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Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

SHARON and GENE ATKINSON, Plaintiffs/Appellants, vs. GEM INSURANCE COMPANY, & PREMIER MEDICAL NETWORK & SARA MEADOWCROFT, and Does 1 to 20, inclusive, Defendants/Appellees	)	Case No.: 97-0491-CA Category: 15

COPY

REPLY BRIEF OF PLAINTIFFS - APPELLANTS ATKINSON

Appeal from the Third Judicial District Court
Salt Lake County, State of Utah,
Honorable HOMER WILKINSON, Judge Presiding.

UTAH COURT OF APPEALS
BRIEF

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CORRECTED STATEMENT OF FACTS:

Plaintiffs/Appellants initially move to correct certain errors in the Defendants'/Appellees' Statement of the Case. In their brief Defendants/Appellees assert:

1) "Premier pre-authorized the surgery . . ." **Brief,** pages 3 and 8. Defendants offer no reference to the record confirming this because there is no documentation. Premier never authorized the surgery nor any part of it. To make assertions without citations to the Record violates **Rule 24(a)(9)** of the **Utah Rules of Appellate Procedure**. Also, in **Uckerman v. Lincoln Nat'l Life Ins. Co.,** 588 P2d. 142, (UT. 1978) the court said:

> **The Supreme Court need not, and will not, consider any facts not properly cited to, or supported by, the record.**

At page 5, point 6, Defendants assert, "Premier refused to certify Plaintiffs' request for pre-certification of the hospital charges . . . " Direct contradiction of this misrepresentation is found in **Appendix "A"** to Plaintiffs' Opening Brief. This exhibit is a letter from **Premier** to the Atkinsons wherein **Premier** says it "was unable to pre-certify" the Atkinsons' request for benefits because "it did not meet (Premier's) criteria for medical necessity/appropriateness." **Record** 6, point 12; and 36, point 12; 146, 191, point 4. (It is a document admissible under **Rule 901 (b)(4)** of the **Utah Rules of Evidence.**)

2) That Mrs. Atkinson "attempts to have the court believe that their contractual claim is for more than the hospital charges. It is not." **Brief** @22 Plaintiffs have complained of a direct loss in paying for the surgery in addition to claiming the costs and reasonable attorney's fees associated with this lawsuit, for severe emotional distress and for other special and general damages. **Record** @ 24-25. Under, **Beck v. Farmers,** (1985) 701 P2d. 795, 801-802, all these are recoverable contract damages.

3) Defendants say they moved for summary judgment "after Plaintiffs had conducted significant discovery." Defendants' **Brief,** pages 4 and 8. The only discovery accomplished was that Plaintiffs served 2 sets of interrogatories and 2 requests for production of document (on each Defendant) which produced 1560 documents. Yet, Defendants first filed their motion for summary judgment on 10/17/96 only 90 days after answering Plaintiffs' complaint on 07/17/96. **Record,** 60 & 33. No depositions were set before Defendants brought their motion and Judge Wilkerson suspended further discovery during the pendency of the summary judgment motion. **Record** @ 294, page 11, lines 5-7. Plaintiffs had no opportunity to depose anyone concerning any of the 1560 pages of documentation Defendants produced.

4) **"GEM** paid benefits for the oral surgery, anesthesiologist, anesthesia, and all other benefits related to the oral surgery .

. ." **Brief,** page 7, point 16 and pages 11, 22 & 23. **GEM** and/or **PREMIER** never certified any part of the Plaintiffs' request for benefits. Again, Defendants make no citation to the record proving **GEM** certified any part of the Atkinson's request for benefits. Thus, again they violate **Rule 24(a)(9)** of the **U.R.A.P.**

GEM paid certain charges connected with the surgery only after they were on formal notice that Plaintiffs intended to sue them. **Record,** 194, 235. **GEM** paid the first claim 05/06/96 only 46 days before Plaintiffs' filed their lawsuit and the policy requires the Atkinson wait at least 60 days after notice to **GEM** of the claim before filing suit. **Record,** 220, 1, 111, and 251. It is clear that since Defendants never approved any part of the Plaintiffs' request for benefits, they were not going to pay for it. And it was only by the threat of an incipient lawsuit that **GEM** finally paid certain costs associated with the surgery. Plaintiffs characterize such conduct as bad faith.

A R G U M E N T S:

PREMIER AS GEM'S AGENT:

Defendants allege, "Premier is not an insurer at all. Also Plaintiffs do not have a direct contractual relationship with Premier." **Brief,** page 6, point 7. Plaintiffs have alleged and Defendants have agreed **Premier** is an agent of **GEM.** **Record,** 85,

143-145, and 188-192. Plaintiffs allege **Premier** is **GEM's** agent when deciding whether to pre-certify or deny certification to a **GEM's** insured's request for benefits. Likewise, **Premier** is **GEM's** agent under the definitions promulgated by the **Utah Insurance Commissioner's Rules (R590-89-4 (A)(B)** and **(F))** and under the **Insurance Code's, "Claims Practices Act", U.C.A. 31A-26-303(1). Record,** 143-145, 188-192.

Plaintiffs are third party beneficiaries of the **GEM - Premier** contract. **Record,** 145-146; 188-192. As additional authority for the Atkinson's right to sue **Premier** in bad faith because **Premier** was **GEM's** agent and that the Atkinson's were third party beneficiaries of the **GEM - Premier** contract, Plaintiffs cite, **Barney v. Aetna Cas. & Sur. Co.,** 185 CA3d 972; 230 Cal. Rptr. 215, 219:

> Where a contract confers on one party a discretionary power affecting the rights of others, a duty is impose to exercise that discretion in good faith and in accordance with fair dealing. (citations omitted.)

Further, under **Broadwater v. Old Republic,** (UT, 1993) 854 P2d 527,536, third party beneficiaries are those persons:

> **Recognized as having enforceable rights created in them by a contract to which they are not parties and for which they give no consideration.** (citations omitted.)
>
> **To have an enforceable right, the contracting parties must have clearly intended to confer a separate and distinct benefit upon the third party.** (citations omitted.)
> See also arguments in
> **Record,** @ 145-146; 188-191.

Plaintiffs have alleged **GEM** and **Premier** acted in bad faith, made misrepresentations and conspired to defraud them of the benefits of their contract. **Record,** 5-18 In **Beck,** our Supreme Court recognized both an insurer's duty to act in good faith and that a breach of this duty can result in tortuous causes of action. **Beck** supra, @ 800, ftnt. 3

Plaintiffs herein are members of the class (**GEM's** insureds) for whose benefit the **GEM - PMN** contract was expressly made and consequently are expressed third party beneficiaries thereunder.

> **A third party may enforce contract expressly made for his benefit and in appropriate cases his right to enforce the contract extends to implied covenants.**
>
> **Northwest Mut. Ins., v. Farmers Ins. Grp,** 76 CA3d 1036; 143 Cal. Rptr., 415, 421-422. (CA 1978)

EMERGENCY SURGERY:

Counsel argues, "Mrs. Atkinson's treatment was not of an emergency in nature in that the treatment took place approximately 10 months after diagnosis." **Brief**, page 12. Yet, on 12/15/95, Dr. Bull said:

> . . . . .She underwent two vessel coronary artery bypass grafting at Salt Lake Regional Medical Center on November 6th, 1995. In follow-up she made a satisfactory recovery following this procedure. She **now requires** oral surgery for removal of multiple abscessed teeth. . . .
>
> **Record,** @ 257.

On 12/20/95, Dr. Castle said:

> Sharon Mayes-Atkinson has symptomatic artery disease for which on November 6, 1995, she had two vessel coronary bypass graft surgery. **At that time**, she had abscesses in her mandible for which she was treated with antibiotics. It has been strongly recommended that she have this corrected as soon as her cardiac condition and recovery have stabilized."
>
> **Record,** @ 258.

On 12/20/95, Dr. Walker said:

> The above named patient is scheduled to have a subtotal odontectomy on December 29, 1995 at Salt Lake Regional Medical Center. . . .
>
> **Record,** @ 259.

And on 12/21/95, Dr. Evers said:

> . . . . At this time she is stable . . .
>
> **Record,** @ 256

Basically, these records reflect Sharon Atkinson underwent heart surgery on 11/06/95 and the problem of the abscessed teeth required immediate medical intervention so soon as she stabilized from the surgery. She was considered stable on 12/21/95 and surgery was scheduled for 12/29/95, eight days later. The delay from 12/29/95 to 02/05/96 was solely caused by Defendants refusal to approve the surgery. In the interim, Plaintiffs had to secure the money for the surgery. So, in difference to Defendants' counsel's opinion, the records reflect this was urgent surgery.

ABSCESSED TEETH vs. POISONED BLOOD:

Defendant's counsel argues the condition underlying Mrs. Atkinson's surgery was "abscessed teeth" in difference to

"poisoned blood." **Brief**, @ 10 & 18. The distinction is medically without merit. It is not contested that her four treating doctors agreed that her abscessed teeth required extraction. Why? Because they were "abscessed." "Abscess" means, a localized collection of pus formed by tissue disintegration and surrounded by an inflamed area. *American Heritage Dictionary, New College Edition*.

Mrs. Atkinson needed the teeth removed to stop further infection, i.e., to stop further disintegration of the tissue surrounding her teeth. The infection, the pus was entering her bloodstream and this needed to be stopped. Thus, the underlying condition addressed by extracting the teeth was the pus generated by the tissue disintegration. This was a medical problem and should have been covered under the medical provisions of her policy.

Assuming arguendo, this was not a "medical" problem but rather a dental one, in moving to stop the infection, the surgery was a "preventive" procedure. And under the **GEM's** Outline of Coverage, the dental benefit for "preventive" dental care is paid at 100%. A hundred percent would include all hospital charges. This directly contradicts the exclusion. **Record,** @ 113, point 5, Optional Coverage.

GENERAL vs. LOCAL ANESTHESIA:

In their Brief Plaintiffs assert that several provisions of the dental policy are inconsistent with the exclusion. One such

provision provided that, "**General** anesthesia is a benefit only when used in conjunction with oral surgery." **Brief**, @ 13-15 **Record,** @ 254, point 3. That is, it is a benefit only when used in a hospital setting and "general anesthesia and oral surgery must be provided by different providers." Understandably, the Atkinsons could reasonably believe that because the general anesthesia was covered, so were the hospital charges. Defendants now argue that this is not inconsistent with the exclusion because teeth extractions, even with anesthesia, are usually done in a dentist's office. **Defendants' Brief**, @ 19. Defendants, however, fail to distinguish between "local" and "general" anesthesia. General anesthesia is usually done in a hospital setting by an anesthesiologist while a local anesthesia can be administered in a dental office by a dentist. Moreover, the Defendants' argument violates the policy requirement that the care "be provided by different providers", i.e., the dentist can't provide the anesthesia. Finally, **local** anesthesia is not a covered benefit. See, **Record** Point 7, pages 109 & 254.

It is widely understood that general anesthesia is a delicate medical procedure that can cause many serious complications including death. Defendants' argument ignores both this and Dr. Walker's position:

> . . . . Due to the extensive nature of her oral surgery and her co-existent cardiac disease, she will require monitoring under the care of an **anesthesiologist** during her oral surgery. **Record,** @ 257.

Another important point is that while the policy requires a licensed dentist, Mrs. Atkinson's surgery was performed by Dr. Walker a dentist, a medical doctor, a surgeon and a Diplomat of the American Board of Oral and Maxillofacial Surgery. **Record,** 253 point 4, 257. Clearly, the anesthesia required here was not a novocain injection and this surgery was not simply "pulling a tooth."

DEFENDANTS' OFF-POINT ARGUMENTS:

1) Defendants miss the point when they argue that that an insurer could exclude coverage for cancer or that this policy excludes treatment for injuries sustained during the commission of a felony. They attempt to use these loose examples as analogies to the present exclusion. **Brief,** page 16. But they miss the point in assuming that the cancer and felony exclusions are unambiguous. If, like the exclusion in contest, these exclusions are ambiguous then they would not be enforceable.

Instantly, the pivotal issue surrounds the question of whether the exclusion is ambiguous, not whether an insurer has a right to draft exclusions into an insurance policy.

2) Plaintiffs cited legal authority that reflects that insurance policy provisions must be construed from the perspective an average, reasonable purchaser of insurance. Plaintiffs' **Brief**, @ 23. Defendants have not disputed this.

Defendants' **Brief**, 13,14, & 17. But, Defendants then go on to argue the interpretation should be from a legal or judicial perspective. On page 18 of their brief, Defendants admit to ambiguity between provisions of the policy. Continuing, they argue that the court should enforce the specific provisions of the exclusion (which exclude all hospital changes incurred "in conjunction with dentistry') over the general provisions which (Defendants admit) would pay such costs as hospital room and board charges.

Again, Defendants miss the point. The question is: **Is the exclusion ambiguous to the average, reasonable purchaser of insurance?** The average, reasonable purchaser of insurance would surely be confused by Defendants argument requiring a court to prefer an interpretation of a specific exclusion over a general provision providing coverage. The ambiguity question is determined from the perspective of the average, reason-able, purchaser of insurance not from a court's perspective. At least, Defendants' argument does admit to the ambiguity. Accordingly, the exclusion cannot be enforced.

3) Another example wherein Defendants miss the point in contest is when they assert that:

> Utah has expressly rejected the doctrine of reasonable expectations, holding that the reasonable expectations of an insured may not be used to enforce a contract when those expectations conflict with the plain terms

> of the policy. . . . Therefore, Plaintiffs have no claim based on the reasonable expectations doctrine.
> **Brief,** @ 21-21.

The point ignored/missed is that the Atkinsons' "reasonable expectations" are not in "conflict with the plain terms of the policy." The Atkinson's reasonable expectations do not conflict with any "plain terms" of the exclusion. The Atkinsons believe the exclusion is not plain, but rather ambiguous both in itself and when read in references to other provisions of the policy. The exclusion's ambiguities conflict with their "reasonable expectations." So, while Defendants' case law citations may be correct statements of the law, the factual application they attempt to plug into this law is fatally defective.

ISSUES OTHER THAN COVERAGE ISSUES:

In a footnote on page 4 of their Brief, Defendants argue that because: 1) Defendants moved for summary judgment on all the issues and because 2) Judge Wilkinson granted summary judgment on all the issues and because 3) Appellants' did not address the other issues in their opening brief but addressed only the coverage question, summary judgment on the other causes of action must stand.

Reference to the record however, proves otherwise. Plaintiffs' brief addressed only the exclusion issue because Judge Wilkinson

mandated this approach. He granted summary judgement on all the issues when he found the exclusion was not ambiguous. **Record** @ 293; page 12, line 20 to page 13, line 7.

Commonsense dictates that:

> If Judge Wilkinson voided Plaintiffs' entire Complaint because he found the exclusionary clause was not ambiguous, then if Plaintiffs prevail in this appeal, all their causes of action should be brought back from limbo.

At the 04/18/97 hearing, Judge Wilkinson heard oral arguments from Mr. Fife. Initially, Mr. Fife asked the court if he should address the other, 'claims against **GEM,** first", but the Court said no and directed him to speak only to the coverage question. **Record,** 293; page 4, lines 18-24. Later, after arguing the coverage question, Mr. Fife asked the Court if he should address any other questions. The Court replied, **"No, I wanted to hear just that".** **Record,** @ 293; page 7, lines 6-8.

Plaintiffs' counsel, Mr. Fay, then argued the coverage question. **Record,** @ 293; pages 7-11. After finishing his coverage question arguments, Mr. Fay inquired, "Is there any other issue the court would like me to address?" The court said, "No." **Record,** @ 293; page 11, lines 6-8.

Mr. Fife then commenced his rebuttal argument addressed solely to the coverage dispute. **Record,** @ 293; page 11. When Mr. Fay

asked the court if he could respond, the court said, No. **Record,** @ 293; page 12, lines 13-15. Immediately thereafter, the court threw-out Plaintiffs' entire Complaint because it found the exclusion was not ambiguous. **Record,** 293, page 12:20 to 13:7.

At the hearing, on four different occasions the Court refused to permit arguments addressed to other issues. Thus, the record from the hearing is silent on all references to other causes of action upon which Plaintiffs could mount arguments in their favor to cause reversal of the court's summary judgment.

Plaintiffs addressed all the information that was available from the court hearing in their Opening Brief. And, while earlier they made written arguments addressed to these other claims, there is no reference how the court ruled on these arguments save exactly what Plaintiffs have addressed.

One of the **California Maxims of Jurisprudence** is:

> **WHEN THE REASON IS THE SAME**
> **THE RULE SHOULD BE THE SAME.**
> **Cal. Civil Code: 3511**

Here the reason the Court voided the Plaintiff's entire Complaint was because of its' finding on the coverage question. Accord-

ingly, if the Court was wrong on the coverage question, all the claims should be reinstated, because that was the only known ground upon which they were voided.

In **State v. Irwin,** 924 P2d 5, (UT Ct. App., 1996) the court said:

> **AN APPELLATE COURT MAY ADDRESS AN ISSUE RAISED FOR THE FIRST TIME ON APPEAL IF APPELLANT ESTABLISHES THAT THE TRIAL COURT COMMITTED PLAIN ERROR, IF THERE ARE EXCEPTIONAL CIRCUMSTANCES, . . .**

The **Irwin** court continued:

> **The exceptional circumstances concept serves to assure that manifest injustice does not result from the failure to consider an issue on appeal.**

Plaintiffs offer that when the trial court closed-off all arguments on all the other issues, it committed plain error and for this Tribunal to refuse to consider all those other issues would result in manifest injustice to Plaintiffs.

SURVIVING ISSUE:

Plaintiffs assert that notwithstanding everything else, one issue still survived summary judgment, i.e., the reasons underlying **Premier's** refusal to pre-certify Plaintiffs' request for benefits.

Repeatedly, **Premier** has asserted it pre-authorized the surgery, but refused to pre-authorize the hospital charges because of the

exclusion,"(**Record**, @ 70 & 164, point 6, and Plaintiffs' **Brief** pages 34-36) Plaintiffs claim this is false. Plaintiffs assert **Premier** denied Atkinson's request for benefits because the request, "did not meet (Premier's) criteria for medical necessity or appropriateness." See, **Record,** 6, point 12; 36 point 12; 146, 191 @ point 4, and **Appendix "A"** to Appellants' Opening Brief.

In their brief, Defendants argue that:

> Defendants delineated the undisputed, material facts . . . <u>including the reason for Premier's refusal to pre-certify Mrs. Atkinson's hospital expenses</u> . . . <u>These factual issues were addressed in the affidavits of Sara Meadow-croft who had personal knowledge of the facts</u>."
>
> Defendants' **Brief** @ 12.

And further, Appellants should have filed an affidavit to counter Meadowcroft's allegations. Because they did not, their claim must fail. Defendants' **Brief** @ 12.

This is plain error. Plaintiffs direct the Court to Meadow-croft's affidavits. **Record,** @ 62-66 and 219-221. Meadowcroft's affidavits are not nearly so broad as Defendants would like this Court to believe. In her affidavits, Meadowcroft swears:

- She works for **GEM,** <u>examined **GEM's** file</u> and has personal knowledge of the **GEM** file.
- <u>**GEM** refused</u> to pay for the claim for hospital charges relying on the dental exclusion.

Record @ 62-63

In her second affidavit she states:

- She works for **GEM,** reviewed **GEM's** file and has personal knowledge of the **GEM** file.
- Pursuant to the terms of Ms. Atkinson's health and dental insurance policies, **GEM** refused to pay for the claim from the facility at which the surgery was performed.
- **GEM** adjudicated the claim for the anesthesiologist, the dentist and for the tooth extraction surgery.
- Ms. Atkinson's surgery was performed at a facility within **GEM's** preferred provider organization, accordingly her deductible was $1400. And, if the policy permitted payment for the facility, **GEM** would have paid $232.70.

Record @ 219-221

Meadowcroft's affidavits make no mention that:

- She ever worked for **PREMIER;** or that,
- She reviewed any **Premier** records, or that,
- She has personal knowledge of the **Premier** file; or that,
- **She knows Premier pre-authorized the surgery, but refused to pre-authorize the hospital charges because of the exclusion.**

So, what Defendants have asserted that MEADOWCROFT knew and testified-to through her affidavits is blatantly false. Accordingly, Plaintiffs were not required to file a rebuttal affidavit to issues not addressed by Meadowcroft's affidavits.

Plaintiffs assert **Premier** denied Atkinson's request for benefits because it, "did not meet our criteria for medical necessity or appropriateness." **Record** @ 6 point 12, 146, 191 @ point 4. **Premier** denied this allegation in their Answer. **Record,** @36, point 12. See also **Appendix "A"** to Appellant's Opening Brief.

Defendants also allege Plaintiffs did not contest this issue at trial and accordingly, the claim should fail. But as shown supra, Plaintiffs have addressed the trial court's repeated refusal to hear any arguments except the coverage dispute arguments. Thus, when the court foreclosed argument on this issue, Plaintiffs should not be charged with a failure to bring it before the trial court.

Defendants also allege plaintiffs did not raise this against them in the summary judgment motion. This is manifest error, see the **Record** at pages 146 and 191, point 4.

All these issues were before the trial court. In **Judge Wilkinson's** order it says:

> . . . the court, having heard oral argument by counsel for the parties, <u>having reviewed the various motions</u> and supporting memorandum and the file herein, . . .
> **Record,** 276.

According to the Judge's order all the arguments and points and authorities were before the court and reviewed by it before it

decided to grant the summary judgment. Thus, all such issues are before this Tribunal.

The last objection Defendants make on this issue is that it is not material to any of the Plaintiffs claims. **Brief**, 28-30. Defendants' repeatedly have alleged, "Premier pre-authorized the surgery but refused to pre-authorize the hospital charges based upon an exclusion in the policy . . ." **Brief,** pages 3, 5 @ point 6; and 8. Plaintiffs point out that **Premier** advised them they refused to authorize any part of the surgery because the Atkinson's request, "did not meet (**Premier's**) criteria for medical necessity or appropriateness." Is this material?

Plaintiffs say **Premier** refused their request because it wasn't "medically necessary and appropriate". Yet, Defendants say **Premier** pre-authorized the surgery but refused to authorize the hospital charges because of the exclusion. In reviewing **Appendix "A"** to Plaintiffs Opening Brief, we find Premier directly contradicted by its' own document. Obviously, Premier is lying. If Plaintiffs can show this lying to a jury they substantially support their charge of Premier's misrepresentations.

Also, Plaintiffs have complained against Premier for breaches of their duties of good faith and fair dealings owed Plaintiffs. **Beck,** supra, at 801, says:

> . . . the implied duty of good faith performance contemplates, at the very least, that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid, will fairly evaluate the claim ....
>
> . . . and to refrain from action that will injure the insured's ability to obtain the benefits of the contract.

Plaintiffs have alleged **Premier** did not diligently investigate the claim or fairly evaluate it. Plain-tiffs allege this because four medical doctors (3 of which are Premier approved providers) told Premier this surgery was necessary and appropriate. Consequently, Premier's misrepresentations will support Plaintiffs' action for bad faith. And it would support Plaintiffs' allegations that when Premier failed to diligently investigate and fairly evaluate their request, Premier engaged "in actions that injured the Atkinson's ability to obtain the benefits of their contract". **Beck** @ 801.

These facts convincingly show that Premier's representations were material to Plaintiffs' claims of bad faith and misrepresentation Such conduct violates **U.C.A. 31A-26-303 (2)(a), (3)(b)** and **(h).**

In their Brief at page 29, Defendants cited two cases: **Wilder v. Tanouye**, 753 P2d. 816,821 (HA, 1991) for the proposition that: A fact is material if,

> once proved, it would have the effect of establishing or refuting one of the essential elements of a ~ use of action . . .

And, **Atherton Condo Bd. V. Blume Development,** 799 P2d. 250, 257, (WA, 1990) for the premise:

> A material fact is also one upon which the outcome of the litigation depends in whole or in part.

Plaintiffs adopt this case law. Plainly, the reasons why **Premier** denied the Atkinson's request for benefits is material to their charges of bad faith and misrepresentation. Premier's representation can establish their bad faith. The charges of bad faith and misrepresentation will depend upon the reason Premier denied the Plaintiffs' claim for benefits.

Defendants complain Plaintiffs wove argument into their Rule 56(e) affidavit. Defendants' Brief, page 26, ftnt. 8, and page 27, ftnt. 9. Plaintiffs admit this. In addressing the very same issue in **Broadwater v. Old Republic**, supra, at 532, the court said:

> Defendants assail two of the affidavits submitted by plaintiff because they contain opinion, legal conclusions, and facts not supported by adequate foundation. Although a review of the affidavits confirm this assessment, portions of the affidavits do comply with Rule 56(e). The objectionable statements consist of legal arguments and conclusions and did nothing more than supplement the arguments made in plaintiff's memorandum. **We fail to see how this prejudiced defendants**.

DEFENDANTS ADMISSION THAT SUMMARY JUDGMENT WAS NOT WARRANTED TO SOME OF THE CAUSES OF ACTION.

Defendants told the trial court that, "with regard to a few of Plaintiff's claims" further discovery might "lead to facts supporting their claims to the extent that those claims may be based on issues" other than the coverage dispute. **Record,** 162. Defendants also told the court:

> . . . Plaintiffs could discover additional facts supporting their claim that Defendants intentionally inflicted emotional distress on or made misrepresentations to Plaintiffs" outside of denying their claim for the hospital charges. To the extent that discovery may aid Plaintiffs in establishing these facts, **they should be allowed to conduct such discovery. . . .**
>
> **Record,** 176 ftnt. 10

C O N C L U S I O N:

Long before the controversy arose between the Atkinsons and the Defendants, an unbiased, professional evaluated the Atkinson's request for benefits. Dr. Crayton Walker, as a Premier approved provider and one of Mrs. Atkinson's doctors, would seem to offer a neutral evaluation. His evaluation would be competent in that he is a dentist, an M.D., a surgeon and a Diplomat of the American Board of Oral and Maxillofacial Surgery. Before this dispute arose, Dr. Walker said:

> I act as an insurance review expert in oral and maxillofacial surgery for Alta Health Strategies and the MRI Institute of America. This scheduled surgery is appropriate and necessary for the care of this patient. **I feel**

> **that this hospitalization should be authorized and should be covered under the patient's major medical insurance plan**. She is not a candidate for outpatient surgery.
> **Record,** 259.

EXCLUSIONS MUST BE CLEAR.

In **<u>Alf v. State Farm</u>**, 850 P2d. 1272, 1275 (UT 1993) and in **<u>Village Inn v. State Farm</u>**, 790 P2d. 581, 583; (UT App., 1990) quoting **<u>Wagner v. Farmers Ins. Exchange</u>,** 786 P2d. 763,764; (UT App. 1990) our court have repeatedly held:

> The insurer may exclude from coverage certain losses by using **"language which clearly and unmistakably communicates to the insured** the specific circumstances under which the expected coverage will not be provided."

The phrase in "conjunction with dentistry" did not "clearly and unmistakably communicate" to the Atkinsons the "specific circumstances under which the coverage they expected would not be provided." Nor, when the Atkinsons read the entire policy with all the medical and dental benefits does the solitary exclusion become plain and "clearly and unmistakably communicate" to them exactly what is not covered.

DEFENDANTS' INTERPRETATION UNREASONABLY RESTRICTS COVERAGE.

Defendants want a strict, literal interpretation of the exclusion. But:

> Where a strict, literal interpretation of a clause would unreasonably restrict coverage of the insurance policy, such an interpretation cannot be foisted onto a layman nor can it be defended in terms of the risks which the layman sought to insure against.
>
> **Miller v. Elite Ins. Co.**, 10 CA3d.739;
> 161 Cal. Rptr. 322, 328-329 (CA 1990)

To side with the Defendants' interpretation can cause absurd results clearly not intended. For instance, assume:

> Mrs. Atkinson was involved in a serious motor vehicle collision wherein her face was forcefully propelled into the steering wheel. Six teeth were knocked out but all six were recovered.
>
> Rushed to hospital, the emergency room dental surgeon used hundreds of stitches to restore the separated teeth back into the jaw.
>
> Comes now defendants and deny all the hospital charges because replacing the teeth was "dental work" and hospital charges in conjunction with dental work are excluded.

The interpretation the Defendants want to impose on the Atkinsons tortures commonsense. Plaintiffs wanted full coverage, so they purchased both medical and dental coverage. The hospital charges should have been paid because the exclusion is ambiguous, and because the nature of the surgery took it out of dental care and into medical care.

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SURGERY WAS A MEDICALLY NECESSARY SICKNESS PROCEDURE.

Under the terms of the policy, the need for the surgery should properly be classified as a "medically necessary" "sickness" benefit. **"Sickness"** is defined as "an illness or disease which first manifest itself after the effective date of coverage and while the insurance is in force." **Record,** 100-101 and 244. Defendants make no contest that this surgical need first manifested itself after the effective date of the policy. "Medically necessary" is defined as: Service supplies or accommodations received for Sickness or which are:

> . . . .
>
> (b) **received in the most appropriate setting** (here the hospital);
>
> (d) appropriate for the diagnosis or treatment of a Sickness or injury based on generally accepted medical practice in your State; and,
>
> (e) **would adversely affect the condition or quality of medical care received if omitted** as determined by established medical review mechanisms.
> **Record,** 100 & 244.

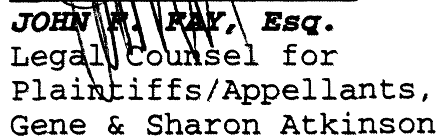
Plaintiff's four treating doctors have attested that the hospital setting was most appropriate and that Mrs. Atkinson was not a candidate for outpatient care. **Record**, 256-259. Given that three of the four doctors are **Premier** approved physicians this should qualify them as an established medical review. Thus, this surgery fits perfectly under a "medically necessary sickness" benefit.

RELIEF REQUESTED.

Plaintiffs respectfully request this Tribunal to reverse the summary judgment because it went against the weight of the evidence, because the court committed plain error in precluding a full hearing on all the issues and because it results in substantial injustice to the Atkinsons.

Dated: 05, May, 1998.

Respectfully submitted;



JOHN F. KAY, Esq.
Legal Counsel for
Plaintiffs/Appellants,
Gene & Sharon Atkinson

****RplyBrief**

CERTIFICATE OF SERVICE:

I, John F. Fay declare that on the 6 of May, 1998, at approximately 2 30, o' clock, I personally delivered two copies of Plaintiffs'/Appellants' Reply Brief to KEVIN FIFE, Esq. Counsel for Defendants.

Said services was made at:

> **COHNE, RAPPAPORT & SEGAL**
> 525 East 100 So., Suite 500
> Salt Lake, UT 84111

I made this Declaration under the penalties of perjury of the laws of the State of Utah. If called as a witness I could and would testify to the truth hereinabove.

Executed in Salt Lake, this 6 day of May, 1998.

/s/

JOHN F. FAY, Esq.
Legal Counsel for Plaintiffs/Appellants.