

76365-2

No. 96516-1

76365-2

No. 76365-2-I

IN THE COURT OF APPEALS – DIVISION I
OF THE STATE OF WASHINGTON

FILED
May 2, 2017
Court of Appeals
Division I
State of Washington

GROUP HEALTH COOPERATIVE,
a Washington non-profit corporation,

Plaintiff/Respondent,

vs.

NATHANIEL COON and LORI COON,
husband and wife,

Defendant/Appellant.

APPEAL FROM THE SNOHOMISH COUNTY SUPERIOR COURT
Honorable George F.B. Appel, Judge

BRIEF OF RESPONDENT

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A. INTRODUCTION

Group Health Cooperative paid \$372,634.07 for medical expenses arising from treatment Appellant Nathaniel Coon received from The Everett Clinic pursuant to Appellants' Medical Coverage Agreement with Group Health ("Agreement"). When Appellants claimed The Everett Clinic committed medical malpractice, Group Health notified Appellants of its subrogation lien in the amount of the medical expenses it had paid.

Appellants had no evidence that The Everett Clinic breached its duty of care or that it had caused Appellant's injury, so they voluntarily settled the claim for less than policy limits and released all claims against The Everett Clinic without prior notice to Group Health. By settling, Appellants breached express subrogation terms of their Agreement with Group Health by failing to notify Group Health before settling, by releasing all claims against The Everett Clinic, and by failing to protect Group Health's subrogation interest. Claiming they were not "made whole," Appellants then further breached the Agreement by disbursing funds in the amount of Group Health's subrogation interest rather than holding the disputed funds in trust pending resolution of Group Health's claim.

Appellants are barred from enforcing a contract they have materially breached. And, because Appellant's injuries were not

“compensable,” (i.e., Appellants had no basis in tort or contract for recovery), the “made whole” doctrine does not apply and Appellants bear the risk of loss. Regardless, by choosing to settle for less than policy limits in a case they could not win much less file suit on, Appellants received not only full compensation but a windfall settlement. Consequently, Group Health is entitled to reimbursement of its subrogation lien in full, plus interest, as a matter of law, and the trial court’s order granting summary judgment to Group Health should be affirmed.

B. SUMMARY OF THE ISSUES

1. Is this appeal moot when the trial court entered an order concluding that Appellants breached the parties’ agreement and Appellants did not appeal that order?

2. Was Summary Judgment for Group Health proper because Appellants materially breached the parties’ Agreement by failing to notify Group Health before settling their claim, by releasing all claims against The Everett Clinic, by failing to protect Group Health’s subrogation interest, and by disbursing disputed funds rather than holding them in trust?

3. Was Summary Judgment for Group Health proper because the made whole doctrine does not apply when Appellant’s injury was not

compensable, Appellants had no viable theory of liability, and Appellants settled for less than policy limits?

4. Was Summary Judgment for Group Health proper because Appellants were fully compensated when there was an adequate pool of funds to satisfy their claim of damages and they settled for less than policy limits because they had no viable cause of action?

C. STATEMENT OF THE CASE

Group Health Cooperative¹ (“Group Health”) provided medical coverage to Appellants through a Medical Coverage Agreement. Clerk’s Papers (CP) 409-458. When Appellant Nathaniel Coon incurred medical expenses arising from treatment provided by The Everett Clinic, Group Health paid \$372,634.07 on his behalf. CP 288.

Appellants subsequently alleged The Everett Clinic committed medical malpractice regarding a fungal infection Appellant developed after undergoing knee surgery. CP 142. Group Health notified Appellants of its contractual subrogation claim for \$372,634.07. CP 288. The Medical Coverage Agreement required Appellants to reimburse Group Health for the benefits it provided in this matter from any amount Appellants received from The Everett Clinic by settlement:

¹ Group Health Cooperative is now known as Kaiser Permanente; however, for the purposes of this appeal Respondent will be referred to as Group Health Cooperative or Group Health.

B. Subrogation and Reimbursement Rights

The benefits under this Agreement will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this Agreement. If GHO² provides benefits under this Agreement for the treatment of the injury or illness, GHO will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness and the Member shall reimburse GHO for all benefits provided, from any amounts the Member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise.

CP 343.

Appellant could not identify the source of the fungal infection or produce evidence that The Everett Clinic breached its standard of care or caused the infection. CP 145, 158-59, 172, 253. One of Appellants' two damages experts did "not believe that a plaintiff's verdict was even possible" due to Defendants' lack of evidence of liability. CP 102. He opined, "Based upon the nature and cause of Mr. Coon's infection and ultimate AKA, the prospects for a plaintiff's verdict, had this case been litigated, truly approached 0%." CP 100. Appellants' other damages expert opined that she "did not find any evidence that the Everett Clinic breached the standard of care." CP 114. With no theory of liability and no evidence to prevail on a claim for medical malpractice, Appellants' counsel stated, "As an attorney, I could not ethically file such a lawsuit." CP 285.

² In the Plan, Group Health is referred to as "GHO."

Despite having no viable theory of liability, Appellants settled with and fully released The Everett Clinic for \$2 million, which was less than policy limits, at pre-litigation mediation without first notifying Group Health. CP 253. The Appellants' Medical Coverage Agreement required Appellants to notify Group Health of any tentative settlement and prohibited Appellants from prejudicing Group Health's subrogation and reimbursement rights:

The Injured Person and his/her agents shall do nothing to prejudice GHO's subrogation and reimbursement rights. *The Injured Person shall promptly notify GHO of any tentative settlement with a third party and shall not settle a claim without protecting GHO's interest.* If the Injured Person fails to cooperate fully with GHO in recovery of GHO's Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHO for 100% of GHO's Medical Expenses.

CP at 343 (emphasis added).

Appellants requested that Group Health waive its subrogation interest, claiming they had not been "made whole." CP 253. Group Health declined the request. CP 283. Disputed funds were nevertheless disbursed to Appellants³ in further violation of the parties' Agreement, which required that such funds be held in trust until Group Health's subrogation and reimbursement rights were fully determined:

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to

³ CP 281.

hold such monies in trust or in a separate identifiable account until GHO's subrogation and reimbursement rights are fully determined and that GHO has an equitable lien over such monies to the full extent of GHO's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of GHO's Medical Expenses.

CP 343.

Group Health sued Appellants for declaratory relief and a determination that it had a valid and enforceable subrogation claim and was entitled to judgment against Appellants in the amount of the subrogation claim. CP 492-96. Group Health prevailed on cross-motions for summary judgment. CP 509-13⁴. And it was awarded judgment against Appellants in the amount of \$372,634.07, plus pre-judgment and post-judgment interest. CP 4-5. Appellants appeal only the order granting Group Health's motion for summary judgment. CP 1-9, 506-13.

D. ARGUMENT

1. This appeal is moot because the trial court entered an order concluding that Appellants breached the Medical Coverage Agreement and Appellants did not appeal that order.

The trial court's Order Denying Defendants' Motion for Summary Judgment concludes that Appellants breached the parties' Medical Coverage Agreement. That order was not appealed. Appellants now seek to enforce terms of the Agreement they breached, which they cannot do. Therefore, this appeal is moot.

An appellate court will dismiss a case if it is moot. RAP 18.9(c).
“A case is moot when it involves only abstract propositions or questions, the substantial questions in the trial court no longer exist, or a court can no longer provide effective relief.” *Spokane Research & Def. Fund v. City of Spokane*, 155 Wn.2d 89, 99, 117 P.3d 1117 (2005).

The substantial question in the trial court is whether Group Health is entitled to reimbursement of its subrogation lien by Appellants. The parties’ Medical Coverage Agreement states that Appellants must reimburse Group Health for 100% of the medical expenses it paid for failing to cooperate with Group Health in recovering its subrogation lien:

If the Injured Person fails to cooperate fully with GHO in recovery of GHO’s Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHO for 100% of GHO’s Medical Expenses.

CP at 343. Appellants breached the parties’ Agreement by entering a full and final settlement and release of all claims with The Everett Clinic without prior notice to Group Health, by settling with The Everett Clinic without protecting Group Health’s interest, by refusing to reimburse Group Health’s subrogation lien from the settlement funds, and by failing to hold disputed funds in trust until Group Health’s subrogation rights were fully determined. By breaching the Agreement in these ways, Appellants failed to cooperate fully with Group Health and are, therefore,

⁴ The Order Denying Defendant’s Motion for Summary Judgment has been requested in a

responsible for directly reimbursing Group Health for its entire subrogation claim.

In the trial court and this appeal, Appellants attempt to enforce a provision of the parties' Agreement that limits Group Health's subrogation rights "to the excess of the amount required to fully compensate the Injured Person for the loss sustained." CP at 343. However, Appellants materially breached the parties' insurance contract. And a party is barred from enforcing a contract that it has materially breached. *Rosen v. Ascentry Technologies, Inc.*, 143 Wn. App. 364, 369, 177 P.3d 765 (2008) (citing *Bailie Communications, Ltd. v. Trend Bus. Sys.*, 53 Wn. App. 77, 81, 765 P.2d 339 (1988)). Thus, the issues raised by Appellants are merely theoretical and can provide no substantive relief. This appeal should be dismissed as moot.

2. Summary Judgment for Group Health was properly granted because Appellants breached the Medical Coverage Agreement and the "made whole" doctrine does not apply.

Appellants challenge the trial court's order granting Group Health's motion for summary judgment on its declaratory relief claims that Group Health had a valid and enforceable subrogation claim and that it was entitled to declaratory judgment against Appellants in the amount of the subrogation claim. Summary judgment for Group Health should be affirmed.

An order granting summary judgment is reviewed de novo. *Cook v. USAA Cas. Ins. Co.*, 121 Wn. App. 844, 847, 90 P.3d 1154 (2004). Summary judgment is proper when “there is no genuine issue as to any material fact and ... the moving party is entitled to a judgment as a matter of law.” CR 56(c). “All facts and reasonable inferences are considered in the light most favorable to the nonmoving party.” *Liberty Mut. Ins. Co. v. Tripp*, 144 Wn.2d 1, 10, 25 P.3d 997 (2001) (quoting *Mountain Park Homeowners Ass'n v. Tydings*, 125 Wn.2d 337, 341, 883 P.2d 1383 (1994) (citations omitted)). Where no disputed material facts exist, the question is whether judgment is appropriate as a matter of law. *Cook*, 121 Wn. App. at 847.

Declaratory judgment actions are governed by the Uniform Declaratory Judgments Act (UDJA), chapter 7.24 RCW. The UDJA provides “[a] person interested under a . . . written contract . . . may have determined any question of construction or validity arising under the . . . contract . . . and obtain a declaration of rights, status or other legal relationship thereunder. RCW 7.24.020. Further, “[a] contract may be construed either before or after there has been a breach.” RCW 7.24.030.

Here, Group Health sued Appellants for a declaratory ruling that Group Health had a valid and enforceable subrogation claim under the parties’ Medical Coverage Agreement after Appellants failed to notify Group Health before settling its claim against and fully releasing The

Everett Clinic and after Appellants failed to hold the disputed funds in trust pending resolution of Group Health's subrogation claim.

a. The undisputed evidence shows Appellants breached the Medical Coverage Agreement and, as a result, are responsible for reimbursing Group Health for 100 percent of the medical expenses it paid.

The Medical Coverage Agreement issued by Group Health to the Appellants required Appellants to promptly notify Group Health of any *tentative* personal injury settlement with a third party. It also prohibited Appellants from settling their personal injury claim without protecting GHC's interest. Significantly, the Medical Coverage Agreement also required that Appellants hold any funds recovered from any source as compensation for medical injuries or expenses *in trust* or in a separate identifiable account until Group Health's subrogation and reimbursement rights could be fully determined.

Disregarding their obligations under the Medical Coverage Agreement, Appellants failed to cooperate with Group Health by (1) failing to notify Group Health of any tentative settlement prior to entering into it; and 2) failing to protect Group Health's subrogation interest when they released The Everett Clinic from "any and all liens and/or expenses incurred as a result of" Appellant Coon's injuries. CP at 255.

Once Appellants received the settlement funds, that portion representing Group Health's' subrogation claim was to be held in trust pending full resolution of the claim. It is undisputed that all settlement funds have been disbursed. And the trial court has concluded that Appellants breached the Medical Coverage Agreement in an unchallenged order that Appellants did not appeal.

The Agreement expressly provided that “[i]f the Injured Person fails to cooperate fully with GHO in recovery of GHO’s Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHO for 100% of GHO’s Medical Expenses.” CP at 343. Appellants breached their duties under the parties’ Agreement and obstructed Group Health’s recovery of its subrogation claim. Thus, as a matter of law, Group Health is entitled to reimbursement by the Appellants of 100 percent of the amount paid by Group Health for Appellant’s medical expenses.

b. Appellants must reimburse Group Health for medical expenses paid on their behalf pursuant to the doctrine of subrogation.

“Subrogation is an equitable doctrine the essential purpose of which is to provide for a proper allocation of payment responsibility.” *Mahler v. Szucs*, 135 Wn.2d 398, 411, 957 P.2d 632 (1998). The doctrine is “guided by the principle that *a party suffering compensable injury is*

entitled to be made whole but should not be allowed to duplicate his recovery.” *Thiringer v. Am. Motorists Ins. Co.*, 91 Wn.2d 215, 220, 588 P.2d 191 (1978) (emphasis added).

Washington case law provides that *Thiringer*’s “made whole” rule applies only when (1) the insured’s settlement exhausts the tortfeasor’s assets, or (2) a judge or arbitrator determines full compensation and the amount is reduced by contributory fault. *See, e.g., Id.* (“made whole” rule applied where settlement exhausted third party carrier’s policy); *Metropolitan Life v. Ritz*, 70 Wn.2d 317, 422 P.2d 790 (1967) (“made whole” rule did not apply where settlement did not exhaust tortfeasor’s assets); *Truong v. Allstate Property and Cas. Ins. Co.*, 151 Wn. App. 195, 211 P.3d 430 (2009) (“made whole” rule did not apply where settlement did not exhaust tortfeasor’s assets); *Sherry v. Financial Indem. Co.*, 132 Wn. App. 355, 131 P.3d 922 (2006) (“made whole” rule applied: arbitrator determined full compensation and amount awarded was less than arbitrator’s determination); *Cook*, 121 Wn. App. 844 (“made whole” rule did not apply because no liable third party); *Peterson v. Safeco Ins. Co. of Illinois*, 95 Wn. App. 254, 260, 976 P.2d 632 (1999) (question of full compensation does not arise until the assets, or at least those assets readily accessible through a liability policy, have been exhausted).

Muller v. Society Ins., 309 Wis.2d 410, 750 N.W.2d 410 (2008), a case from Wisconsin, best articulates the “made whole” doctrine as it is discussed and applied in Washington through *Thiringer* and its progeny.

Muller determined whether an insurer could retain in full a subrogation settlement after its insureds settled with the tortfeasor and the tortfeasor’s insurer for less than policy limits. *Id.* at 416. The *Muller* court concluded that the “made whole” doctrine did not apply and that the insurer was entitled to retain its subrogation settlement because the insurer and insured were not competing for an inadequate pool of funds. *Id.* at 417. The court so held even though the insureds unilaterally settled for less than policy limits and claimed they were not fully compensated for their loss. *Id.* at 424. The insurer preserved the insured’s right to be the first to receive available settlement funds. *Id.* at 426-27 (alteration added). And the insured’s settlement saved them the cost and work of proving their case in court, two resources they were reluctant to expend. *Id.* at 445–46, 448. The Court opined that granting any portion of the insurer’s subrogation recovery to the insureds under the circumstances would have negative consequences. *Id.*

From these facts, the *Muller* court succinctly stated that the “made whole” doctrine does not apply and equity favors the insurer’s right to satisfy its subrogation interest when (1) the insurer has paid under the contract; (2) the insurer has given the insured the opportunity to settle with

the third party; (3) the pool of available settlement funds is adequate to cover all claims; and (4) the insureds settle their claim even though the settlement is not enough to cover all alleged claims. *Id.* at 449.

Summary judgment for Group Health in this case is consistent with the “made whole” rule as set forth in *Muller* and as developed in the line of Washington cases cited above. Here, it is undisputed that Group Health paid Appellant’s medical expenses, that no liable tortfeasor exists, and that Appellants’ settlement did not exhaust The Everett Clinic’s assets. As this Court expressly stated in *Cook*, “The *Thiringer* full compensation rule has never been applied in situations where there was no liable third party.” 121 Wn. App. at 848. “[W]hen the insured has no basis in tort or contract for a recovery, such as in [Appellants’] situation, then *Thiringer* does not apply.” *Id.* at 849. Appellants did not have to settle. “If the gross settlement did not reflect what [Appellants], or [their] attorney, believed to be full compensation, then they had no obligation to accept it. They could have, instead, [litigated] to have the question of full compensation decided.” *Peterson*, 95 Wn. App. at 260.

Because the “made whole” rule does not apply, Appellants’ claimed “damages” and whether the settlement “fully compensated” Appellants are not material facts that control the outcome of this case. *See Dowler v. Clover Park Sch. Dist. No. 400*, 172 Wn.2d 471, 484, 258 P.3d 676 (2011) (defining genuine issue of material fact).

3. Even if the “made whole” rule applies, Appellants have been “made whole” by accepting a less-than-policy limits settlement for a claim that could not be ethically litigated instead of having damages determined by a fact finder.

Appellants erroneously argue that a genuine issue of material fact must exist because the fact of their settlement does not raise a *presumption* that they were “made whole.” Appellants maintain that existing Washington Supreme Court authority in *Liberty Mutual v. Tripp*, 144 Wn.2d 1, 25 P.3d 997 (2001), overrules *Peterson* and *Truong*⁵ to the extent these cases hold that settlement is evidence of full compensation.

Appellants misstate the holding in *Tripp*. The *Tripp* Court held only that a settlement for less than the tortfeasor’s policy limits does not raise a *presumption* of full compensation. *Id.* at 22. It did not hold that settlement for less than policy limits was not *evidence* of full compensation. *See id.*

Also, *Truong* did not rely on *Peterson* for the proposition that or conclude that proof of a settlement creates a *presumption* of full compensation. *Truong*, 141 Wn. App. at 205. Instead, *Truong* held that a settlement for less than the tortfeasor’s policy limits is *some evidence* (which is short of a presumption) that an insured has been fully compensated and that the insured must bring forth evidence to rebut the evidence of the settlement (pursuant to the summary judgment standard).

⁵ *Truong v. Allstate Property Cas. Ins. Co.*, 151 Wn. App. 195, 211 P.3d 430 (2009).

141 Wn. App. at 201, 205. Thus, *Peterson* and *Truong* are still good law for the proposition that settlement is *some evidence* of full compensation. In fact, the Washington State Supreme Court denied review of a case that relied on *Peterson* and *Truong* for the proposition that settlement is *some evidence* of full compensation. *King County v. Jones*, 179 Wn.2d 1016, 318 P.3d 280 (2014).

The issue in this case is whether Appellants produced evidence showing that they suffered *compensable damages*, that there was an inadequate pool of available settlement funds to cover all claims, and that a judge or arbitrator determined Appellants' damages. *See Thiringer*, 91 Wn.2d at 220. Appellants produced no such evidence and, as a result, failed to raise a genuine issue of material fact.

Appellants' attorney admitted Appellants had no viable theory of liability and no expert medical support to establish liability and/or causation against The Everett Clinic. Appellants' experts conceded that Appellants' damages were contingent upon a finding of liability, which all involved agree was impossible. Appellants could not ethically file suit against The Everett Clinic and did not have damages determined by a judge or an arbitrator. Instead, Appellants settled their claim for less than policy limits in an arms-length transaction, released The Everett Clinic from all medical liens, and promised to pay any such liens from the settlement proceeds. Given this, Appellants' evidence is insufficient to

rebut Group Health's evidence that Group Health has a valid subrogation lien and the right to satisfy that lien from Appellants' settlement proceeds. Reasonable minds can reach only one conclusion: Group Health is entitled to judgment as a matter of law.

E. CONCLUSION

For the reasons stated above, this appeal should be dismissed as moot or the trial court's order granting summary judgment in favor of Group Health for \$372,634.07 should be affirmed.

Respectfully submitted on May 1, 2017.



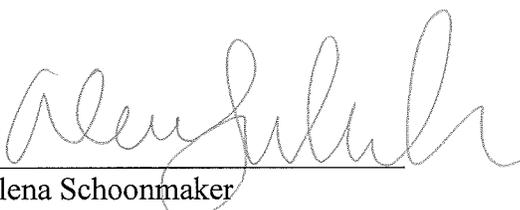
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PROOF OF SERVICE (RAP 18.5(b))

I, , do hereby certify under penalty of perjury that on May 1,
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