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MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS & CLARK COUNTY

DANA ROLAN, on her own behalf and on behalf of the class she represents, Plaintiffs, vs. NEW WEST HEALTH SERVICES, DARWIN SELECT INSURANCE COMPANY and ALLIED WORLD ASSURANCE COMPANY and DARWIN NATIONAL ASSURANCE COMPANY, Defendants.	Cause No. DDV 2010-91 Honorable Christopher D. Abbott **PLAINTIFES' RESPONSE TO ALLIED WORLD'S MOTION FOR SUMMARY JUDGMENT**

COME NOW plaintiffs and respond to Allied World's Motion for Summary Judgment as follows.

I. SUMMARY OF POSITION

From the insured's perspective, the most important information appears on the "declaration page" at the beginning of every insurance policy. *Hardy v. Progressive Specialty Ins. Co.*, 2003 MT 85, ¶23. It is there that the insured gains a reasonable expectation of the extent of coverage it has purchased. *Hardy, supra*;

Transamerica Ins. Group v. Osborn, 627 F. Supp. 1405 (D. Mont. 1986). *See also, Morrison v. American Intern. Ins*., 887 A.2d 166, 381 N.J. Super. 532 (N.J. 2005).

The declaration page of Allied's MCEO policy tells New West it has purchased and is protected by a "$1,000,000 … Limit of Liability for *each Claim*" and "$3,000,000 in the Aggregate *for all Claims*" (Emphasis added). There are no warnings or indications these coverages are in any way limited other than in amount. You have to read five pages into the policy to find a contradictory statement that "Related Claims Deemed Single Claim." There is no definition there, however, defining "related." You have to read 11 pages into the policy to find a definition for "Related Claims." It is so broad that if read literally, any claim made against New West is related to every other claim made against New West. It covers every claim that is "related logically, causally or in any way." For instance, the mere fact a claim has been made against New West is "logically, causally or in any way" connected to every other claim made against New West. A claim made for denial of health benefits is related to every other claim for health benefits—regardless of the ground for the denial. For all intents and purposes, the "related claim" definition pretty much nullifies the "$3,000,000 aggregate limits set forth on the declaration page.

The "related-claims" exclusion is relatively rare. In almost a half a century of practice related to insurance coverages, the undersigned has never come across

it until now. It does not appear in most types of casualty insurance, such as automobile, property and probably most business policies. In those policies, you get what you pay for as shown on the declaration page: A lower amount for a single claim and a higher amount for multiple claims.

Not surprisingly, the treatment of "related-claims" exclusions by the courts has not been uniform. There are the decisions Allied relies on which pretty much give insurance companies a freedom to contract in any way they want with exclusions as broad as they want. There are other cases where the exclusion is declared ambiguous in relationship to the circumstances of the case or because it is simply too imprecise to be enforceable. These are the cases New West submits the Montana Supreme Court would follow.

One important circumstance is the presence of an insured who has individual and separate fiduciary duties to each person bringing a claim. Many courts have held that by definition, claims made against fiduciaries by multiple people are generally considered separate claims and not related claims. This applies to New West, which has individual fiduciary and high statutory duties to each client it injures. This alone, therefore, defeats Allied's related claim defense.

The "related-claims" exclusion is rare enough that the Montana Supreme Court has never addressed it. Our insurance laws, however, are such that it is likely

Montana will follow the authorities advanced by New West. "We construe insurance policies against the insurer and in favor of the insured." Terms are interpreted "according to their usual, common-sense meaning as viewed from the perspective of a reasonable consumer of insurance products." And ambiguities are construed in favor of the insured. *Parker v. Safeco Ins. Co. of Am*., 2016 MT 173, ¶14.

Of significant, or perhaps critical, importance is Montana's recognition that exclusions which render coverage illusory or defeat the reasonable expectations of the insured are unenforceable whether ambiguous or not. *Hardy, supra*.

New West's position is presented below.

II. THE CLAIMS ARE NOT RELATED

A. THE CIRCUMSTANCES

The circumstances show the claims, here, are not "related" in the ordinary sense of the word.

First, they are not related in the sense New West engaged in a single act at a single time that harmed multiple people. To the contrary, New West engaged multiple discrete acts and omissions that harmed different people at different times over a decade or more.

Second, the claims are not related in the sense that only a single legal theory applies. The Class made multiple legal claims against New West. It:

(1) Violated contractual duties. DN1, ¶23;
(2) Violated made-whole laws. DN1, ¶¶6, 23;
(3) Violated the Unfair Settlement Practices Act. DN1, ¶¶20, 27-31; and
(4) Engaged in conduct worthy of punitive damages. DN1,¶¶20, 32.

Third, the claims are not related in the sense New West used the same method to avoid paying benefits in each instance. In some cases, it informed the insured the tortfeasor was responsible for paying. In other cases, it informed the medical provider the tortfeasor was responsible for paying. In still other cases, New West would pay, but then seek subrogation against its insureds or the tortfeasor's insurer. DN1, ¶22. All of these different methods are illegal under Montana law. Some are illegal "subrogation" and some are illegal "pseudo-subrogation." *Rolan v. New West (Rolan I)*, 2013 MT 220.

Fourth, the claims are not related in the sense they caused the same harm to everyone. New West's violations caused different harm to different people. Ms. Rolan, for instance, has lost over $100,000 in benefits and has suffered severe emotional distress due to the added burden of this lawsuit on top of her severe injuries. Unlike all others, she requested reimbursement under the made-whole laws and was forced to sue when New West refused to pay. For others, benefit

losses most likely will be lower and their damages for Unfair Settlement Act violations will be different or even non-existent depending on the circumstances.

Fifth, as an insurer, New West has separate and independent fiduciary and statutory duties to each of its insureds. By definition, claims by many cannot be deemed "related" given these separate and independent duties. As shown below, courts have held this is an important factor for finding claims are not "related."

In order to gain a settlement in 2019, Rolan and the Class were required to give up all of the different types of claims which occurred at different times under different circumstances. The settlement agreement reads: "[T]he Class and Ms. Rolan hereby fully and forever release and discharge New West, its member-owners, officers, directors, and employees from any and all actions, claims, causes of action, demands, or expenses for damages or injuries, whether asserted or unasserted. They did not simply give up their made-whole claims.

These circumstances make it both fair and legal to conclude we are dealing with unrelated claims. Therefore, the $3,000,000 coverage for aggregate claims applies.

B. THE LAW IN SUPPORT

There are many cases holding that under circumstances similar to those here, a "related-claims" provision is ambiguous or unenforceable and therefore, cannot

defeat aggregate coverage. This is especially true when separate fiduciary duties are at issue, which is the case here.

In *Scott v. American Nat. Fire Ins. Co., Inc*., 216 F. Supp. 2d 689 (N.D. Ohio 2002), three clients filed separate malpractice suits against their attorney for failing to properly create a corporation that would protect their interests. The attorney's malpractice policy contained a broad "related-claims" provision quite similar to the one here:

> Claims alleging, based upon, arising out of or attributable to the same or related acts, errors, or omissions shall be treated as a single claim regardless of whether made against one or more than one insured. All such claims, whenever made, shall be considered first made during the policy period …. in which the earliest claim arising out of such acts, errors or omissions was first made and all such claims shall be subject to the same limits of liability.

Id. at 693.

The issue was whether or not "the malpractice claims [were] … separate claims subject to [the] aggregate insurance policy limits, or [were] 'related' claims subject to a single claim limit." *Id.* at 690. The Court held they were "separate" claims given the circumstances.

The Court applied standard contract laws similar to or identical to those used in Montana. *Id.* at 693.

The Court also recognized that courts differ over how broadly "related-claims" exclusions should be defined. It cited some of the cases Allied is relying on as examples of courts that used broad definitions of "related" to deny aggregate coverage. *Id*. at 694. Under the circumstances, however, these cases did not apply. Among other things, they were not cases involving separate fiduciary duties to those injured:

> [S]ome courts … focus on the distinctness of the attorney's duty to the clients, see *St. Paul Fire & Marine Ins. Co.,* 787 F. Supp. at 188; *Continental Cas. Co. v. Grossmann*, 271 Ill. App.3d 206, 207 Ill. Dec. 719, 648 N.E. 2d 175 (1995), or on the commonality of the losses, see *Nat'l. Union Ins. Co. of Pittsburgh, Pa.,* 23 F. Supp. 2d at 1070 (holding that malpractice claims were unrelated where the losses generated by the attorney's mistakes were different and not coterminous).
>
> ***Under this approach, if the attorney's duties are distinct and separate, or the actions result in distinct harms, then the actions in breaching those duties give rise to separate malpractice claims.*** In *St. Paul Fire & Marine Ins. Co.*, the Court found that three malpractice claims arising from an attorney's multiple representation of three clients in a criminal trial were unrelated. … The claims were not related because the attorney owed each client a separate duty.
>
> The St. Paul Fire & Marine Ins. Co. Court used the narrower causal connection definition of related but noted that it would reach the same result under the logical connection definition because "[a]lthough the errors and omissions [the attorney] committed grew out of highly similar factual situations, [the attorney] had a separate duty to each client and was rendering separate services to each." *Id*. Therefore, the Court found that the attorney committed multiple acts and omissions that "resulted in discrete losses to each of the defendants." *Id*.

Id. at 694 (emphasis added).

"In the absence of binding authority, the Court reason[ed] that [*Scott* was] more analogous to those cases that apply the separate duty to distinct harm approach. Using that approach, Scott's malpractice actions [were] unrelated because Scott owed separate and distinct duties to" his clients. *Id.* at 695.

Scott applies here. Like Scott, New West owed separate fiduciary duties to each insured: "Under the law in Montana, an insurance company owes what is called a fiduciary duty to its insured …. This duty is no less than that of a trustee." *Tynes v. Bankers Life Co*., 224 Mont. 350, 730 P.2d 1115, 1124 (1987). More than that, the legislature has created several high duties insurance companies owe separately to each insured. *Id.* Therefore, this Court should rule as a matter of law that the independent fiduciary and statutory duties New West owed to each insured makes each claim "separate" and not related.

In *Lexington Ins. Co. v. Lexington Healthcare Grp., Inc.*, 311 Conn. 29, 84 A.3d 1167 (Conn. 2014), a nursing home fire killed or injured several people. Thirteen negligence actions for wrongful death or serious bodily injury resulted. The trial court held a "related-claims" provision did not defeat aggregate coverage and the appeal court affirmed.

Like the one in Rolan, the "related-claims" provision was broad:

> "All claims arising from continuous, related, or repeated medical incidents shall be treated as arising out of one medical incident. Only the [p]olicy in effect when the first such claim is made shall apply to all such claims."

Id. at 1174. Like Allied, here, the insurance company argued "several … courts have determined the term to be unambiguous."

The Court was not persuaded because, "Language in an insurance contract … must be construed in the circumstances of [a particular] case, and cannot be found to be ambiguous [or unambiguous] in the abstract." *Id.* at 1175. Under the circumstances:

> It is far from clear from the policy's use of the term "related," with no more specific definition of that term provided, that the parties intended multiple losses suffered by multiple people, each caused by a unique constellation of negligent acts, errors and omissions, to be aggregated into a single loss, for purposes of coverage limits, simply because they shared a common, precipitating factor. Consequently, like the trial court, we construe the term in favor of providing more coverage, and hold that the individual defendants' claims do not arise from related medical incidents.

Id. at 1177.

Reviewing case law, the Court noted that "related claims" in its ordinary and plain sense pertains to a single undertaking that resulted in the same loss. "Conversely, multiple acts of negligence by an insured usually are held to be unrelated when, although connected by some aspect, they have caused distinctly different damages." *Id.*

The Court also approved cases holding the "related-claims" provision cannot defeat coverage where the insured owes a separate fiduciary duty to each person injured especially when they suffer different injuries. *Id.* at 1178-79 (reviewing several cases).

Applying *Lexington*, here, the claims are separate---not related. Like *Lexington*, New West separately caused "multiple losses [to] multiple people" through separate means. "[M]ultiple acts of negligence by an insured usually are held to be unrelated when, although connected by some aspect, they have caused distinctly different damages." *Id*. Even stronger than *Lexington,* the multiple acts occurred over a decade—not as a result of a single fire and New West, by definition, owed "separate" fiduciary and statutory duties to each insured.

Further, the "related-claims" exclusion in Allied's policy is ambiguous. It states claims are related if "logically, causally or in any other way" related. Words and phrases in an insurance policy are ambiguous when they are so imprecise and elastic as to lack any certain interpretation..." *Frost v. Whitbeck*, 2002 WI 129, 257 Wis. 2d 80, 90, 654 N.W. 2d 225 (Wis. 2002). The term related "in any way," is so imprecise it is incapable of meaning.

Likewise, "related logically," lacks any precise meaning: "Logic, like beauty, is in the eye of the beholder and greatly depends upon the subjective mental process of the reviewer. Incidents may be 'logically related' for a wide

variety of indefinable reasons." *Arizona Property and Cas. Ins. Guar. Fund* v. *Helme*, 153 Ariz. 129, 735 P.2d 451, 456-457 (1987) (holding "logically related" is ambiguous).

The only term which arguably is certain enough to avoid ambiguity is "related … causally." However, New West's wrongful acts occurring at different times, involving different people and causing different amounts of damages are not causally related and therefore, the "related-claims" exclusion does not apply.

See also, Financial Management v. Am. Intern., 506 F.3d 922 (9th Cir. 2007) (holding claims made by two investors against advisor are not related and distinguishing *Gregory* and *Bay City, supra*); *Beale v. American Nat. Lawyers Ins*., 843 A.2d 78 (Md. 2004) (holding attorney sued for malpractice involving five children with lead poisoning were not "related" because he owed separate fiduciary duties to each, following *Scott, supra*, and rejecting or distinguishing cases Allied relies on here.)

C. MONTANA LAW

Although Montana has never ruled on the "related-claims" exclusion, it has ruled that exclusions which create illusory coverage and/or do not meet reasonable expectations of the insured are either ambiguous or cannot be enforced. This either supports the conclusion that the "related-claims" provision, here, will not meet with favor or provides independent grounds for refusing to enforce it.

In *Hardy v. Progressive Specialty Ins. Co*., 2003 MT 85, the Montana Supreme Court adopted both the doctrine of reasonable expectations and illusory coverage. Hardy wanted to stack three $50,000 uninsured/under-insured motorist coverages to give him $150,000 in coverage after a serious accident. The only problem was his Progressive policy expressly would not allow it. It stated coverages could not be stacked and therefore, Hardy had only $50,000 in coverage. This explanation, however, conflicted with the declaration page which listed that he bought three under-insured coverages. *Id.* at ¶9.

The Montana Supreme Court *en banc* ruled for Hardy. The declaration page, showing three coverages, conflicted with offset provisions later in the policy, allowing recovery of only one coverage. "Consequently, we conclude that the policy in this case is subject to more than one reasonable interpretation and is, therefore, ambiguous" and would be construed against the insurer.

The Montana Supreme Court also held, "Public policy considerations that favor adequate compensation for accident victims apply… in spite of the fact that UIM coverage is not mandatory in Montana." *Id.* It determined *Transamerica Ins. Group v. Osborn*, 627 F. Supp 1405 (D. Mont. 1986) was "persuasive." "The federal court concluded that the UIM definition and the offset provision contradicted the declaration page and the reasonable expectation of the insured. …

It stated that the illusory nature of the coverage conflicted with the reasonable belief that the insured purchased $50,000 of additional UIM coverage." *Id.* at 22.

The *Hardy* Court also rejected the Ninth Circuit's position that requiring an adequate explanation on the declaration page would "rob[] the declaration page of any value because it effectively required full disclosure of the UIM provision on the declaration page." To the contrary:

> From a consumer's point of view, a declarations page may be his or her only plain and simple source of information and, if misleading, is of no value. A declarations page which suggests coverage in an amount which is not actually available is misleading.

Id. at ¶23. Furthermore, coverage can be illusory even if it is not totally defeated by an exclusion later in the policy. *See, Hardy, supra* at ¶28.

Hardy either supports New West's position or provides separate legal bases for holding that the "related-claims" exclusion, here, is ambiguous and unenforceable. New West had a reasonable expectation that if sued in class action, the aggregate coverage would apply. Its sole business was adjusting and paying millions of medical bills in an efficient, uniform and systematic manner for over 100,000 insureds. Therefore, if a legal mistake occurred when adjusting a certain type of claim, the same mistake would occur over and over again when adjusting the same type of claims. Its major concern, therefore, was with multiple or aggregate claims—not a single claim. Had it known Allied was going to interpret

"related claims" so broadly as to defeat its expectation, New West could have sought class action coverage through another insurer.

Moreover, the evidence shows New West did, in fact, have this expectation. Several months before Rolan filed her claims, New West had been sued in *Diaz v. State of Montana*, which involved virtually identical class action claims. It sent the complaint to Allied to analyze coverage and gain a defense. On April 27, 2009, Joseph Sappington, Esq., Allied's Senior Claims Analyst, responded with a ten-page, single-spaced letter. He addressed the same E&O policy applicable in Rolan's case—albeit for the preceding policy period when *Diaz* made her claims. He "analy[zed]" the *Diaz* made-whole and class action claims in light of the factual and legal allegations in the complaint. He set forth the pertinent limitations and exclusions. He defines the term "claim," but did not mention, let alone raise, the term "related claim." He concluded, "Accordingly, the MCEO policy provides for a per claim limit of liability of $1,000,000 and a *Maximum Aggregate Limit of Liability* of $3,000,000 …." Attachment 1, p. 5. **Nowhere did he place any limitation on aggregate coverage. Nor did he mention the "related-claims" exclusion.**

Had Sappington accurately informed New West in *Diaz* the "related-claims" provision negated class action coverage, New West would have had the opportunity to revise its policy for the next policy period, which is when Rolan

made her claims. But Allied did not raise the "exclusion until 2016--seven years into the lawsuit and eight years after *Diaz.* Allied's failure to disclose defeated the actual reasonable expectations of New West.

In addition, Allied's interpretation of its "related-claims" exclusion makes aggregate coverage illusory. Aggregate coverage was what New West needed, given the nature of its claims-adjusting business. According to Allied's interpretation, the "related-claims" provision wipes it out.

Hardy also states Montana's public policy "favor[s] adequate compensation for accident victims." *Hardy*, at ¶20. Allied's belated announcement about "related claims" has basically destroyed compensation for everyone in this class action. If it is allowed to stand, class members will receive pennies on the dollar. Rolan will lose most of the $200,000 with interest she is now owed.

In summary on this point, Montana insurance law favors New West. Our Court does not favor broad exclusions which tend to negate coverages set forth on the declaration page. It also gives weight to the reasonable expectations of the insured and factors in the public policy that insurance is intended to compensate the injured public. Moreover, the doctrines in *Hardy* provide additional independent grounds for following cases such as *Scott* and *Lexington*, *supra*.

III. ALLIED'S POSITION SHOULD BE REJECTED

Allied's authorities are not compelling under the circumstances of this case for a variety of reasons.

First, *WFS Financial, Inc. v. Progressive Cas. Ins. Co., Inc.,* 2007 WL 1113347 (9th Cir. 2007) is an unpublished opinion. According to Ninth Circuit rules, unpublished opinions are not to be cited as authorities. Indeed, we could not find the case in the FASTCASE database. The summary we located on the web stated it was unpublished. Beyond this, we note our Court in *Hardy* rejected the Ninth Circuit's position on illusory and reasonable expectation doctrines and the importance of the declaration page.

Bay Cities Paving v. Lawyers' Mutual Ins. Co., 855 P.2d 1263 (Cal. 1993) and *Gregory v. Hone Ins. Co*. 876 F.2d 602 (7th Cir. 1989) are factually distinguishable, which is important since ambiguities depend upon the circumstances of the case. *Bay City* involved multiple legal claims made by a single client against a single defendant. *Gregory, supra*, solely held a single attorney working on a single transaction who injured multiple persons were "related" claims. *Id.* at 606. It recognized that under different circumstances, claims may not be related. These cases were not found to be persuasive by *Scott* and *Lexington, supra*. Finally, these cases are in conflict with *Hardy*, *supra*, which recognizes that even clearly-written exclusions in conflict with the declaration page create an ambiguity and can be illusory.

American Medical Securities v. Executive Risk, 393 F. Supp. 2d 693 (E.D. Wisc. 2005) involves class actions, but is inconsistent with *Scott* and *Lexington* which recognize an insured with fiduciary duties results in separate—not "related" claims. Moreover, its broad interpretation does not comport with *Hardy, supra*.

Finally, Allied argues that class action claims are by definition related, relying on Justice McKinnon's dissent in *Rolan III.* First of all, if the other justices felt the same as the dissent, the case would not have been remanded for consideration of the "related-claims" issue.

Second, even cases Allied relies upon recognize the "related-claims" exclusion must be interpreted according to its "plain and ordinary" meaning—not a technical, legal one. *E.g., Gregory, supra* at 605. "This reliance on common understanding of language is bedrock." *Bay Cities*, *supra* at 699. It is the law in Montana. *See e.g., Parker v. SafeCo*., 2016 MT 173, ¶20. There are several technical requirements to form a class under M. R. Civ. P. 23. Most lawyers and judges are not familiar with their technical meaning—let alone health insurers like New West and doubtfully, casualty insurers like Allied. Therefore, neither could have intended that the technical legal requirements of Rule 23 were to be incorporated into the "related-claims" exclusion. The "plain and ordinary" meaning of "related" claims would not include claims occurring over a several year period involving separate people and separate damages—especially when based on a person with separate fiduciary duties to each person injured. These are the circumstances existing here.

Finally, it was within Allied's ability to make it clear "related" claims applies to class action claims. All it had to state was that class action claims are "related claims." It would not have complicated the declaration page to do so. It would have clarified the policy language. But Allied did not do so. It is responsible for any doubt or ambiguity.

In summary on this point, Allied is not entitled to a summary judgment that its "related-claims" provision nullifies class action coverage. Rolan and the Class should be entitled to an order that the $3,000,000 aggregate limit applies under the above authorities.

IV. CONCLUSIONS AND RELIEF REQUESTED

Rolan and the Class request the following:

(1) Allied's Motion for Summary Judgment should be denied.

(2) Rolan's Cross-Motion for Summary Judgment should be granted.

(3) If necessary, Rolan's Motion to Amend the pleadings to add affirmative defenses for illusory coverage and reasonable expectations should be granted. These doctrines are not set forth in M. R. Civ. P. 8, which lists several affirmative defenses. They could be considered concepts related to contract interpretation, rather than affirmative defenses. Anticipating Allied might argue otherwise, however, Rolan has made a Motion to Amend under M. R. Civ. P. 15,

which is to be construed liberally to allow amendments whenever "justice so requires."

DATED this 8th day of June, 2022.

THUESON LAW OFFICE

ERIK B. THUESON
58 South View Road
Clancy, MT 59634

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I served true and accurate copies of the foregoing document upon counsel of record by the following means:

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DATED this 8th day of June, 2022.

Elaynetta Simmons

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VIA EMAIL ahuschka@nwhp.com

April 27, 2009

To: Angela Huschka
New West Health Services
130 Neill Ave.
Helena, MT 59601

Re:		
	Insured:	New West Health Services
	Insurer:	Darwin Select Insurance Company
	Policy No.:	0303-5534 (MCEO Policy)
	Policy Period:	04/01/2008 to 04/01/2009
	Policy Limit:	$1,000,000 for each Claim made in the Policy Period and $3,000,000 in the aggregate for all Claims
	Retention:	$50,000
	Subject:	Diaz, Jeannette
	Darwin Ref. No.:	20091175
	Insured:	New West Health Services
	Insurer:	Darwin National Assurance Company
	Policy No.:	0303-5533 (HCDO Policy)
	Policy Period:	04/01/2008 to 04/01/2009
	Policy Limit:	$1,000,000 for each Claim made in the Policy Period and $3,000,000 in the aggregate for all Claims
	Retention:	$50,000[1]
	Subject:	Diaz, Jeannette
	Darwin Ref. No.:	20091177

Dear Ms. Huschka:

I am writing on behalf of Darwin National Assurance Company ("DNA") with respect to the referenced Health Care Organization Directors and Officers Liability Insurance Policy Including Employment Practices Liability Coverage Policy (the "HCDO Policy") and Darwin Select Insurance Company ("DSI") in respect to the Managed Care Organization Errors and Omissions Liability Policy (the "MCEO Policy") (HCDO Policy and MCEO Policy collectively, the "Policies"; DSI and DNA collectively "Darwin"). This letter provides you with a summary of

[1] Applies to Insuring Agreement B(1) & (2).

coverage under the above Policies in connection with the above referenced action. We previously acknowledged receipt of this matter on April 7, 2009.

This letter will refer to certain allegations asserted by the plaintiffs. We recognize that such allegations are unsubstantiated contentions at this time. We cite the allegations only for analytical reasons. Nothing in this letter is intended to suggest or imply that the allegations have any legal or factual merit.

This letter does not modify any of the terms and conditions of the Policy. Please note that the words that appear in **bold** print below are defined in the Policy.

SUMMARY OF FACTS

We have reviewed the Proposed Amended Compliant[2] (the "Amended Complaint") captioned, *Jeannette Diaz, Leah Hoffman-Bernhardt, Rachel Laudon, individually and on behalf of others similarly situated v. Blue Cross and Blue Shield of Montana, New West Health Services, Montana Comprehensive Health Association, State of Montana, and John Does 1-100*[3], filed on or about March 16, 2009 in the Montana First Judicial District Court, Lewis & Clark County (the "Action"). This summary of facts is based on the allegations contained in the Amended Complaint.

Plaintiffs, residents of Montana, bring the Action on behalf of themselves and on behalf of those similarly situated. The Plaintiffs claim that they suffered injuries caused by the legal fault of others and have not been made whole. It is further alleged that the Defendants have avoided payment of medical bills that they are allegedly contractually obligated to pay by claiming the medical costs are the responsibility of those at fault. The Plaintiffs allege that Defendants' failure to pay benefits violates Montana's constitution, statutory law, common law and established public policy. More specifically, the Plaintiffs allege that the Defendants' actions violate Montana's "made whole" law which is enumerated in MCA §33-30-1102, "the insurer's right to subrogation. . . may not be enforced until the injured insured has been fully compensated."

Plaintiff, Hoffman-Bernhardt alleges that that in September 2005 she was severely injured as a result of a motor vehicle collision. The person who negligently caused the accident was insured by State farm. Between 2005 and 2007 it is alleged that State Farm paid medical costs of several thousand dollars directly to the Plaintiff's medical providers under it liability policy. Allegedly, the Plaintiff submitted a claim to Defendant New West requesting that the insurance plan pay for

[2] The original Complaint was filed on or about October 23, 2008. To the extent that the Plaintiffs' Motion to Amend Complaint is not granted by the Court, Darwin reserves all of its rights under the Policies and at law to revise its coverage determination accordingly.

[3] We cannot provide an analysis of the coverage, if any, available to the DOE defendants without more detailed information concerning those defendants' true identities and the capacities in which they served or were related to an **Insured**. Accordingly, Darwin hereby reserves all of its rights under the Policies and applicable law to review the applicable coverage(s), if any, afforded to those particular individuals and entities should they be identified during the course of these proceedings.

the cost of medical care she had incurred as a result of the collision. Defendant New West allegedly declined to pay the benefits because everything billed to them was refunded and billed to the auto insurer, State Farm. Plaintiff claims that New West had no right to "refund" any medical payments when she had not first been "made whole." By allegedly violating Montana's "made whole" laws, Plaintiff claims that the Defendants were unjustly enriched at the Plaintiff's expense.

The three named Plaintiffs each allege similar factual circumstances and each bring causes of action for declaratory relief regarding payments due and owing to them by the Defendants.[4] It is alleged that the conduct of the Defendants violates MCA §§33-18-201 *et seq.* which prohibits failures to pay claims on a variety of grounds, violation of MCA §§27-1-311 and 27-1-312 for breach of the insurance contracts, and violation of MCA §27-1-712 by asserting denials or failing to pay claims due to the existence of third party liability when the defendants allegedly knew there existed no reasonable or lawful ground for doing so given Montana's "made whole" laws. Lastly, the Plaintiffs allege that the Defendants violated MCA §28-2-405 and MCA §28-2-406 sounding in deceit and constructive fraud.

The Complaint further sets forth actions for class certification, declaratory relief and payment, and other class claims for payment and breach of contract and similar Montana statutes as those referred to above. Plaintiffs seek both monetary damages, exemplary damages, declaratory relief, restitution, attorneys' fees and costs.

SUMMARY OF COVERAGE UNDER THE MCEO POLICY

The Insuring Agreement to the MCEO Policy (§ I) states that the **Underwriter** will pay on behalf of any **Insured Loss** which the **Insured** is legally obligated to pay as a result of a **Claim** that is first made against the **Insured** during the **Policy Period** or during any applicable Extended Reporting Period. New West Health Services ("New West") is an **Insured Entity** and is therefore an **Insured** under the MCEO Policy. (Definitions §§ IV(G), (H)).

"**Claim**" is defined in Definitions § IV(C) as any written notice received by any **Insured** that a person or entity intends to hold an **Insured** responsible for a **Wrongful Act** which took place on or after the retroactive date listed in ITEM 7 of the Declarations. In clarification and not in limitation of the foregoing, such notice may be in the form of an arbitration, mediation, judicial, declaratory or injunctive proceeding. A **Claim** will be deemed to be made when such written notice is first received by any **Insured**.

"Wrongful Act" is defined as

> (1) any actual or alleged act, error or omission in the performance of, or any failure to perform a **Managed Care Activity** by any **Insured Entity**

[4] Count 1 of the Proposed Amended Complaint on behalf of Plaintiff Diaz appears to make allegations against only Defendants the State of Montana and Blue Cross, Count 2, made on behalf of Plaintiff Hoffman-Bernhardt appears to make allegations against the State of Montana, New West and Blue Cross, Count 3 on behalf of Plaintiff Laudon appears to make allegations against the Montana Comprehensive Health Association and Blue Cross.

> or by any **Insured Person** acting within the scope of his or her duties or capacity as such;
>
> (2) any actual or alleged act, error or omission in the performance of, or any failure to perform, **Medical Information Protection**, by an **Insured Entity** or by any **Insured Person** acting within the scope of his duties or capacity as such; and
>
> (3) any **Vicarious Liability** for:
>
> > (a) the performance of, or any failure to perform:
> >
> > > (i) a **Managed Care Activity**;
> > >
> > > (ii) **Medical Information Protection**;
> >
> > (b) the rendering of, or failure to render, **Medical Services**; provided, that **Wrongful Act** shall not include any **Insured's** actual or alleged direct liability for the rendering of, or failure to render, **Medical Services**; or
> >
> > (c) any actual or alleged **Sexual Activity**; provided, that **Wrongful Act** shall not include any **Insured's** actual or alleged direct liability for any **Sexual Activity**.

(Definitions §IV(W).

The definition of "**Managed Care Activity**" means any of the following services or activities: **Provider Selection**; **Utilization Review**; advertising, marketing, selling, or enrollment for health care or workers' compensation plans; **Claim Services**; establishing health care provider networks, reviewing the quality of **Medical Services** or providing quality assurance; design and/or implementation of financial incentive plans; wellness or health promotion education; development or implementation of clinical guidelines, practice parameters or protocols; triage for payment of **Medical Services**; and services or activities performed in the administration or management of health care plans or workers' compensation plans. (Definition § IV(K)).

Specifically, "**Utilization Review**," is defined to mean "the process of evaluating the appropriateness or necessity of **Medical Services** for purposes of determining whether payment or coverage for such **Medical Services** will be authorized or paid for under any health care plan, but only if performed by an **Insured**" and "**Claim Services**" is defined to mean "the submission, handling, investigation, payment or adjustment of claims for benefits or coverages under health care or workers' compensation plans." (Definition § IV(U), (D)).

As the Complaint includes allegations sounding in a **Managed Care Activity**, and the allegations were apparently first made against an **Insured** in writing during the **Policy Period**,

the conditions precedent to the Insuring Agreement appear to be satisfied. Accordingly, the MCEO Policy provides for a Per **Claim** Limit of Liability of $1,000,000 and a Maximum Aggregate Limit of Liability of $3,000,000 subject to a $50,000 retention applicable to **Loss**, including **Defense Expenses**, for each **Claim**.

Under the MCEO Policy the **Underwriter** has the right and duty to defend any **Claim** made against any **Insured** which is covered by this MCEO Policy even if the allegations of such **Claim** are groundless, false or fraudulent. (Insuring Agreement § I). In addition and pursuant to the MCEO Policy, the amount stated in ITEM 3(a) of the Declarations shall be the maximum aggregate Limit of Liability of the **Underwriter** for all **Loss**, including **Defense Expenses**, resulting from all **Claims** for which this MCEO Policy provides coverage, regardless of the number of **Claims**, the number of persons or entities included within the definition of **Insured**, or the number of Claimants. (Conditions § III(A)(1)). Further, "The obligation of the **Underwriter** to pay **Loss**, including **Defense Expenses**, will only be in excess of the applicable retention set forth in ITEM 4 of the Declarations." (Conditions § III(A)(3)).

Note also that under the MCEO Policy, no **Insured** may incur any **Defense Expenses** or admit liability for or settle any **Claim** without the **Underwriter's** written consent. (Conditions § III(D)(1)). The **Underwriter** will have the right to make investigations and conduct negotiations and, with the consent of the **Insureds**, enter into such settlement of any **Claim** as the **Underwriter** deems appropriate. If the **Insureds** refuse to consent to a settlement acceptable to the claimant in accordance with the **Underwriter's** recommendation, then subject to the **Underwriter's** maximum aggregate Limit of Liability set forth in ITEM 3(a) of the Declarations, the **Underwriter's** liability for such **Claim** will not exceed:

(a) the amount for which such **Claim** could have been settled by the **Underwriter** plus **Defense Expenses** up to the date the **Insureds** refused to settle such **Claim** (the "Settlement Amount"); plus

(b) sixty percent (60%) of any **Loss** and/or **Defense Expense** in excess of the Settlement Amount incurred in connection with such **Claim**. The remaining forty percent (40%) of **Loss** and/or **Defenses Expenses** in excess of the Settlement Amount will be carried by the **Insured** at its own risk and will be uninsured.

In addition, pursuant to Conditions § III(B)(1), if during the **Policy Period** or any applicable Extended Reporting period, any **Claim** is first made against any **Insured**, the **Insureds** must, as a condition precedent to any right to coverage under this Policy, give the **Underwriter** written notice of such **Claim** as soon as practicable thereafter and in no event later than:

(a) with respect to a **Claim** made during the **Policy Period**, ninety (90) days after the end of the **Policy Period**; or

(b) with respect to a **Claim** made during an Extended Reporting Period, ninety (90) days after such **Claim** is first made.

Further, pursuant to Conditions § III(D)(2) the **Underwriter** will have no obligations to pay **Loss**, including **Defense Expenses**, or to defend or continue to defend any **Claim** after the **Underwriter's** maximum aggregate Limit of Liability, as set forth in ITEM 3(a) of the Declarations, has been exhausted by the payment of **Loss**, including **Defense Expenses**. If the **Underwriter's** maximum aggregate Limit of Liability, as set forth in ITEM 3(a) of the Declarations, is exhausted by the payment of **Loss**, including **Defense Expenses**, the premium will be fully earned.

As we are assuming New West's defense in this matter I will be in contact with you shortly to discuss the retention of Kimberly Beatty of Browning, Kaleczyc, Berry & Hoven as counsel.

Given the allegations in the Complaint, please appreciate the potential implication of the following MCEO Policy provisions, which may operate to limit or preclude coverage in this matter.

The MCEO Policy stipulates that, except for **Defense Expenses**, the **Underwriter** shall not pay **Loss** for any **Claim** brought about or contributed to by:

(1) any willful misconduct or dishonest, fraudulent, criminal or malicious act, error or omission by any **Insured;**

(2) any willful violation by any **Insured** of any law, statute, ordinance, rule or regulation; or

(3) any **Insured** gaining any profit, remuneration or advantage to which such **Insured** was not legally entitled.

Determination of the applicability of Exclusion A may be made by an admission or final adjudication in a proceeding constituting a **Claim**, or in a proceeding separate from or collateral to any proceeding constituting a **Claim**. (Exclusions § II(A) as amended by Endorsement No. 6).

Section II Exclusions § (C)(6), sets forth that the **Underwriter** shall not pay any **Loss**, including **Defense Expenses**, for any **Claim** for any actual or alleged express or assumed liability of any **Insured** under an indemnification agreement; provided, that this EXCLUSION (C)(6) shall not apply to any tort liability that would have attached to the **Insured** in the absence of such agreement and is otherwise insured under the Policy.

Section II Exclusions § (C)(7), sets forth that the **Underwriter** shall not pay any **Loss**, including **Defense Expenses**, for any **Claim** based upon, arising out of, resulting from, or in any way involving any actual or alleged:

(a) failure to obtain, implement, effect, comply with, provide notice under or maintain any form, policy, plan or program of insurance, stop loss or provider excess coverage, reinsurance, self-insurance, suretyship or bond.

(b) commingling or mishandling of funds with dishonest intent;

(c) failure to collect or pay premiums, commissions, brokerage charges, fees or taxes.

The MCEO Policy defines **Loss** as **Defense Expenses** and any monetary amount which an **Insured** is legally obligated to pay as a result of a **Claim**; including punitive, exemplary or multiplied damages ("Punitive Damages") awarded in connection with any **Claim** covered by this Policy, other than **Claims** for **Antitrust Activity**, and only if such Punitive damages are insurable under applicable law. law.[5] **Loss**, however, does not include:

1) fines, penalties, or taxes and punitive, exemplary or multiplied damages provided that:

   (a) if punitive, exemplary or multiplied damages (hereafter referred to as "Punitive Damages") are awarded in connection with any **Claim** covered by this Policy, other than **Claims** for **Antitrust Activity**, the maximum amount payable by the **Insurer** attributable to Punitive Damages for any **Claim**, or in the aggregate for all **Claims**, is $3,000,000. This Punitive Damages Limit of Liability is part of, and not in addition to, the aggregate Limit of Liability indicated in ITEM 3(a) of the Declarations; and

   (b) if fines, penalties or Punitive Damages are awarded in connection with any **Claim** for **Antitrust Activity**, the maximum amount payable by the **Insurer** is the amount indicated in ITEM 3(b) of the Declarations. This Antitrust Limit of Liability is part of, and not in addition to, the aggregate Limit of Liability indicated in ITEM 3(a) of the Declarations; and

   (c) the coverage described in subparagraphs (a) and (b) above shall apply unless prohibited by law;

2) fees, amounts, benefits or coverage owed under any contract with any party including providers of health care services, health care plan or trust, insurance or workers' compensation policy or plan or program of self-insurance;

3) non-monetary relief or redress in any form, including without limitation the cost of complying with any injunctive, declaratory or administrative relief; or

4) matters which are uninsurable under applicable law,

(Definitions § IV(J) as amended by Endorsement No. 5).

[5] Endorsement No. 7 to the Policy discusses which jurisdiction's law shall apply when determining the insurability of Punitive Damages.

Note that pursuant to Conditions § III(G)(1), the MCEO Policy shall be excess of and shall not contribute with:

(a) any other insurance or plan or program of self-insurance, unless such other insurance or self-insurance is specifically stated to be in excess of this Policy; and

(b) any indemnification to which an **Insured** is entitled from any entity other than another **Insured**.

This Policy shall not be subject to the terms of any other policy or insurance or plan or program of self-insurance.

Accordingly, please immediately (1) advise whether there are any other insurance policies available to respond to the allegations in this matter; (2) advise what steps have been taken to secure coverage on behalf of the **Insured** under any other potentially applicable insurance policy; and (3) send us a copy of the coverage position(s) issued by any other insurance carrier(s) in connection with this matter. We expressly reserve all rights with respect to any and all other insurance and indemnification.

In addition, Conditions § III(G)(2), if any other policy or policies issued by the Underwriter or any of its affiliated companies, or by any predecessors or successors of the Underwriter or its affiliated companies, shall apply to any **Claim**, then the aggregate limit of liability with respect to all **Loss** under this Policy and all covered loss under such other policies shall not exceed the highest applicable limit of liability, subject to its applicable deductible or retention, that shall be available under any one of such policies, including this Policy. This Condition (G)(2) shall not apply with respect to any other policy which is written only as specific excess insurance over the Limit of Liability of this Policy.

SUMMARY OF COVERAGE UNDER THE HCDO POLICY

After reviewing the foregoing materials in conjunction with the HCDO Policy, we regret to inform you that for the following reasons, there does not appear to be any coverage available for this matter under the HCDO Policy.

The Insuring Agreement to the HCDO Policy (§ I(B)(2)) states that the **Insurer** will pay on behalf of an **Insured Entity Loss** from **Claims** first made against an **Insured Entity** during the **Policy Period** for **Wrongful Acts**. New West Health Services ("New West") is identified in the HCDO Policy as the **Parent Corporation** and is therefore both an **Insured Entity** and an **Insured** under the HCDO Policy. **Insured Entity** means the **Parent Corporation** and any **Subsidiary** created or acquired on or before the Inception Date in ITEM 2(a) of the Declarations. (Policy II(H)).

"**Claim**" is defined in § II(B) of the HCDO Policy in relevant part as (1) any written demand for monetary relief; or (2) any civil proceeding in a court of law or equity, which is commenced by the filing of a complaint, motion for judgment or similar proceeding. Section II(Z)(5) of the

HCDO Policy defines **Wrongful Act** as including "any other actual or alleged act, error, omission, misstatement, misleading statement or breach of duty by any **Insured Entity**".

A **Claim** is deemed first made when an **Insured** receives notice of the **Claim**. (Policy § II(B)). The original Complaint was filed on or about October 23, 2008. As we are unsure as to when the **Insured** was served with the original Complaint Darwin reserves all of its rights and defenses under the Polices and at law regarding when the **Claim** is to be deemed first made.[6]

As the Complaint is a written demand for monetary damages and is a civil proceeding, was first made against an **Insured Entity** during the **Policy Period**, and is based, in part, on the actions of an **Insured Entity**, the conditions precedent to the Insuring Agreement appear to be satisfied. However, certain specific exclusions to the HCDO Policy preclude coverage for this **Claim** in its entirety.

Exclusion III(C)(5) provides:

> C. This Policy shall not provide coverage for any **Claim** based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving:
>
> (5) any actual or alleged act, error or omission in the performance of, or failure to perform, **Managed Care Organization Business Activities** by any **Insured** or by any individual or entity for whose acts, errors or omissions an **Insured** is legally responsible, except that this Exclusion C(5) shall not apply to **Claims** for **Provider Selection Practices** performed solely for an **Insured Entity**, and provided that the **Insured Entity** is not a **Managed Care Organization**.

"**Managed Care Organization Business Activities**" means "services or activities performed in the administration or management of healthcare plans; **Provider Selection Practices**, **Utilization Review**; case management; disease management; advertising, marketing or selling healthcare plans or healthcare insurance products; handling, investigating, or adjusting claims for benefits or coverages under healthcare plans; establishing healthcare provider networks; and reviewing the quality of **Medical Services** or providing quality assurance." (Policy §II(N)). "**Utilization Review**" means "the process of evaluating the appropriateness, necessity, or cost of Medical Services for purposes of determining whether payment or coverage for such Medical Services will be authorized or paid for under any health care plan. **Utilization Review** shall include prospective review of proposed payment or coverage for Medical Services, concurrent review of ongoing **Medical Services**, and retrospective review of already rendered **Medical Services** or already incurred costs." (Policy §II(X)).

[6]Darwin further reserves its rights under the Policies and at law to the extent that New West first received written notice of the **Claim** prior to being served with the original Complaint, and/or to the extent that there may exist a **Related Claim** to this matter under the HCDO Policy (see Conditions §IV(I); Definitions §II(U)).

The allegations in the Complaint indicate that the **Claim** arises from and is directly related to New West's conduct of **Managed Care Organization Business Activities**, including but not limited to, **Utilization Review** services, handling, investigating or adjusting claims for benefits or coverages under healthcare plans. As such, there is no coverage for the **Claim** under the HCDO Policy.

As it appears that there is no coverage for this **Claim** in its entirety under the HCDO Policy, we are not providing any additional comment regarding other coverage issues that may exist with respect to this **Claim**. If you possess any additional information that you believe would bear on coverage in this matter, please forward that information to me at your earliest convenience.

DNA's position with respect to this matter is based on the information provided to date, and is subject to further evaluation should additional information become available. DNA continues to expressly reserve all rights and defenses under the HCDO Policy, and available at law and in equity, with respect to this matter, including but not limited to, the right to assert additional terms and conditions of the HCDO Policy which may become applicable as new information is learned, and the right to deny coverage for this matter on additional and/or alternative bases.

CONCLUSION

Please keep us advised of any significant developments in this matter, and send us copies of significant motions, pleadings, orders, correspondence and other documents.

Darwin National Assurance Company and Darwin Select Insurance Company respectfully reserve all of their rights and defenses under the Polices and available at law with respect to this matter.

Please feel free to contact me if you have any questions.

Very truly yours,

Joseph Sappington

cc: Gina Nawrot
CRC of Illinois
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