No. _____

Court of Appeals No. 74448-8-I

SUPREME COURT
OF THE STATE OF WASHINGTON

LEXINE OTEY, individually and on behalf of the class of similarly situated insureds,

Petitioner,

v.

GROUP HEALTH COOPERATIVE, a corporation,

Respondent.

PETITION FOR REVIEW

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IDENTITY OF PETITIONER, CITATION TO COURT OF APPEALS DECISION, & INTRODUCTION

Petitioner Lexine Otey seeks review of ***Otey v. Group Health Cooperative***, Washington State Court of Appeals No. 74448-8-I (May 15, 2017), and the Order Denying Reconsideration (June 16, 2017). The appellate court also denied publication on June 16, 2017.

Otey has healthcare insurance with Group Health (GHC) that includes coverage for inexpensive outpatient prescription drugs. Although GHC is charged between $3 and $5 for such drugs, it charges members like Otey between $13.60–$14.75 for them. GHC does not disclose its actual charge – or its profits – to its members.

Yet GHC's adhesion contract says that "Charges will be for **the lesser of** the Cost Shares for the Covered Service or the **actual charge** for that service. Cost Shares **will not exceed actual charge** for that service." "Cost Shares" are defined as the "**portion of the cost** of Covered Services for which the Member is liable."

The Court of Appeals, applying a novel analysis that conflicts with established precedent, held that the contract *unambiguously* allows GHC to secretly mark up such drugs, above the actual charge, reaping hidden profits. The adhesion contract is ambiguous at best. This Court should accept review, reverse, and remand for trial.

ISSUES PRESENTED FOR REVIEW

1. Whether the trial court erred in failing to find this adhesion contracts' undefined term "actual charge" ambiguous, failing to interpret it in favor of Otey?

2. Whether the trial court erred in failing to find this adhesion contract's terms like "cost share," "portion of the cost," and "copayment" ambiguous, failing to interpret them in favor of Otey?

3. Whether the trial court erred in ruling that GHC may exclude coverage (declining to pay any portion of the costs) for inexpensive drugs that GHC admits are "covered," without any clear and unequivocal language of exclusion stated in the contract?

4. Whether the trial court erred in adopting GHC's "aggregate" theory of cost sharing to deny cost-sharing coverage for inexpensive prescription drugs?

5. Whether the trial court erred in dismissing Otey's bad faith and Consumer Protection Act claims solely based on its coverage and breach of contract rulings, where these claims raised genuine issues of material fact, and where GHC submitted no evidence supporting dismissal as a matter of law?

FACTS RELEVANT TO PETITION FOR REVIEW

A. Otey has healthcare insurance with GHC that includes coverage for inexpensive outpatient prescription drugs, but GHC does not actually cover them.

Otey has healthcare insurance with GHC that includes coverage for inexpensive outpatient prescription drugs. This Petition arises from courts interpreting ambiguous contract terms ("actual charge," "cost share," "portion of the cost," and "covered services") in a light most favorable to GHC, permitting GHC to overcharge Otey for her inexpensive prescription drugs. CP 1-16, 45-70.

GHC's contract provides coverage for outpatient prescription drugs in three tiers. GHC admits Tier 1 and 2 drugs are "covered" by the insurance. CP 108-09, 160-61; RP 12/4/15 at 4-5, 13-15. For all Tiers, certain terms and conditions are defined as follows:

> (a) a member (or subscriber) is liable for payment of "Cost Shares for Covered Services";
>
> (b) "Cost Shares" are the "portion of the cost of Covered Services for which the Member is liable";
>
> (c) Cost Shares "will not exceed the **actual charge** for that service";
>
> (d) "Cost Share" includes copayments and deductibles;
>
> (e) there are no deductibles for prescription drugs; and
>
> (f) "copayment" means the "specific dollar amount a Member is required to pay at the time of service," which (for outpatient prescription drugs) varies by Tier:

> (i) for Tier 1 (preferred generic drugs) the member pays the lesser of $15, or the "**actual charge** for that service";
>
> (ii) for Tier 2 (preferred brand-name drugs) the member pays the lesser of $30, or the "**actual charge** for that service";
>
> (iii) for Tier 3 (non-preferred generic and brand-name drugs) the member pays "100% of all charges."

CP 108-09, 160-61; RP 4-5, 13-15 (emphases added).

The term "actual charge" is not defined in the contract.

B. Procedural History.

For purposes of summary judgment, GHC did not contest the factual allegations in Otey's complaint. GHC also stipulated that "GHC's wholesale drug expenses for Ms. Otey's prescriptions identified in the Complaint are less than the amounts she was charged for those prescriptions..." CP 41. The only substantive evidence GHC put forward was its Health Coverage Agreements for 2014 and 2015, and an HMO Certificate from the Washington State Insurance Commissioner. CP 84-195. GHC offered no evidence to refute Otey's allegation that GHC charges members 100% of the drug cost plus a profit markup of 3 to 5 times its cost to obtain prescription drugs.

Instead, GHC argued that its pricing is "irrelevant" because the contract clearly states a member's financial responsibility is to

pay the copayment or "actual charge" levied by the pharmacy, whichever is less. CP 28, 30-31, 76.

By contrast, Otey alleged that GHC overcharged for various Tier 1 and 2 prescription drugs at prices ranging from $13.60 to $14.75; these drugs cost GHC between $3 and $5 each; but the actual charges are not disclosed to members. CP 4-5. Otey also alleged that the contract terms "copayment" and "cost share" mean that "both parties to the contract must contribute to the cost of . . . prescription drugs." CP 12 at ¶ 48. GHC's failure to share the cost of prescription drugs, concealing the actual cost of drugs, and overcharging members a hefty profit markup, are unfair and/or deceptive acts or practices in violation of the Consumer Protection Act (CPA). CP 10-13 at ¶¶ 37-55. GHC's failure to share in the cost of prescription drugs was a breach of contract that amounts to "overcharg[ing]" members. CP 14 at ¶ 63. And "ambiguities in the contract must be construed against" GHC. CP 14 at ¶ 62.

On December 4, 2015, the trial court granted GHC's motion and dismissed all claims. CP 83. The order stated there was "no genuine issue of material fact." *Id.* At the hearing, the trial court explained its ruling. First, the contract language was not ambiguous. RP 32-33. The terms "copayment," "cost share," and "actual charge"

could have "only one reasonable interpretation" to mean amounts owing by a Member. *Id.* Second, nothing in the contract language "suggest[ed] to the Court an ambiguity or at least a . . . reasonable possibility" that "requires Group Health to share the cost for a particular bottle of pills" or the "cost of a particular service." RP 33-34. The "insurance" provided to members occurs when a member's out-of-pocket limit is reached and the GHC pays for all services thereafter. RP 33. Third, since the contract terms were "clear and unambiguous" and GHC "followed the terms of the contract," Otey's CPA claim also had to be dismissed. RP 34.

The Court of Appeals affirmed. Applying a novel approach to interpreting adhesive insurance contracts, it held that "Otey's offered interpretation is not reasonable when read in the context of the entire contract." Slip Op. at 1 (copy attached). For instance, as to "actual charge," it held that, "Although the word 'actual' could mean wholesale cost or otherwise limit the costs GHC may charge members *in a different type of contract*, here there is no language *in the Agreement* that can support this interpretation." *Id.* at 10-11 (emphases added). The court cited no authority for its approach, which is not only unprecedented, but also contradicts a great deal of appellate precedent.

REASONS THIS COURT SHOULD ACCEPT REVIEW

A. The Court of Appeals' novel approach to interpreting adhesive insurance contracts conflicts with a great deal of this Court's precedent. RAP 13.4(b)(1).

The interpretation of insurance contracts is well settled under Washington law. Appellate courts interpret insurance contracts *de novo* as a question of law. ***Queen Anne Park Homeowners Ass'n v. State Farm Fire & Cas. Co.***, 183 Wn.2d 485, 489, 352 P.3d 790 (2015). The contract – taken as a whole – is given "a fair, reasonable, and sensible construction as would be given to the contract by the average person purchasing insurance." ***Queen Anne Park***, 183 Wn.2d at 489 (internal quotations omitted); *accord* ***Kitsap Cnty. v. Allstate Ins. Co.***, 136 Wn.2d 567, 964 P.2d 1173 (1998). Unambiguous contracts require no interpretation. ***Am. Star Ins. Co. v. Grice***, 121 Wn.2d 869, 874, 854 P.2d 622 (1993). But a contract susceptible to more than one reasonable interpretation is ambiguous. ***Am. Star***, 121 Wn.2d at 874.

The "proper inquiry is not whether a learned judge or scholar can, with study, comprehend the meaning of an insurance contract," but rather "whether the . . . contract would be meaningful to the layman." ***Boeing Co. v. Aetna Cas. & Sur. Co.***, 113 Wn.2d 869, 881, 784 P.2d 507 (1990). Undefined terms are given their ordinary

and common meaning. ***Int'l Marine Underwriters v. ABCD Marine, LLC***, 179 Wn.2d 274, 284, 313 P.3d 395 (2013); ***Moeller v. Farmers Ins. Co. of Wash.***, 173 Wn.2d 264, 272, 267 P.3d 998 (2011).

And ambiguities are always resolved in favor of coverage. ***Moeller***, 173 Wn.2d at 276. They must "be interpreted as broadly as is reasonably proper in order to provide the greatest coverage possible." ***McDonald Indus., Inc. v. Rollins Leasing Corp.***, 95 Wn.2d 909, 915, 631 P.2d 947 (1981) (*quoting* 12 COUCH at § 45:125: "[T]he meaning and construction most favorable to the insured must be applied, even though the insurer may have intended another meaning"); *see also* ***Queen Anne Park***, 183 Wn.2d at 491.

The Court of Appeals ignored the controlling law on interpreting ambiguous provisions. It also "distinguished" copious authority from other courts finding "actual charge" ambiguous,[1] cited no authority to the contrary, and held that even though "actual" "could

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[1] *See, e.g.*, BA 7-9 (citing, *inter alia*, ***Pedicini v. Life Ins. Co.***, 686 F. Supp. 2d 692, 696-97 (W.D. Ky. 2010), *aff'd in part, vacated in part on other grounds*, 682 F.3d 522, 528-29 (6th Cir. 2012); ***Guidry v. Am. Pub. Life Ins. Co.***, 512 F.3d 177, 182-84 (5th Cir. 2007); ***Ward v. Dixie Nat'l Life Ins. Co.***, Nos. 06-2022 & 06-2054, 257 Fed. Appx. 620, 625-27, 2007 U.S. App. LEXIS 27699 (4th Cir. Nov. 29, 2007) (unpublished); ***Conner v. Am. Pub. Life Ins. Co.***, 448 F.Supp.2d 762, 765-66 (N.D. Miss. 2006); ***Metzger v. Am. Fid. Assur. Co.***, No. CIV-05-1387-M, 2006 U.S. Dist. LEXIS 70061, at *12-14 (W.D. Okla. Sept. 26, 2006).

mean wholesale cost or otherwise limit the costs GHC may charge Members in a different *type* of contract, here there is no language *in the Agreement* that can support" Otey's interpretation. Slip Op. at 10-12 (emphases added). With due respect, the word "actual" is all that Otey needs to support her interpretation.[2]

The problem with the Court of Appeals' approach is patent: it effectively shields GHC from responsibility for the "opportunistic ambiguity" it has laid into its own adhesion contract. *See* David Horton, *Flipping the Scripts: Contra Proferentem and Standard Form Contracts*, 80 Colo. L. Rev. 431, 482 (2009) ("drafters have greater incentives to use ambiguity opportunistically in language that details their obligations"). That is, it is typical in standardized adhesion contracts to see no clearly expressed duties (e.g., what GHC must pay for drugs) or precise formulas (e.g., calculation of Member benefits) binding on the drafter. *Id.* The appellate decision encourages this sort of behavior, leaving members vulnerable to hidden price gouging for drugs that the contract tells them are "covered," but that

[2] "The word 'actual' is defined as 'existing in fact or reality,' or in a word, 'genuine.'" ***Armstrong v. Safeco Ins. Co.***, 111 Wn.2d 784, 791, 765 P.2d 276 (1988) (quoting WEBSTER'S THIRD NEW INT'L DICT. 22 (1981); BA 8. An "actual charge" thus must exist in reality, which GHC's hidden, arbitrary, ad hoc profit-taking does not.

are not actually covered. GHC has no accountability and its members have no legal recourse for these intentional and material nondisclosures of material fact affecting hundreds-of-thousands of GHC members across Washington.

And the Court of Appeals has no legal authority to support its novel holding that the "Agreement's scope is confined to the costs members are responsible for while under GHC's insurance coverage" and that the "absence of such values [*i.e.*, the wholesale costs that GHC hides from its members] means that the phrase 'actual charge' cannot be reasonably interpreted to mean GHC's wholesale cost to purchase the drugs." Slip Op. at 11. This circular reasoning permits insurers to write adhesion contracts that are wholly one-sided. Indeed, it *encourages* them to create ambiguous contracts (to fool their insureds) in hopes that our courts will not read the plain language like an insured, but instead look solely within the adhesive contract for nonexistent confirmation of what any ordinary insured would reasonably believe from the plain language.

This novel approach directly conflicts with this Court's precedents cited above, and many more. The Court should grant review to vindicate its exemplary history of protecting insureds from this sort of predatory drafting and consumer abuse.

B. The appellate court's reasoning also conflicts with a great deal of Court of Appeals precedent. RAP 13.4(b)(2).

Similarly troubling is the Court of Appeal's simplistic suggestion that in "interpreting insurance contracts, courts use the same interpretive techniques employed on other commercial contracts." Slip Op. at 5 (citing ***Int'l Marine***, 179 Wn.2d at 282). On the contrary, insurance contracts are of a different character from regular contracts in that they are construed in favor of coverage. ***Moeller***, 173 Wn.2d at 272. Unlike the insured in ***Int'l Marine*** (ABCD), for instance, Otey is not a business entity that hired an insurance broker to purchase coverage to fit her individualized insurance needs. Unlike ABCD, she had a one-size-fits-all employer-sponsored health plan with no opportunity to purchase additional coverage riders to shift more drug costs to GHC. *Cf.* ***Signal Ins. Co. v. Walden***, 10 Wn. App. 350, 353-54, 5517 P.2d 611 (1973) (insured has no opportunity to bargain for modifications of coverage; coverage can be accepted or rejected only as a package).

And unlike commercial contracts negotiated between equals in a free-market system, the healthcare market lacks freedom. *See, e.g.*, ***Colon Health Ctrs. of Am., LLC v. Hazel***, 813 F.3d 145, 158 (4th Cir. 2016) ("Many of the classic features of a free market are

simply absent in the health care context"). As our appellate courts have repeatedly held, insurance contracts are adhesion contracts. *See* ***Seattle Nw. Sec. Corp. v. SDG Holding Co., Inc.***, 61 Wn. App. 725, 738, 812 P.2d 488 (1991) ("Insurance contracts are often characterized as contracts of adhesion"); ***McCann v. Wash. Pub. Power Supply Sys.***, 60 Wn. App. 353, 362, 803 P.2d 334 (1991) (quoting *Comment*, 46 WASH. L. REV. 377, 408-09 (1971)) (same); ***Brower Co. v. Garrison***, 2 Wn. App. 424, 430, 468 P.2d 469 (1970) (same). They are standard-form printed contracts, prepared by one party and submitted to the other on a "take it or leave it" basis, where the parties did not have equal bargaining power. ***Zuver v. Airtouch Commc'ns, Inc.***, 153 Wn.2d 293, 304, 103 P.3d 753 (2004).

"Because they are generally contracts of adhesion, courts look at insurance contracts in a light most favorable to the insured." ***Averill v. Farmers Ins. Co. of Wash.***, 155 Wn. App. 106, 118, 229 P.3d 830 (2010); ***Petersen-Gonzales v. Garcia***, 120 Wn. App. 624, 632, 86 P.3d 210 (2004) ("applying general principles of contract interpretation, reviewing courts construe ambiguities in these [adhesive] agreements against the drafter"). Unresolved ambiguity in unnegotiated standard-form insurance provisions are construed against the drafter/insurer "with added force," where (as here)

exceptions or limitations on coverage are concerned. ***Queen City Farms, Inc. v. Cent. Nat. Ins. Co. of Omaha***, 126 Wn.2d 50, 83, 882 P.2d 703 (1994).

The Court of Appeals failed to cite or apply these precedents. Interpreting both the insurance contract and Otey's arguments in favor of GHC, the court states that "she alleges that the average person would interpret [Cost Share] to mean that GHC would be responsible for paying a portion of the cost of drugs, rather than shifting the entire cost to the Member." Slip Op. at 7. It also says that Otey argued that the phrase "portion of the cost" in the definition of Cost Share indicates to an average insured that she will pay one portion of the cost (the Cost Share) and GHC will pay another portion. *Id.* Otey's real argument is that, *taken as a whole*, the contract suggests to an average insured that there will be cost *sharing*, and *co*-payments. The contract does not even hint that the member alone will pay the entire cost, *plus* a hidden markup arbitrarily imposed by GHC.

But the Court of Appeals focuses solely on the internal definitions and terms in the contract – as one might in an ordinary arm's-length commercial contract – not on an average insured's reasonable interpretation of the plain language. Slip Op. at 5-8. Much

less does it interpret this adhesion contract most favorably to the insureds. This analysis conflicts with the above appellate precedents, and many more.

Similarly, hidden and undisclosed fees, profits, and charges, are typically CPA violations that survive summary judgment. *See, e.g.*, ***Peterson v. Kitsap Cnty. Fed. Credit Union***, 171 Wn. App. 404, 425-29, 287 P.3d 27 (2012) (charging hidden fee that is pure profit beyond actual cost of reconveyance raises issue of fact precluding summary judgment); ***Dwyer v. J.I. Kislak Mortg. Corp.***, 103 Wn. App. 542, 547-548, 13 P.3d 240 (2000) (reversing summary judgment dismissing CPA claim involving $50 "Misc Service Chgs" that could deceive reasonable consumers). Here, GHC obtained hidden profits on inexpensive prescription drugs without disclosing its hefty markup of 3 to 5 times the cost. Overcharging on "covered" drugs to avoid sharing in the cost and taking windfall profits without disclosure is a case that should go to trial. *See, e.g.*, ***Van Noy v. State Farm Mut. Auto. Ins. Co.***, 142 Wn.2d 784, 789, 796, 16 P.3d 574 (2001) (reversing summary judgment dismissing breach of contract, bad faith, and CPA claims). The Court of Appeals' analysis conflicts with these precedents. This Court should grant review.

C. The appellate court's novel approach presents an issue of substantial public interest that should be determined by the Supreme Court. RAP 13.4(b)(4).

The appellate court's novel approach also presents an issue of substantial public interest that should be determined by the Supreme Court. RAP 13.4(b)(4). Healthcare and healthcare reform are at the top of our state and national agendas. Keeping and protecting healthcare insurance, and the scope of healthcare coverage for consumers, remain ongoing public policy issues for all Washington citizens. This is particularly true where, as here, insurers seek to emasculate coverage and nickel-and-dime away healthcare reimbursements. This is precisely what this case is about and why this Court should accept review.

When a domestic insurer like GHC, which insures hundreds of thousands around this state, begins to whittle away at reimbursements based on vague and ambiguous policy provisions in adhesion contracts of insurance, this Court must step in. These clauses must be read together in a light most favorable to the insured, not the insurer. The Court should accept review.

Contrary to the Court of Appeals' view that "actual charge" can only mean the charge to a member, "actual charge" is reasonably interpreted to mean the "charge to GHC" or the "cost to GHC." That

is, the GHC plan does in fact "use the costs incurred by GHC in procuring drugs or services as a reference point for determining the cost charged to the Member." *See* Slip Op. at 10. The "actual charge" to GHC is the reference point from which GHC determines whether the payment owed by the member is the Cost Share or a lesser amount. Without using the actual charge to GHC as a reference point, there is no way to determine whether the Member owes less than the Cost Share (copayment).

For example, if the actual charge for a Tier I drug is $45, that is the reference point to determine that the Member owes a $15 copayment and that GHC covers the remaining $30. Likewise, if the actual charge for a Tier I drug is $3.00, that is the reference point to determine that the Member is responsible for that actual charge, rather than a $15 copayment. The term actual charge thus necessarily denotes the actual charge to GHC, not its after-the-fact, made-up $13.90 charge to the Member. Since the actual charge to GHC is a reasonable and logical interpretation of the undefined term actual charge, this Court should grant review and find for Otey.

Interpreting a similar clause in an HMO plan, a Minnesota district court explained why the HMO's prescription drug cost

necessarily must be the reference point for determining any payment owed by a member:

> Because the plans state that the member pays the lesser of the co-pay or the "prescription drug cost"– the "contracted reimbursement rate" – the natural reading of this prescription benefits provision requires assessment of the reimbursement rate without consideration of the co-payment, in order to determine which is lower, and, correspondingly, whether or not it is a ZBD [zero balance due from HMO to pharmacy] situation. UHC's interpretation essentially ignores the alternative nature of the plan provision by skipping this step[.]

Smith v. United HealthCare Servs., Inc., No. 00-1163, 2003 U.S. Dist. LEXIS 15012, at *28 (D. Minn. Aug. 28, 2003).

The same is true here. Unless the actual charge to GHC is the reference point, there is no way to determine whether the Member owes less than the Cost Share (copayment). The Court of Appeals instead read the insurance contract in the light most favorable to GHC, holding *Otey* responsible for GHC's vague and ambiguous drafting. That conflicts with established practice and precedents. This Court should grant review.

CONCLUSION

Protecting insurance consumers has a long and proud tradition in this Court. This appeal presents an opportunity to put paid to many insurers' tactic of remaining silent on their own duties, lulling courts into thinking that they somehow have none. These trial and appellate courts cannot logically have believed that GHC has no duties under its contract to insure hundreds-of-thousands of Washington citizens. Yet this tacit premise is all that their decisions rest upon.

"Actual charge," "copayment," "portion of the cost," "Cost Shares": all of these phrases at least imply to a reasonable insurance consumer that GHC is paying the other portion of the cost. The adhesion contract is ambiguous at best. This Court should grant review, reverse, and remand for trial.

RESPECTFULLY SUBMITTED 17th day of July, 2017.

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CERTIFICATE OF SERVICE

I certify that I caused to be mailed via U.S. mail, postage prepaid, and/or emailed, a copy of the foregoing **PETITION FOR REVIEW** on the 17th day of July 2017, to the following counsel of record at the following addresses:

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ATTACHMENT 1

SLIP OPINION

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

LEXINE OTEY, individually and on behalf of the class of similarly situated insureds, Appellant, v. GROUP HEALTH COOPERATIVE, a corporation, Respondent.	DIVISION ONE No. 74448-8-I UNPUBLISHED OPINION FILED: May 15, 2017

TRICKEY, J. — Lexine Otey, a member of the Group Health Cooperative (GHC), appeals the trial court's grant of GHC's motion for summary judgment and dismissal of her claims. Otey claims that GHC breached its contract by overcharging its insureds for prescription drugs, and violated the Consumer Protection Act[1] (CPA). Specifically, Otey claims that the contract is ambiguous and cannot be reasonably interpreted to allow GHC to charge its members more than the wholesale cost it paid for prescription drugs. Otey's offered interpretation is not reasonable when read in the context of the entire contract. Because nearly all of Otey's arguments rely on her breach of contract argument, and her other arguments are similarly without merit, we affirm.

[1] Ch. 19.86 RCW.

FACTS

Otey is a Member of GHC, meaning she is insured under GHC's health insurance plan. She is covered by GHC's Group Medical Coverage Agreement (the Agreement). Under the Agreement, Members pay at most a $15 copayment for preferred generic drugs (Tier 1), a $30 copayment for preferred brand name drugs (Tier 2), and 100 percent of all charges for nonpreferred generic and brand name drugs (Tier 3). The Agreement defines the terms "Copayment" and "Cost Share" in its Definitions section.[2]

Otey claims that GHC overcharged her for prescription drugs. For example, she was prescribed Methocarbamol and was charged a $13.60 copayment for 28 tablets; the wholesale cost to GHC was between $3.00 and $5.00.

Otey filed a complaint against GHC individually and on behalf of similarly situated Members. She alleged that GHC breached the Agreement by failing to contribute to the payment for prescription drugs despite the terms "Copayment" and "Cost Share" appearing in the Agreement. Otey also claimed that GHC violated the CPA by acting in bad faith when it failed to make copayments or share in the cost of drugs, and did not disclose information that would be material to an objectively reasonable person.

GHC moved for summary judgment. The trial court granted GHC's motion and dismissed Otey's claims. The trial court found that GHC did not breach the Agreement because the challenged definitions were not ambiguous, and did not require GHC to share in the cost of any particular service. The trial court dismissed

[2] Clerk's Papers (CP) at 138, 190.

Otey's CPA claim because the Agreement was not ambiguous and GHC followed its terms.

Otey appeals.

ANALYSIS

Otey maintains that the trial court erred by granting summary judgment to GHC. She first argues that the trial court erred because GHC breached the Agreement because it required GHC to share in the cost of Tier 1 and Tier 2 prescription drugs, and GHC wrongfully overcharged its Members when it failed to do so. Otey next contends that GHC violated the CPA by acting in bad faith when it overcharged its Members and did not disclose its wholesale costs. We consider each of her claims in turn.

"Appellate review of summary judgment is de novo; the reviewing court engages in the same inquiry as the trial court and views the facts and the reasonable inferences from those facts in the light most favorable to the nonmoving party." Michak v. Transnation Title Ins. Co., 148 Wn.2d 788, 794, 64 P.3d 22 (2003). Summary judgment is proper where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Int'l Marine Underwriters v. ABCD Marine, LLC, 179 Wn.2d 274, 281, 313 P.3d 395 (2013); CR 56(c).

Breach of Contract

Otey argues that the trial court erred by granting GHC's motion for summary judgement on her breach of contract claim. Otey asserts that GHC breached the Agreement by overcharging its Members. Otey relies on the Agreement's use of

the terms "Cost Share" and "Copayment" to claim that GHC was required to share in the cost of covered drugs. She further contends that GHC should not have charged her more than the wholesale cost of the drugs because the Agreement states that a Member's copayment will never exceed the "actual charge" incurred. Alternatively, she argues that GHC wrongfully excluded coverage of Tier 1 and Tier 2 drugs under the Agreement.

To prevail on a breach of contract claim, the plaintiff must show the elements of duty, breach, causation, and damages. Baldwin v. Silver, 165 Wn. App. 463, 473, 269 P.3d 284 (2011). To avoid summary judgment, a plaintiff must produce evidence raising genuine issues of material fact as to each element of the claim for breach of contract. Baldwin, 165 Wn. App. at 473. If the duty allegedly breached is not in the contract, the claim of breach of contract cannot be sustained. Fid. & Deposit Co. of Md. v. Dally, 148 Wn. App. 739, 745-46, 201 P.3d 1040 (2009).

Defined Terms "Cost Share" and "Copayment" Ambiguity

Otey argues that the trial court erred in granting summary judgment on her breach of contract claim because GHC breached the Agreement by overcharging its Members. Specifically, she argues that the terms "Cost Share" and "Copayment" may be reasonably interpreted to require GHC to share in the cost of covered drugs, and by failing to do so GHC overcharged its Members. Because "Cost Share" and "Copayment" are defined terms in the Agreement with only one reasonable interpretation, and did not allow GHC to overcharge its Members, we find no error.

The court examines the terms of an insurance contract under their plain language to determine whether there is coverage. Boeing Co. v. Aetna Cas. & Sur. Co., 113 Wn.2d 869, 877, 784 P.2d 507 (1990). "In Washington, . . . 'the [insurance] policy is construed as a whole, and the policy should be given a fair, reasonable, and sensible construction as would be given to the contract by the average person purchasing insurance.'" Kitsap County v. Allstate Ins. Co., 136 Wn.2d 567, 964 P.2d 1173 (1998) (internal quotation marks omitted) (quoting Queen City Farms, Inc. v. Cent. Nat'l Ins. Co., 126 Wn.2d 50, 65, 882 P.2d 703, 891 P.2d 718 (1994)).

"When interpreting insurance contracts, courts use the same interpretive techniques employed on other commercial contracts." Int'l Marine Underwriters, 179 Wn.2d at 282. Defined terms are interpreted in accordance with the definition provided in the policy. Kitsap County, 136 Wn.2d at 576. If the language of an insurance policy is clear and unambiguous, a court may not modify the policy or create an ambiguity. Am. Star Ins. Co. v. Grice, 121 Wn.2d 869, 874, 854 P.2d 622 (1993).

Interpretation of a writing is a question of law that is reviewed de novo. Stewart v. Chevron Chem. Co., 111 Wn.2d 609, 613, 762 P.2d 1143 (1988).

Here, the Financial Responsibilities for Covered Services section of the Agreement states that Members are responsible for costs for a Covered Service up to the Cost Shares amount. The Agreement defines "Cost Share" as "[t]he portion of the cost of Covered Services for which the Member is liable. Cost Share

includes Copayments, coinsurances and Deductibles."[3,4] "Copayment" is defined in the Agreement as "[t]he specific dollar amount a Member is required to pay at the time of service for certain Covered Services."[5] The Copayment amount for Tier 1 drugs is $15.

When the Agreement is read as a whole, the defined terms Cost Share and Copayment are not ambiguous. Cost Share includes Copayments within its definition. Copayments are specific dollar amounts that act as a ceiling on the amount a Member must pay for Covered Services. Copayments do not require either party to pay a percentage of the cost of Covered Services.

The disputed terms in the Agreement are contained in the Financial Responsibilities section. This section does not mention any responsibility of GHC to contribute to the payment of Covered Services that cost less than the Copayment value. Rather, it states that "[t]he Subscriber is liable for payment of the following Cost Shares for Covered Services."[6] For the purposes of Tier 1

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[3] CP at 138, 190.

[4] GHC cites the Washington Administrative Code (WAC) as additional support that the definitions in the Agreement are valid, although the Agreement does not incorporate them. The WAC provisions cited by GHC closely match those in the Agreement, thereby lending support to its offered interpretation. GHC is a health maintenance organization, which is responsible for providing "comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles." RCW 48.46.020(13); WAC 284-43-0160(15). "Cost-sharing" is defined as "amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles." WAC 284-43-0160(9). Cost-sharing in the context of prescription drugs means "amounts paid directly to a provider or pharmacy by an enrollee for services received under the health benefit plan, and includes copayment, coinsurance, or deductible amounts." WAC 284-43-5110(1).

[5] CP at 138, 190.

[6] CP at 100, 153.

prescription drugs, the Agreement shows that Members are liable for up to $15, which would not affect GHC's responsibility to pay. But any amount for a Covered Service exceeding the Cost Shares value would be paid by GHC under the Agreement. Therefore, when the definitions of the challenged terms are read in the context of the Agreement as a whole, they are not ambiguous.

Otey argues that the term Cost Share is ambiguous for two reasons. First, she alleges that the average person would interpret it to mean that GHC would be responsible for paying a portion of the cost of drugs, rather than shifting the entire cost to the Member. Otey next cites the undefined phrase "portion of the cost" contained in the definition of Cost Share to argue that, due to the use of this term in the Agreement's Financial Responsibilities section, GHC was required to share in the cost of prescription drugs with the insured Member.[7]

Otey's arguments are unpersuasive for three reasons. First, Cost Share explicitly includes Copayments in its definition, which in turn are set amounts listed in the Agreement that act as a ceiling on the price Members will be required to pay for certain Covered Services. Second, GHC will pay a portion of the cost of Tier 1 drugs, but only if the actual charge incurred by the Member for the drugs is greater than the $15 Copayment value. Third, after a Member reaches her "Out-of-pocket Limit" for the year, GHC is solely responsible for paying any further Cost Shares.[8] The Agreement does not make GHC responsible for the costs Otey incurred simply because the Copayment threshold was not reached.

[7] CP at 138, 190.
[8] CP at 102, 140.

In the alternative, Otey argues that the Agreement does not adequately define the term Cost Share, and that this court should use dictionary definitions to determine its common meaning. Courts give undefined terms in a policy their "'plain, ordinary, and popular' meaning." Boeing Co., 113 Wn.2d at 877 (quoting Farmers Ins. Co. v. Miller, 87 Wn.2d 70, 73, 549 P.2d 9 (1976)). Courts may look to standard English dictionaries to determine the ordinary meaning of undefined terms. Kitsap County, 136 Wn.2d at 576. But the Agreement defines both Cost Share and Copayment. Therefore, neither term is undefined. We decline to adopt Otey's proposed dictionary definitions.

"Actual Charge"

Otey argues that summary judgment on her breach of contract claim was improper because GHC overcharged its Members when it charged them more than its wholesale cost of purchasing drugs. Specifically, Otey argues that the undefined term "actual charge" in the Agreement can be reasonably interpreted to require GHC to charge Otey only the amount it paid for a drug. Otey contends that the term is ambiguous and should be interpreted in favor of Otey, as the policyholder. Although "actual charge" is undefined, it can only have one reasonable interpretation when read in the context of the Agreement as a whole. Therefore, we find no error.

"The insurance contract must be viewed in its entirety; a phrase cannot be interpreted in isolation." Allstate Ins. Co. v. Peasley, 131 Wn.2d 420, 424, 932 P.2d 1244 (1997). If the language of an insurance policy is clear and unambiguous, the court must enforce it as written. Transcontinental Ins. Co. v.

Wash. Pub. Utils. Dists.' Util. Sys., 111 Wn.2d 452, 456, 760 P.2d 337 (1988). Language of an insurance contract is ambiguous if it is fairly susceptible to two different reasonable interpretations. Am. Star, 121 Wn.2d at 874. Any ambiguity is resolved in favor of the policyholder. Eurick v. Pemco Ins. Co., 108 Wn.2d 338, 340, 738 P.2d 251 (1987).

Undefined terms in an insurance policy are given their ordinary and common meaning. Peasley, 131 Wn.2d at 424. To determine the ordinary meaning of undefined terms, courts may look to standard English dictionaries. Kitsap County, 136 Wn.2d at 576. The contract must be read as an average person would read it, and given a practical and reasonable interpretation. Moeller v. Farmers Ins. Co. of Wash., 173 Wn.2d 264, 272, 267 P.3d 998 (2011).

Interpretation of the language of an insurance policy is a matter of law that this court reviews de novo. Peasley, 131 Wn.2d at 423-24.

Here, the phrase "actual charge" appears in the Financial Responsibilities section of the Agreement:

> The Subscriber is liable for payment of the following Cost Shares for Covered Services provided to the Subscriber and his/her Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.[9]

"Covered Services" are "services for which a Member is entitled to coverage in the Benefits Booklet."[10] As explained above, "Cost Share" is the "portion of the cost of Covered Services for which the Member is liable," and includes

[9] CP at 100, 153.
[10] CP at 138, 190.

Copayments.[11] "Copayment" is the specific dollar amount a Member must pay at the time of service.[12]

Cost Shares act as a ceiling on the cost a Member can incur for a Covered Service. If the actual charge billed to a Member for a given Covered Service is lower than the Cost Share assigned to that service, the Member is responsible for only the actual charge incurred when the Member receives the Covered Service. The Agreement further states that Cost Shares will not exceed the actual charge for that service. If the actual charge incurred by the Member is lower than the Copayment value, the Member is responsible for paying the actual charge incurred. If the actual charge incurred is greater than the Copayment, the Member is responsible for the Copayment only.

The Financial Responsibilities for Covered Services section of the Agreement lays out the costs the Member is responsible for paying. It does not contain formulas or qualifiers that use the costs incurred by GHC in procuring drugs or services as a reference point for determining the cost charged to the Member. As written, and when viewed in the context of the preceding language referring only to the payment of the amount billed to the Member, "actual charge" may only be reasonably interpreted as comparing the actual amount billed to a Member upon receiving a service to the Copayment value assigned to that service. Although the word "actual" could mean wholesale cost or otherwise limit the costs

[11] CP at 138, 190.
[12] CP at 138, 190.

GHC may charge Members in a different type of contract, here there is no language in the Agreement that can support this interpretation.

Otey's offered definition of "actual charge" as the wholesale cost imposed on GHC attempts to reach beyond the scope of the contract as written and incorporate terms and values that are not contained within the Agreement. The Agreement does not incorporate any third party costs into its listed Copayment values. The complete absence of such values means that the phrase "actual charge" cannot be reasonably interpreted to mean GHC's wholesale cost to purchase the drugs. The Agreement's scope is confined to the costs Members are responsible for while under GHC's insurance coverage.

Otey argues that other parts of the Agreement beyond the Financial Responsibilities section demonstrate that "actual charge" also could mean either costs incurred by Members or by GHC. The Agreement states that "[i]n the event the Member elects to purchase a brand-name drug instead of the generic equivalent (if available), the Member is responsible for paying the difference in cost in addition to the prescription drug Cost Share."[13] Otey argues that this language could be reasonably interpreted to mean either the charge incurred by GHC to purchase the drugs or the price charged by GHC to the Member. As discussed above, the Agreement concerns only the financial responsibilities between the Members and GHC, and never mentions GHC's own costs. The additional language cited by Otey does not support her argument that "actual charge" means the cost incurred by GHC.

[13] CP at 109, 161.

Otey's claim that GHC breached the Agreement by charging its Members more than the wholesale costs of the drugs under the "actual charge" language is not a reasonable interpretation of the Agreement, and was properly dismissed.

Relying on federal cases that have held that "actual charge" is ambiguous in the context of supplemental cancer insurance contracts, Otey argues that "actual charge" is always ambiguous when used in health insurance contracts. See, e.g., Pedicini v. Life Ins. Co. of Ala., 686 F.Supp.2d 692 (W.D. Ky. 2010), ("actual charge" in context of supplemental cancer insurance contract could reasonably mean either the amount charged by the medical provider to the patient or a different amount accepted by the medical provider from a third party as payment in full), rev'd in part on other grounds, 682 F.3d 522 (6th Cir. 2012).

In supplemental cancer insurance contracts, direct payments are made to the policyholder when an insured patient undergoes covered cancer treatments. Pedicini, 686 F.Supp.2d at 694. These benefits are paid regardless of whether the patient has other insurance sufficient to cover all medical expenses. Pedicini, 686 F.Supp.2d at 694. When the patient has other insurance covering cancer treatments, the policyholder is able to retain the money as a result of the supplemental coverage. Pedicini, 686 F.Supp.2d at 694. This arrangement renders "actual charge" ambiguous because the insured patient may have to pay either (1) the total amount billed, or (2) the amount a health care provider would be willing to accept as payment in full. Pedicini, 686 F.Supp.2d at 696.

The cases cited by Otey are distinguishable from the present case. The section of the Agreement at issue here concerns Members' responsibility to pay

the Cost Shares listed under the Agreement. The only cost that could be incurred by the Member under the Agreement for Covered Services would be the lesser of the Copayment listed or the "actual charge." This is distinguishable from insurance contracts under which there could be both a total amount billed to the insured and an amount that the provider would accept as payment in full. Because "actual charge" can only be reasonably interpreted to mean one amount in the context of the Agreement, it does not create the ambiguity found in the federal cases relied on by Otey.

Coverage of Tier 1 and Tier 2 Drugs

Otey argues that Tier 1 and Tier 2 prescription drug benefits are within the scope of the Agreement's coverage, but GHC wrongfully claims that it has no duty to pay any portion of their cost. Otey contends that GHC wrongfully made Members pay the entire cost of drugs, as well as any profit GHC decided to add to the price. Otey calls this a "phantom exclusion." Because GHC is responsible for costs of Covered Services that exceed the assigned Cost Shares value and becomes responsible for the entire cost of Covered Services after a Member reaches his or her Out-of-pocket Limit, we find no error.

Courts interpret insurance policies liberally in order to provide coverage wherever possible. Patriot Gen. Ins. Co. v. Gutierrez, 186 Wn. App. 103, 110, 344 P.3d 1277 (2015); Bordeaux, Inc. v. Am. Safety Ins. Co., 145 Wn. App. 687, 694, 186 P.3d 1188 (2008). Exclusionary terms from insurance coverage are construed narrowly because they are contrary to the protective purpose of insurance. Vision One, LLC v. Phila. Indem. Ins. Co., 174 Wn.2d 501, 507, 512, 276 P.3d 300 (2012)

(exclusion of losses "caused by or resulting" from deficient design or faulty workmanship). Insurers have the burden of drafting exclusions in clear and unequivocal terms. Int'l Marine Underwriters, 179 Wn.2d at 288 (policy containing exclusion for contractually assumed liability with an exception for "insured contracts").

As discussed above, the Cost Share and Copayment terms are not ambiguous and do not require GHC to share in the cost of each transaction. Under the Agreement, GHC is responsible for payment of Covered Services costs exceeding the Copayment value, and also for any costs incurred by the Member after his or her Out-of-pocket Limit has been reached. GHC does not exclude the costs of Tier 1 or Tier 2 drugs from its coverage because the amounts paid by a Member count toward his or her Out-of-pocket Limit. After a Member reaches the Out-of-pocket Limit, which includes all Cost Shares for Covered Services incurred by the Member over the calendar year, GHC becomes solely responsible for additional costs. Further, if the cost of a Tier 1 drug exceeds the $15 Copayment or a Tier 2 drug exceeds the $30 Copayment, GHC covers the excess. Under the Agreement, there is no "phantom exclusion" of Tier 1 drugs.

The exclusions in the cases cited by Otey are distinguishable from GHC's coverage of Tier 1 and Tier 2 drugs. The insurance policies at issue contained explicit exclusionary clauses that barred coverage for specific events. See, e.g., Vision One, LLC, 174 Wn.2d at 507 (term excluding coverage for loss or damage caused by specified events). These cases do not support Otey's argument that GHC implicitly excludes Tier 1 and Tier 2 drugs, as there is no exclusionary term

to construe narrowly. Otey does not challenge GHC's exclusion of Tier 3 drugs from coverage under these cases.

Otey argues that Tier 1 and Tier 2 drugs are treated practically the same as Tier 3 drugs, which are explicitly excluded from coverage, because few Tier 1 and Tier 2 drugs will cost more than their Copayment value. Otey does not offer legal authority in support of this argument. As discussed above, this ignores that GHC is responsible for any actual charge exceeding the Copayment value for Tier 1 and Tier 2 drugs, and that GHC is responsible for any Cost Shares incurred after the Member reaches their annual Out-of-pocket Limit.

Otey argues that the trial court erred in applying an "aggregate" cost-sharing theory to the Agreement.[14] This argument is inapplicable. Cost-sharing via copayments and coinsurance assure that both the subscriber and insurance company share in annual pharmacy expenditures. Regence Blueshield v. Office of the Ins. Comm'r, 131 Wn. App. 639, 650, 128 P.3d 640 (2006). Recognized methods of cost-sharing "create a finite and predictable annual expenditure for the subscriber (deductible) or they assure that the subscriber and the insurance company share in all annual pharmacy expenditures (copayments and

[14] Otey also argues that the trial court erroneously considered only GHC's unilateral intent when interpreting the Agreement to require GHC to only share in costs when the "actual charge" exceeded the Cost Share value or after a Member's Out-of-pocket Limit was reached, rather than the language of the Agreement. Washington courts determine the parties' intent by focusing on the objective manifestations in the agreement, rather than on unexpressed subjective intent of the parties. Hearst Commc'ns v. Seattle Times Co., 154 Wn.2d 493, 503, 115 P.3d 262 (2005). Here, as discussed above, the language of the Agreement is not ambiguous. The Financial Responsibilities section requires that Members pay the lower of the Cost Share or "actual cost" incurred. The trial court did not impermissibly rely only on GHC's unilateral intent when it interpreted the Agreement, as it could look to the language of the Agreement to reach its conclusions.

coinsurance)." Regence Blueshield, 131 Wn. App. at 650. A benefit cap limiting a provider's liability that exposes insureds to unpredictable and limitless upper liability is invalid. Regence Blueshield, 131 Wn. App. at 650-51.

The Agreement uses cost-sharing mechanisms recognized by Washington courts. The Agreement contains clear Copayment values which limit a Member's liability for costs of Tier 1 and Tier 2 drugs. In addition, a Member's annual liability for costs is limited by the Out-of-pocket Limit contained in the Agreement. Both of these act as limits on a Member's liability, and do not impermissibly limit GHC's responsibility to cover expenses. The trial court's use of the word "aggregate" to describe the cost-sharing arrangement in the Agreement is irrelevant.

Otey's CPA Violation Claim

Otey argues that the trial court erred when it dismissed her CPA claim. Otey argues that GHC breached the Agreement when it overcharged Members by failing to share in the cost of drugs, and therefore breached the CPA. In the alternative, Otey argues that her CPA claim is an independent claim with unresolved issues of fact to be decided by a jury. Neither argument has merit.

Otey first argues that the trial court erred when it dismissed her CPA violation claim based on its finding that GHC did not breach the Agreement. Otey argues that this court should reinstate her CPA violation claim if we reverse the dismissal of her breach of contract claim. Because we find that Otey's breach of contract claim was properly dismissed, we decline to reinstate her CPA violation claim on that basis.

In the alternative, Otey argues that the trial court erred in dismissing her CPA violation claim because it is independent of the breach of contract claim and depends on unresolved questions of fact. Specifically, she argues that GHC acted in bad faith and did not put forward any evidence that its interpretation of the Agreement was reasonable beyond argument and the Agreement itself. Otey maintains that this was insufficient for summary judgment, and the question of GHC's reasonableness should have gone to a jury.

Parties may bring bad faith claims against their insurer because the insurance company has a quasi-fiduciary duty to its insureds. Cedell v. Farmers Ins. Co. of Wash., 176 Wn.2d 686, 696, 295 P.3d 239 (2013). Good faith requires an insurer to deal fairly with insureds. Mut. of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc., 161 Wn.2d 903, 915 n. 9, 169 P.3d 1 (2007).

Whether an insurer acted in bad faith remains a question of fact. Smith v. Safeco Ins. Co., 150 Wn.2d 478, 484, 78 P.3d 1274 (2003). To succeed on a bad faith claim against an insurer, a policyholder must show the insurer's breach of an insurance contract was unreasonable, frivolous, or unfounded. Smith, 150 Wn.2d at 484.

An insurer is entitled to a directed verdict or a dismissal on summary judgment only if there are no disputed material facts pertaining to the reasonableness of the insurer's conduct under the circumstances or the insurer is entitled to prevail as a matter of law on the facts construed most favorably to the nonmoving party. Smith, 150 Wn.2d at 484.

Otey relies primarily on Coventry Associates v. American States Insurance Co., 136 Wn.2d 269, 961 P.2d 933 (1998). In that case, Coventry submitted a claim to American States for damages that occurred in one of its construction projects. Coventry Assocs., 136 Wn.2d at 274. An American States adjuster briefly investigated the project site and then denied the claim without investigating the cause of the damage or loss of business coverage, and with minimal review of Coventry's policy. Coventry Assocs., 136 Wn.2d at 274. The Supreme Court held that an insured may maintain an action against its insurer for a bad faith investigation of the insured's claim and for violation of the CPA regardless of whether the insurer was ultimately correct in determining coverage did not exist. Coventry Assocs., 136 Wn.2d at 279.

On appeal, Otey asserts only that GHC did not offer evidence beyond argument and that its interpretation of the Agreement was reasonable. Otey does not allege any act of bad faith separate from GHC's interpretation of the Agreement. As discussed above, GHC did not breach Agreement by overcharging its Members. Because Otey does not allege an act of bad faith separate from GHC's alleged breach of the Agreement, Coventry Associates is inapplicable to the present case. Therefore, there is no disputed material fact pertaining to the reasonableness of GHC's alleged breach of the Agreement, and Otey's CPA violation claim does not have a basis independent from her breach of contract claim. We conclude that the trial court did not err in dismissing Otey's CPA violation claim.

Affirmed.

Trickey, J

WE CONCUR:

Verellen, J

Becker, J.

ATTACHMENT 2

ORDER DENYING MOTION FOR RECONSIDERATION

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

LEXINE OTEY, individually and on behalf of the class of similarly situated insureds, Appellant, v. GROUP HEALTH COOPERATIVE, a corporation, Respondent.	No. 74448-8-I ORDER DENYING MOTION FOR RECONSIDERATION

The appellant, Lexine Otey, has filed a motion for reconsideration. The court has taken the matter under consideration. A majority of the panel has determined that the motion should be denied.

Now, therefore, it is hereby

ORDERED that the motion for reconsideration is denied.

Done this 16th day of June, 2017.

FOR THE COURT:

ACJ

ATTACHMENT 3

ORDER DENYING
MOTION TO PUBLISH

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

LEXINE OTEY, individually and on behalf of the class of similarly situated insureds, Appellant, v. GROUP HEALTH COOPERATIVE, a corporation, Respondent.	No. 74448-8-I ORDER DENYING MOTION TO PUBLISH

The appellant, Lexine Otey, has filed a motion to publish herein. The court has taken the matter under consideration and has determined that the opinion is not of precedential value.

Now, therefore, it is hereby

ORDERED that the unpublished opinion filed May 15, 2017, shall remain unpublished.

Done this 16th day of June, 2017.

FOR THE COURT:

ACJ

MASTERS LAW GROUP

July 17, 2017 - 12:29 PM

Filing Petition for Review

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