensive Care Unit of the San Antonio Community Hospital for a period of 29 days during July and August of 1982. We fail to see how the issue comments on the evidence, and appellant cites us no authority for this contention.

Appellant also complains that the trial court erred in not submitting a conditional issue, based on an affirmative answer to special issue one, which asks, "If you have answered -- issue number one 'yes, he has,' then do you find that said intensive care unit was designated by the hospital as the coronary care unit?" The appellee's location [**9] in the hospital was uncontroverted and in any event is not a controlling issue. *Texas Rules of Civil Procedure, Rule 279* (Vernon 1976). As we have already stated, the name of the unit where appellee was confined was, in this case, of secondary importance to the treatment he received. Moreover, the requested issue is an inferential rebuttal issue since it seeks to disprove the existence of an essential element submitted in another issue, *Select Insurance Co. v. Boucher*, 561 S.W.2d 474, 477 (Tex. 1978), and should not be submitted.

Appellant's fourth point of error is overruled.

The judgment of the trial court is affirmed.

APPENDIX E



Jerry Dobias et al., appellants, v. Service Life Insurance Company of Omaha, appellee

No. 89-231

SUPREME COURT OF NEBRASKA

238 Neb. 87; 469 N.W.2d 143; 1991 Neb. LEXIS 198

May 10, 1991, Filed

PRIOR HISTORY: [***1] Appeal from the District Court for Knox County: Merritt C. Warren, Judge.

DISPOSITION: Reversed and remanded for further proceedings.

HEADNOTES

1. **Evidence: Stipulations: Appeal and Error.** In a case in which the facts are stipulated, this court reviews the case as if trying it originally in order to determine whether the facts warranted the judgment.

2. **Insurance: Contracts: Intent.** An insurance policy is to be construed as any other contract to give effect to the parties' intentions at the time the contract was made. Where the terms of such a contract are clear, they are to be accorded their plain and ordinary meaning.

COUNSEL: John Thomas and Gregory M. Neuhaus for appellants.

Scott J. Norby, of Crosby, Guenzel, Davis, Kessner & Kuester, for appellee.

JUDGES: Hastings, C.J., Boslaugh, White, Caporale, Shanahan, Grant, and Fahrnbruch, JJ.

OPINION BY: WHITE

OPINION

[*87] [**144] The plaintiffs, Jerry and Anne Dobias and their daughter Pam, appeal the order of the district court overruling their motion for new trial. The Dobiases had filed this action against [*88] the defendant, Service Life Insurance Company of Omaha, for

its failure to pay benefits under a health insurance [***2] policy. The district court entered judgment for the defendant, finding that the policy did not cover the services received by Pam Dobias when she was a patient at the Immanuel Medical Center's rehabilitation center.

In August 1987, Pam, then 18, was thrown from a pickup truck which overturned. She was taken to a local hospital. She had fractured a vertebra in her back and was flown by Life Flight to Nebraska Methodist Hospital in Omaha. She remained there for 15 days following surgery (a decompression laminectomy and the insertion of Harrington rods to stabilize and support her spine).

Because of her spinal cord injury, Pam was paralyzed from the waist down and faced a number of complications. Her doctors then transferred her to the rehabilitation center at Immanuel Medical Center (Immanuel).

At Immanuel, Pam was placed on the eighth floor, where she received 24-hour acute nursing care and treatment for the complications from the spinal cord injury and paralysis. She suffered from a paralyzed bladder, multiple urinary tract infections, and neuropathic pain due to damage in the spinal cord. She needed training to regulate her bowels, she was given heparin to prevent blood clotting [***3] in the legs, and she was placed on a tilt table to regulate her blood pressure. She received treatment for spasticity, and she was observed for the development of decubitus ulcers of the skin, stress ulcer, and occult head injuries such as subdural hematoma. Pam also received anesthetic skin care training and other therapy before she was released to go home on October 30, 1987, after 74 days at Immanuel.

Pam's father had purchased a health insurance policy from the defendant in 1984. Upon submission of a

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claim, Service Life paid \$ 12,303.91 for Pam's treatment at Methodist, but denied the claim for \$ 42,757.49 for services and care at Immanuel. The insurance company contended that Pam received rehabilitative care, which is not covered by the policy. The Dobiases filed suit in district court, where judgment was entered for the defendant. This appeal followed.

[*89] At issue are two definitions in the policy -- part E, paragraphs 14 and 15:

(14) "Hospital" means a place which:

(a) is legally operated for the care and treatment of sick and injured persons on an in-patient basis at their expense;

(b) is primarily engaged in providing medical, diagnostic, and major surgical [***4] facilities on its own premises or has them available on a prearranged basis;

[**145] (c) has continuous 24-hour nursing services by or under the supervision of registered graduate professional nurses (R.N.'s);

(d) has a staff of one or more doctors available at all times.

(15) "Hospital" does not mean:

(a) convalescent, nursing, rest, custodial, self-care, educational, or rehabilitative homes or units of hospitals used for such care;

(b) facilities primarily treating the mentally ill, aged, drug addicts, or alcoholics.

In finding that the charges were not covered, the trial court held that the policy was clear and unambiguous and that the Immanuel rehabilitation center was not a "hospital," but a separate and distinct unit of Immanuel devoted exclusively to rehabilitation. The plaintiffs-appellants assert as error the trial court's finding that the policy clearly and unambiguously excluded the Immanuel rehabilitation center from the definition of "hospital." The Dobiases suggest that the trial court should have found that the policy was fairly subject to two interpretations and that the trial court should have chosen the interpretation favorable to coverage of Pam's treatment [***5] at Immanuel.

When, as in this case, the facts were submitted by stipulation, "we review this case as if trying it originally in order to determine whether the facts warranted the

judgment." *Dugdale of Nebraska v. First State Bank*, 227 Neb. 729, 731, 420 N.W.2d 273, 275 (1988).

We note first the standards we use in reviewing an insurance policy.

An insurance policy is to be construed as any other [*90] contract to give effect to the parties' intentions at the time the contract was made. . . . Where the terms of such a contract are clear, they are to be accorded their plain and ordinary meaning. . . . On the other hand, where a clause in an insurance contract can be fairly interpreted in more than one way, there is ambiguity to be resolved by the court as a matter of law.

(Citations omitted.) *Malerbi v. Central Reserve Life*, 225 Neb. 543, 550-51, 407 N.W.2d 157, 162 (1987).

Evidence was received from Patrick Beste, the administrative director of the Immanuel rehabilitation center, who indicated that the center is made up of 78 beds licensed as rehabilitation acute care beds on the [***6] eighth floor of Immanuel, which is licensed as a hospital. The eighth-floor rooms are similar to acute care hospital rooms, and Beste testified that the eighth floor meets the Service Life policy definition of a hospital. He said that Pam could have been housed on another floor of the hospital, but she would not have received the same level of care. When the eighth floor is filled, rehabilitation patients may be housed on other floors of the medical center.

Dr. Kip Burkman, a rehabilitation physician at Immanuel who treated Pam, testified that the eighth floor is a part of the medical center. He stated that Pam needed acute inpatient rehabilitation care when she arrived at Immanuel, including 24-hour nursing to monitor for possible multiple complications. Dr. Burkman testified that an internal medical doctor was asked to consult on Pam's case to screen for major medical problems. While at Immanuel, Pam received therapy which was medically necessary and not available at other health care facilities, Dr. Burkman said.

Jerry and Anne Dobiasek both testified that they were not consulted about Pam's transfer to Immanuel. Both said they understood the insurance policy to cover everything [***7] except nursing home and convalescent care.

Barry Malone, vice president for corporate compliance for Service Life, testified that the Dobiasek claim was denied because Pam received rehabilitation services. The company did not have the medical records reviewed

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by a physician or ask Pam's doctors whether she was receiving acute care. Malone stated [*91] that no definition of rehabilitative home is provided in the policy and admitted that Service Life would have paid for Pam's coverage if she had stayed at Methodist after August 17, 1987.

[**146] It is clear from the evidence presented to us that the eighth-floor rehabilitation center at Immanuel meets the criteria of the policy definition of "hospital": It is legally operated for the care and treatment of sick and injured persons on an inpatient basis; it is primarily engaged in providing medical, diagnostic, and major surgical facilities on its own premises; it has continuous 24-hour nursing services; and it has a staff of doctors available at all times.

When Pam was transferred to Immanuel, she was still in need of acute medical care in order to keep her alive. Any rehabilitative care which she received at Immanuel was incidental [***8] to the acute hospital care necessary to avoid the life-threatening complications she faced as a result of the spinal cord injury and paralysis. She received the services while she was a pa-

tient on a particular floor of a hospital which met the requirements of the hospital definition in the insurance policy. A hospital, by any other name, still provides acute medical care, and Pam received acute medical care at Immanuel. It follows that Immanuel qualifies as a hospital under the policy definition.

We must reconcile the provisions of the insurance policy. In doing so, we are asked if Pam was primarily rendered rehabilitative care in a facility which has coincidentally been named a "rehabilitation center." Our answer is no. At Immanuel, Pam received primarily acute care for treatment of her paralyzed bowel and bladder and of multiple urinary tract infections, for prevention of skin ulcers and stress ulcers and of blood clotting in her legs, for regulation of her blood pressure, and for observation of possible later developing occult head injuries.

The care received at Immanuel was care received in a hospital as it is defined in the policy. The trial court's finding was in error, [***9] and we reverse and remand for further proceedings.

Reversed and remanded for further proceedings.

APPENDIX E



STEPHEN B. TAYLOR and MOSS REHABILITATION HOSPITAL v. PHOENIX
MUTUAL LIFE INSURANCE COMPANY

Civil Action No. 77-1322

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF
PENNSYLVANIA

453 F. Supp. 372; 1978 U.S. Dist. LEXIS 17499

May 30, 1978

COUNSEL: [**1] A. Grant Sprecher, Esq., Philadelphia, Pennsylvania, For Plaintiffs.

William H. Lowery, Esq., Phila. Pennsylvania, For Defendant.

JUDGES: Troutman, J.

OPINION BY: TROUTMAN

OPINION

[*373] MEMORANDUM AND ORDER
TROUTMAN, J.

Plaintiff, Stephen B. Taylor, (Taylor) is an individual who was severely injured in a motorcycle accident on October 6, 1974, as the result of which he fractured his spine and is today confined to a wheelchair. He was hospitalized at Chestnut Hill Hospital from the date of accident until November 27, 1974, when he was transferred to Moss Rehabilitation Hospital (Moss), also a plaintiff herein, where bills were incurred in the amount of approximately \$12,000.00 for which recovery is sought under a group insurance policy issued by the defendant, Phoenix Mutual Life Insurance Company (Phoenix) to the Trustees of Service Industry Group Service Fund, of which Taylor Exterminating Company, the employer of Stephen B. Taylor, was a member at the time of his unfortunate injury.

Based upon a seventeen-page stipulation of facts, consisting of seventy-two paragraphs, plus certain supplemental affidavits and other exhibits, presenting all relevant and material facts to the Court, [**2] both the

plaintiffs and the defendant, respectively, seek partial summary judgment.

In construing and interpreting the policy, the insurance contract involved, certain established legal principles are applicable. Insurance contracts are contracts of adhesion, where the insurer prepares the policy for the purchaser having no bargaining power. Where a dispute arises, such contracts are construed strictly against the insurer. *Hionis v. Northern Mutual Insurance Company*, 230 Pa. Super. 511, 327 A. 2d 363 (1974). If a defense is based upon an exception or an exclusion in a policy, the defense is an affirmative one and the burden is on the defendant to establish it. *Weissman v. Prashker*, 405 Pa. 226, 175 A. 2d 63 (1961).

Furthermore, an insurance contract will be given a reasonable interpretation in light of the particular subject-matter, situation and contemplation of the parties. *Dabulos v. Commercial Insurance Company of Newark, New Jersey*, 381 F. Supp. 393 (E.D. Pa. 1974), affirmed, 521 F.2d 18 (3rd Cir. 1975). Pennsylvania courts will rely on public policy in overriding explicit terms in the insurance contract, at least when the contract terms would operate to [**3] defeat the reasonable expectations of the insured. *Sands v. Granite Mutual Insurance Co.*, 232 Pa. Super. 70, 331 A. 2d 711 (1974).

While it is true that where a doubt exists as to the meaning of the language in an insurance contract such language is construed in favor of the insured, it is also true that where the language of the policy is clear and unambiguous, it cannot be construed to mean other than what it says. Such clear language must be given the plain and ordinary meaning of the terms. Where there is no ambiguity or lack of clarity, the law does not permit looking beyond the language of the contract. *South-*

eastern Pennsylvania Transp. Auth. v. Transit Casualty Co., 412 F. Supp. 839 (E.D. Pa. 1976).

The sole issue before the Court is whether Moss is a "hospital" within the definition of that term as used in the group policy issued and whether Moss is, accordingly, entitled to reimbursement for the cost of services rendered to Taylor by Moss during his stay at Moss from November 27, 1974, to March 20, 1975. In reaching its decision the Court will consider the "stipulation of facts" filed by the parties, and various affidavits, depositions and other exhibits called [**4] to the attention of the Court in full and complete memoranda submitted to the Court by counsel in support of the motions filed. Not at issue at this time are allegations that an insurance agent misrepresented to Taylor the extent of the coverage.

[*374] Pertinent to the factual considerations involved and supplementing the stipulation of facts, we quote from pages 3 and 4 of plaintiffs' brief as follows:

"Plaintiffs, in addition to the Stipulation of Facts attached hereto as Exhibit 'A' the affidavits of James R. Neely of the Hospital Association of Pennsylvania which indicates that Moss would be classified by HAP as a short term hospital if their average patient stay was, today, less than thirty days, a fact which has been stipulated to in paragraph 50 of the Stipulation.

"Stephen B. Taylor's physician at Moss was Doctor LaFontant, whose affidavit is attached hereto as Exhibit 'B'. Doctor LaFontant affirms that the treatment received by Taylor at Moss was necessary not only to resolve existing medical problems at admission, including bed sores and a bladder infection, but also was medically necessary to prevent Mr. Taylor's certain lapse into acute medical distress. The [**5] parties have, in this regard, stipulated to the improvement of Taylor's overall physical condition at Moss as the result of his treatment.

"In summary Taylor was severely injured in a motorcycle accident on October 6, 1974 as the result of which he fractured his spine, lost the use of his legs, and is today confined to a wheelchair. He was hospitalized at Chestnut Hill Hospital from October 6, 1974 until November 27, 1974 when he was transferred directly to Moss for further treatment until March 20, 1975.

"At the time of his transfer to Moss, Taylor's overall condition had stabilized though he was afflicted with bed sores, a bladder infection and phlebitis. Mr. Taylor was completely bedridden at the time of his transfer, was catheterized and incontinent. During his stay at Moss Mr. Taylor was cured of his bed sores and bladder infection - which required a cystoscopic examination at Moss. Additionally Taylor was taught to move himself into a wheelchair and to otherwise attend to his personal needs. Services including occupational therapy, physical therapy, psychological counseling and testing were provided to Taylor. Upon his admission Taylor assigned his rights under Phoenix's [**6] policy to Moss."

Likewise supplementing the stipulation are the following facts also called to the Court's attention by the defendant:

"Taylor was hospitalized at Chestnut Hill Hospital immediately after his accident, and during his stay there he had neurosurgery performed on his spine. Taylor remained in Chestnut Hill Hospital from October 6, 1974, through November 27, 1974. Taylor was then moved to Moss because he needed, in his own words, '(rehabilitation), just to show me how to get around again'. (Stephen Taylor Depos. at 7). Taylor remained at Moss from November 27, 1974, to March 20, 1975. During his stay at Moss, Taylor received incidental medical attention; but he was in Moss primarily for rehabilitative care. At Moss, Taylor learned how to get out of bed, get dressed, to cook, and 'just more or less how to take care of myself again.' (Stephen Taylor Depos. at 8-9) Even Taylor's family realized that the bladder and phlebitis treatment he received at Moss could have been handled in Chestnut Hill Hospital and that 'the primary purpose for being transferred to Moss was (so) that he could get rehabilitative care . . .' (Joan Taylor Depos. at 30-31) After his release [**7] from Moss on March 20, 1975, Taylor continued to incur medical expenses. In 1977 he underwent spinal fusion surgery at St.

Francis Hospital in Wilmington, Delaware.

"Phoenix has already paid for the hospitalization charges at Chestnut Hill and at St. Francis, as well as for a great deal of other medical expenses. (Stipulation, PP64, 71, 72 and Joan Taylor Depos. at 32). Phoenix has not paid for Taylor's expenses while at Moss. Phoenix does not believe that Moss is a hospital covered by Taylor's policy; and the parties have stipulated that Moss is classified not as a short-term general hospital, but rather as a long-term specialty hospital [*375] which performs no surgery and is primarily a place for rehabilitative care. (Stipulation, PP4, 32, 35, 52, 54, and 61)."

The definition of the term "hospital" as used in the policy is found in paragraph 70 of the stipulation of facts as follows:

"RELEVANT POLICY PROVISIONS

"COVERED EXPENSES

Covered expenses are the reasonable charges for such of the following services and supplies as are recommended or approved by a physician, surgeon or dentist as essential for the necessary treatment of a Covered Person's injury or [**8] sickness for which insurance is afforded hereunder, provided that a charge shall be deemed unreasonable if it exceeds the prevailing average charge (as determined by Phoenix Mutual) for the particular treatment, care, service, or supply made in the locality where the treatment, care, service or supply was received, taking into consideration the nature and severity of the injury or sickness in connection with which such charge was made:

"(1) Hospital Charges:
Charges made by a hospital, in its own behalf, . . .

"DEFINITIONS . . .

'Hospital' means an institution which is engaged primarily in providing medical care and treatment to sick and injured

persons on an in-patient basis and which fully meets all the requirements set forth in (1) or (2) below:

"(1) It is a short term, acute, general hospital which (a) is primarily engaged in providing by or under the continuous supervision of physicians, to in-patients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons, (b) has organized departments of medicine and major surgery, (c) has a requirement that every patient must be under the care of a physician or dentist, [**9] (d) provides twenty-four hour nursing service by or under the supervision of a registered professional nurse (R.N.), (e) has in effect a hospital utilization review plan meeting the standards set forth in section 1861(k) of United States Public Law 89-97 (Medicare) as amended from time to time, (f) is duly licensed by the agency responsible for licensing such hospitals, and (g) is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, education or rehabilitative care.

"(2) It is a psychiatric hospital as defined by Medicare, qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare . . ."

Although we have considered the entire stipulation, particularly pertinent to our considerations are the following paragraphs thereof:

"1. Moss Rehabilitation Hospital requires that every patient be under the continuous supervision of a physician or dentist.

"2. Moss Rehabilitation Hospital provides twenty-four hour nursing service by or under the supervision of a registered professional nurse (R.N.).

"3. Moss Rehabilitation Hospital [**10] has in effect a 'utilization review plan' meeting the standards set forth in Section 1861(k) of the United States Public Law 89-97 (Medicare).

"4. Moss Rehabilitation Hospital is primarily a place for rehabilitative care. (This stipulation does not contain a definition of 'rehabilitative care'.) Moss Rehabilitation Hospital provides diagnostic and therapeutic services to patients. If a patient who is confined for rehabilitative care has or develops conditions which require diagnostic and therapeutic services, these services are either provided at Moss Rehabilitation Hospital or the patients are transferred elsewhere for treatment.

"5. Moss Rehabilitation Hospital is not a place, except incidentally, for rest, a place for the aged, a place for convalescent care, or a place for custodial care.

"6. If a patient who is admitted to Moss Rehabilitation Hospital for rehabilitative [*376] care has or develops an acute illness, a diagnosis is made at Moss Rehabilitation Hospital and appropriate treatment is ordered, which treatment may consist of transfer to another institution.

"7. Moss Rehabilitation Hospital and Albert Einstein Medical Center ("Einstein"), a short-term, acute [**11] care, general hospital, are separate corporate entities, have their facilities on adjoining parcels of real estate, and are physically connected by means of a corridor. The real estate on which Moss Rehabilitation Hospital is situated is owned by Einstein and leased to Moss Rehabilitation Hospital by Einstein.

"9. Some patients who are admitted to Moss Rehabilitation Hospital for rehabilitative care may subsequently require surgery. Those requiring surgery may receive it at Einstein or may receive it at some other acute care, general hospital. If they receive surgery at some other hospital, they are discharged to that hospital. If they receive surgery at Einstein, they are discharged to Einstein if they remain there for post-operative recovery or treatment. If they receive surgery at Einstein and are returned the same day to Moss Rehabilitation Hospital, they are not formally discharged from Moss Rehabilita-

tion Hospital. The patients of Moss Rehabilitation Hospital who are operated on at Einstein and who receive post-operative care at Moss Rehabilitation Hospital are billed by Moss Rehabilitation Hospital for the surgery.

"11. Members of the staff of Einstein [**12] are accorded associate staff privileges at Moss Rehabilitation Hospital upon request. (Jeanes Hospital and the American Oncologic Hospital have a similar arrangement.) The Statement of Relationships referred to above provides that the physicians on the staff of Einstein have the privilege of admitting patients to Moss Rehabilitation Hospital and Willowcrest. It is a common practice for physicians on the medical staff of an acute care, general hospital, who are also on the staff of a specialty hospital or an extended care facility, to admit patients to these specialty hospitals or to extended care facilities. The Medical Staff of Moss Rehabilitation Hospital is selected by Moss Rehabilitation Hospital in accordance with its bylaws. There are three categories of staff membership at Moss Rehabilitation Hospital -- active, associate, and honorary. The members of the associate staff must be members of the staff of Einstein or of another affiliated hospital.

"22. Moss Rehabilitation Hospital was incorporated in Pennsylvania on July 17, 1959, 'to provide rehabilitation and medical care for chronically ill persons'.

"26. Bylaws of Moss Rehabilitation Hospital set forth [**13] that the purpose of the corporation is 'to provide physical restoration services for disabled and chronically ill persons through an integrated program of medical, psychological, social and vocational services under competent professional supervision.'

"27. Moss Rehabilitation Hospital is a totally separate corporate entity from Einstein; Moss Rehabilitation Hospital receives none of its operating or other funds from Einstein; the two institutions have separate Boards of Directors with no interlock; and the two institutions have separate Medical Staffs, with each staff organized under separate Staff Bylaws. *See also* No. 11 above.

"29. Hospitals are also classified as either (a) short-term acute care hospitals or (b) long-term care hospitals. Short-term acute care hospitals treat patients for diseases or conditions that ordinarily require hospitalization for appreciably shorter periods of time than that required in a long-term care hospital.

"30. Einstein is a general hospital rendering short-term, acute care for patients.

* * *

"32. Moss Rehabilitation Hospital is a specialty hospital rendering rehabilitative care for its patients.

[*377] "33. Short-term, [**14] acute care, general hospitals have organized departments of medicine and surgery.

"34. Moss Rehabilitation Hospital has no department of medicine or surgery. Rather, as stated in its Staff Bylaws:

"As the Hospital is a specialized hospital to which all patients are admitted for the purpose of rehabilitation, the customary medical departmentalization of a general hospital does not apply as an organizational form.'

"Thus Moss Rehabilitation Hospital is organized in a single department called 'Rehabilitation Medicine'. However, the Moss Rehabilitation Hospital active and associate staffs together include members from sub-specialties of medicine.

"35. Moss Rehabilitation Hospital has no emergency room and performs no surgery.

"36. Moss Rehabilitation Hospital would not admit someone who was suffering a heart attack.

* * *

"39. Moss Rehabilitation Hospital is a place where patients go primarily for rehabilitative care, which care is designed to restore a patient to his maximum function.

"40. At Moss Rehabilitation Hospital:

"The Medical Director (is) responsible for the clinical organization of the Hospital and for the supervision of professional therapeutic [**15] departments, i.e., physical therapy, occupational therapy, speech therapy, psychology, social service, etc.'

Some of the psychological services and occupational therapy rendered to patients includes psychological counseling, psychological testing, and vocational evaluation.

"41. Most of the services referred to in No. 40 above are not offered patients in the average short-term acute care, general hospital.

"42. Plaintiff Stephen B. Taylor, while a patient at Moss Rehabilitation Hospital, received services, including treatment, from substantially all the therapists referred to in No. 40 above.

* * *

"47. On the basis of information provided by the hospitals themselves, the American Hospital Association (AHA), the national organization for all hospitals in the United States, classifies Moss Rehabilitation Hospital for purposes of service to patients as a rehabilitation facility, and not as a medical and surgical facility.

* * *

"49. The AHA classifies a hospital as either long-term or short-term depending on whether the average length of stay of more than 50% of its patients is 30 days or more, in which event it is classified as a long-term hospital.

"50. The average [**16] length of stay of patients at Moss Rehabilitation Hospital is 28 days, and under the AHA method of classification, Moss Rehabilitation Hospital is classified as a short-term hospital.

"51. The average length of stay of patients at acute care, general hospitals in the Philadelphia area, according to the Delaware Valley Hospital Council, is approximately 8.5 days.

"52. On the basis of information provided by the hospitals themselves and verified by the Association, the Hospital Association of Pennsylvania (HAP), the statewide organization for hospitals in Pennsylvania, classifies Moss Rehabilitation Hospital as a long-term rehabilitation hospital; but HAP does not define 'long-term' in relation to the particular number of days for the average length of stay. The parties hereto do not know what specific criteria HAP utilizes to classify hospitals on the basis of information provided by those hospitals.

* * *

"54. On the basis of information provided by the hospitals themselves, the Delaware Valley Hospital Council (DVHC), the organization of all hospitals in the Greater Philadelphia Area, classifies Moss Rehabilitation Hospital as a long-term, specialty (rehabilitation) hospital; [**17] but the DVHC does not define 'long-term' in relation to the particular number of days for the average length of stay. The parties hereto do not know what specific criteria DVHC utilizes [*378] to classify hos-

pitals on the basis of information provided by those hospitals.

* * *

"61. On the basis of surveys, the Regional Comprehensive Health Planning Agency (RCHP), which succeeded to the planning responsibilities of HSC, classifies Moss Rehabilitation Hospital as a long-term, specialty (rehabilitation) hospital.

* * *

Referring specifically to the definition of the term "hospital" as used in the policy and quoted in paragraph 70 of the stipulation, supra, it will be noted that the policy expressly lists eight criteria which an institution must satisfy to qualify as a "hospital" and thus qualify for policy coverage. The hospital must:

1. Be a short-term, acute general hospital; and
2. Be primarily engaged in providing diagnostic and therapeutic service to in-patients under the continuous supervision of physicians; and
3. Have organized departments of medicine and major surgery; and
4. Have every patient under the care of a physician; and
5. Have twenty-four hour [**18] nursing service under the supervision of a registered nurse (R.N.); and
6. Have a hospital utilization review plan meeting the standards set forth in Section 1861(k) of United States Public Law 89-97 (Medicare); and
7. Be duly licensed; and
8. Not be, "other than incidentally", a place for the aged, drug addicts, alcoholics, rest, convalescence, or custodial, educational or rehabilitative care.

The defendant concedes that Moss meets criteria 2, 4, 5, 6, and 7. It denies that criteria 1, 3 and 8 are met.

In considering the issues thus raised it should be noted that while the parties have agreed upon the long and involved stipulation, requiring a great deal of study, research, effort, and patience, all in an effort to ease the Court's task, they have then proceeded to complicate the task by forthwith diluting the stipulation with affidavits and other exhibits varying some natural inferences flowing from the stipulation and basing conflicting arguments thereon.

For example, considering criterion 1, the defendant, notwithstanding paragraphs 49, 50 and 51 of the stipulation which suggest that Moss is a "short-term" hospital because the average length of stay is less than 30 [**19]

days, contends, on the basis of its Exhibit 2, that during the relevant period 1974-1975, the average length of stay was 30 days and that Moss was, therefore, a "long-term" hospital. ¹ We are reluctant to consider such statistical data dehors the record in determining the "long-term, short-term" issue. Rather on the basis of the stipulation we conclude that Moss qualifies as "short-term" within the terms of the policy.

1 Plaintiffs have also diluted the stipulation by submitting various affidavits.

However, it does not, in our opinion meet the "acute" requirements of the policy. Paragraph 32 of the stipulation recognizes that Moss renders "rehabilitative care for its patients". Obviously, "rehabilitative" care is at the opposite end of the spectrum from "acute" care. "Acute" care suggests a crisis or the need for immediate care and attention, whereas "rehabilitative" care suggests long-term treatment or care designed to restore a patient to his or her former capacity, usually requiring less specialized [**20] medical skills of longer duration, although of no less importance to the patient. Illustrating that Moss does not meet the "acute" requirement are paragraphs 35 and 36 of the stipulation stating that Moss "has no emergency room" and would not accept a patient "suffering a heart attack". Thus, we conclude that Moss does not meet the "acute" requirement of criterion 1.

Additionally, criterion 1 requires that the institution be a "general" hospital, whereas paragraph 32 of the stipulation states that Moss is a "specialty" hospital "rendering rehabilitative care". Therefore, assuming that Moss is a "long-term" hospital as contended by plaintiffs, it is not an "acute, [*379] general hospital" as required by the definitional terms of the policy.

Criterion 3 unequivocally requires that Moss have organized departments of medicine and major surgery. Paragraph 34 of the stipulation states that Moss "has no department of medicine or surgery" much less "organized" departments in those specified fields. Such clear and unequivocal language should quickly and conclusively resolve the issue. Not so. Plaintiffs contend that Moss qualifies under the terms of the policy because while "organized [**21] in a single department called 'Rehabilitation Medicine' with active and associate staffs including members from sub-specialties of medicine" (plaintiffs' brief, page 22) and while no surgery is performed at Moss, its patients receive surgery and other required services at the Albert Einstein Medical Center (Einstein), which is physically connected by a corridor to Moss Rehabilitation Hospital." Moss and Einstein have a written statement of relationships coordinating their facilities and services at Einstein when not available at Moss. Plaintiffs rely upon cases such as *Reserve Life Insurance Company v. Marr*, 254 F.2d 289 (9th Cir.

1958); *Reserve Life Insurance Company v. Mattocks*, 6 *Ariz. App.* 450, 433 P. 2d 303 (1967); *Raynor v. American Heritage Life Insurance Co.*, 123 *Ga. App.* 247, 180 S.E. 2d 248 (1971); *McKinney v. American Security Life Insurance Co.*, 76 So. 2d 630 (*La. App.* 1955); *Meyers v. Aetna Life Insurance Company*, 39 Pa. D. & C. 2d 1, affirmed, 207 Pa. Super. 526, 218 A.2d 851 (1966). Relying upon such cases, plaintiffs contend that even though Moss is not departmentalized and does not, in its facilities, provide the services in question, such [**22] services are provided through its affiliation with Einstein. They thus contend that Moss varies only "in its organizational form" and, therefore, in fact, meets the requirements of the policy.

All this temptingly leads far afield from the real issue. The question is not what services were rendered, the quality thereof, how they were rendered, by whom they were rendered or the organizational background making such services possible at this institution. The issue is whether Moss is a "hospital" within the meaning of that term as defined by the policy. However, a field trip cannot be avoided if one is to follow the cases upon which plaintiffs rely because in none of those cases were the definitional provisions of the policy the same as those here involved nor were they as clear and precise. For example, as defendant points out, in *Meyers* the policy provided:

"The term 'hospital' means only an institution which is engaged primarily in providing, for compensation from its patients, facilities for diagnosis and treatment of bed patients under the supervision of a staff of doctors and which provides the services of registered nurses (R.N.) 24 hours a day. (39 D & C 2d at 3). [**23]

"* * * the policy in *Meyers* contained no limitation to short-term general hospitals, no requirement of major surgical facilities, and no clause excluding institutions designed primarily for rehabilitative care."

For example, in *Marr* the Court stated:

"There is no requirement in the policies that the insured be confined in a 'general' hospital, nor is there any exclusion from the term 'hospital' of a psychiatric or nursing hospital * * *". (254 F.2d at 290)

Here, the policy contains positive requirements that the "hospital" be a "general" hospital, not primarily devoted to rehabilitative care. Thus, *Marr* is not controlling. For similar reasons other authorities cited and relied upon by plaintiffs are distinguishable or otherwise not controlling and we decline to follow them.

We are thus brought to criterion 8 requiring that "hospital" as defined in the policy not be "other than incidentally" a place for the aged, drug addicts, alcoholics, rest, convalescence or custodial, educational or rehabilitative care. Common sense dictates that any institution dealing with the acute illnesses of the human body must necessarily engage in a certain amount of "rehabilitative [**24] care". Full recovery requires both acute care and rehabilitative care. Some institutions are necessarily designed primarily [*380] to provide rehabilitative care and it is this type of institution that is not included within the policy here involved. Not excluded is the rehabilitative care which necessarily follows acute treatment and is "incidental" thereto. Both types of institution are desirable and necessary. Insurance policies can be and are written to cover either or both. In the policy here involved "rehabilitative" care other than that "incidental" to acute care is clearly excluded. Turning again to the stipulation of facts, and particularly paragraph 4 thereof, we find "Moss Rehabilitation Hospital is primarily a place for rehabilitative care. (This stipulation does not contain a definition of 'rehabilitative care')."

Plaintiffs stress, by affidavit, that the plaintiff Taylor received specialized treatment at Moss in excess of that normally included in "rehabilitative care" and thus contend that coverage exists. The defendant counters with other evidence such as the deposition of the plaintiff Taylor. Thus, both parties dilute or supplement the stipulation of [**25] facts. The Court's task is thus complicated. However, the resulting conflicts do not relate to material facts precluding the proper consideration of the cross-motions for partial summary judgment here filed. Accordingly, on the basis of the entire record before us and giving due consideration to the able presentation of counsel, we conclude that Moss was, as the stipulation unequivocally stated, "primarily a place for rehabilitative care" and, therefore, did not meet criterion 8.

Finally, plaintiffs urge that public policy requires that defendant provide reimbursement to Moss for the hospitalization of the plaintiff Taylor. Considering Taylor's serious and permanent condition and the cost of treatment and rehabilitation, natural feelings and instincts dictate that every effort be made to ease his burdens. But public policy does not so dictate. Rather, public policy dictates that legitimate and unambiguous contracts entered into without fraud, duress, coercion or improper conduct shall be fairly interpreted and enforced.

In *Pennsylvania Manufacturers' Association Insurance Company v. Aetna Casualty and Surety Insurance Company*, 426 Pa. 453, 233 A.2d 548 (1967), the Court, [**26] in affirming a judgment on the pleadings on the definition of "insured", quoted approvingly from *Topkis v. Rosenzweig*, 333 Pa. 529, 5 A.2d 100 (1939):

"It is settled that where the language of the policy is clear and unambiguous it cannot be construed to mean otherwise than what it says." (426 Pa. at 457).

Other authorities agree. Volume 1 of *Couch on Insurance* 2d § 15:37 states:

"It is the duty of the courts in interpreting insurance contracts to enforce and carry out the contract which the parties have made, without importing anything into the contract by construction contrary to its express terms, or the plain meaning of its terms, or attempting to make a better or different contract If the terms of the contract are clear and express, the courts cannot extend or enlarge the contract by implication or construction so as to embrace a risk, object, or limitation distinct from that originally contemplated and not included in the express provisions." (1 *Couch* at 709-11)

It is a recognized principle of law that:

"Insurance companies have the same rights as individuals to limit their liability and to impose whatever conditions they please upon [**27] their obligations, not inconsistent with public policy or statutory provisions." (2 *Couch on Insurance* § 19:64, at 204)

There are a multitude of types of insurance, each with its own unique provisions, coverage rates and protected risks. The consumer is free to contract for the insurance he wants, but he is not free to expect that because he has an insurance policy, he is protected against all risks.

Regrettably, the treatment at Moss was not covered by the policy here involved. The extended and persuasive arguments advanced by plaintiffs' counsel must fail in the face of the clear and precise provisions of the policy.

[*381] We shall grant defendant's motion for partial summary judgment and deny plaintiffs' motion for partial summary judgment.

ORDER

TROUTMAN, J.

AND NOW, this 26th day of May, 1978, IT IS ORDERED that plaintiffs' motion for summary judgment is DENIED; IT IS FURTHER ORDERED that defendant's motion for summary judgment is GRANTED.