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COURT OF APPEALS OF OHIO, EIGHTH DISTRICT

COUNTY OF CUYAHOGA

NO. 62200

SHELLEY L. SVEC Plaintiff-Appellant vs. ENTERPRISE GROUP PLANNING, INC. Defendant-Appellee	:	JOURNAL ENTRY AND OPINION

DATE OF ANNOUNCEMENT OF DECISION: APRIL 29, 1993

CHARACTER OF PROCEEDING: Civil appeal from Common Pleas Court No. CV-184945

JUDGMENT: AFFIRMED.

DATE OF JOURNALIZATION: MAY 10 1993

APPEARANCES:

For Plaintiff-Appellant:
SEYMOUR GROSS
450 Standard Building
Cleveland, Ohio 44113

For Defendant-Appellee:
PAUL W. FLOWERS
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KRUPANSKY, J.:

Plaintiff-appellant Shelley Svec appeals from an order of the trial court granting summary judgment in favor of defendant-appellee Enterprise Group Planning, Inc. ("Enterprise"). The parties' dispute involves the enforceability of a pre-existing exclusion condition in a group medical insurance policy covering plaintiff underwritten by Cincinnati Equitable Insurance Company ("Equitable") and administered by Enterprise.

Plaintiff filed a complaint and amended complaint in the trial court against defendant alleging breach of contract, breach of fiduciary duty, and intentional infliction of emotional distress based on defendant's failure to pay certain medical expenses pursuant to a group medical insurance contract. Plaintiff did not join as parties to the action the insurance carrier, Equitable, or her former employer, the group policyholder, Research Organics, Inc.

Plaintiff alleged that the defendant Enterprise improperly denied her claim for $5,304.40 in medical expenses incurred by plaintiff at Marymount Hospital for treatment of rhinitis and sinusitis during March, 1989. Plaintiff alleged this denial was based upon an undisclosed pre-existing condition exclusion in the group master medical insurance policy between defendant and her former employer, Research Organics, Inc.

Defendant filed an answer and amended answer and counterclaim denying the substantive allegations of plaintiff's complaints.

Defendant's answers raised, affirmative defenses denying liability under the group medical insurance policy based on exclusions for (1) pre-existing conditions, (2) conditions which arose in the course of employment, and (3) medical conditions for which the insured was entitled to workers' compensation benefits[1]. Defendant's fraud counterclaim alleged generally that plaintiff misrepresented the facts surrounding her medical condition and the medical treatment for which she sought reimbursement in the medical insurance claim form submitted to defendant.

Defendant subsequently filed a motion for summary judgment arguing that it was not liable to plaintiff since the medical expenses incurred by plaintiff were excluded from coverage based on the medical insurance policy exclusions for (1) pre-existing conditions, (2) conditions which arose in the course of employment, and (3) medical conditions for which the insured was entitled to workers' compensation benefits. Defendant's motion for summary judgment was supported by copies of the following documents, *viz.*: (1) a two-page excerpt from the medical insurance policy containing these exclusions, (2) a group health insurance enrollment card signed and executed by plaintiff, (3) an individual enrollment supplement completed by plaintiff concerning her prior medical

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[1] Defendant's answer and amended answer and counterclaim also raised the affirmative defense of failure to join indispensible parties since plaintiff's complaint and amended complaint named neither the insurance carrier Cincinnati Equitable Insurance Company nor plaintiff's former employer Research Organics, Inc. as defendants.

history, (4) the medical insurance claim form submitted by plaintiff to defendant, (5) the letter denying her claim sent by defendant to plaintiff's employer, and (6) plaintiff's deposition testimony which had previously been filed with the trial court.

Plaintiff filed a brief in opposition to defendant's motion for summary judgment arguing that defendant should be precluded from enforcing any of these group medical insurance policy exclusions since plaintiff received no notice of the exclusions prior to filing her claim. Plaintiff's brief in opposition was supported by the following documents, *viz.*: (1) a health care cost containment brochure, (2) plaintiff's two paragraph affidavit, and (3) three documents related to plaintiff's workers' compensation claim for these same medical conditions which were ultimately disallowed.

Each party filed additional briefs prior to the trial court's ruling on defendant's motion for summary judgment. Defendant's reply memorandum argued plaintiff's coverage under the policy was void *ab initio* due to plaintiff's failure to disclose her pre-existing rhinitis and sinusitis conditions and treatments in her group insurance application materials. Defendant's reply memorandum was supported by copies of the following documents, *viz.*: (1) two additional workers' compensation claim forms completed by plaintiff seeking reimbursement for her condition, (2) a letter from plaintiff's treating physician describing plaintiff's condition and treatment history, and (3) a copy of

plaintiff's entire deposition testimony. Plaintiff's surrebuttal brief made additional legal arguments and did not present any additional evidentiary materials.

The trial court granted defendant's motion for summary judgment and dismissed plaintiff's complaint in an order journalized July 3, 1991. The trial court's order also dismissed defendant's counterclaim for fraud with prejudice. Plaintiff timely appeals raising the following sole assignment of error:

> THE TRIAL COURT ERRED WHEN IT GRANTED APPELLEE'S MOTION FOR SUMMARY JUDGMENT WHEN APPELLANT DEMONSTRATED PER CIVIL RULE 56 THAT THERE WERE DISPUTED FACTS AS TO WHETHER DELIVERY OF THE INSURANCE CERTIFICATE OCCURRED AND WHETHER APPELLANT HAD KNOWLEDGE OR NOTICE OF THE INSURANCE POLICY LIMITATIONS AND EXCLUSIONS.

Plaintiff's sole assignment of error lacks merit.

Plaintiff contends the trial court improperly granted summary judgment in favor of defendant on her complaint since she established a genuine issue of material fact concerning (1) whether she received notice of the group medical insurance policy exclusions, and (2) whether defendant should be precluded from enforcing the exclusions since the literature she received did not contain such exclusions. It should be noted at the outset that none of plaintiff's claims in this case involve oral representations by Equitable, the insurance carrier, defendant Enterprise as administrator, or plaintiff's employer, Research Organics, concerning the scope of medical insurance coverage.

The Ohio Supreme Court has recognized that summary judgment is warranted pursuant to Civ. R. 56 when, after construing the evidence in the light most favorable to the nonmoving party, the following three conditions are satisfied, *viz.:* (1) there is no genuine issue as to any material fact; (2) the movant is entitled to judgment as a matter of law; and (3) reasonable minds can come to but one conclusion and that conclusion is adverse to the nonmoving party. *Bostic v. Connor* (1988), 37 Ohio St.3d 144, 146; *Kilbourn v. Henderson* (1989), 63 Ohio App.3d 38, 41.

The evidence presented by the parties in connection with defendant's motion for summary judgment in the case *sub judice* reveals the following facts. Plaintiff's coverage under the group medical insurance policy *sub judice* became effective October 18, 1988. Plaintiff was treated by Dr. Michael J. Papsidero for various medical conditions commencing in 1986 prior to the effective date of her insurance. Dr. Papsidero treated plaintiff for recurrent rhinitis and sinusitis on two occasions in April 1988. Plaintiff's treatment on April 25, 1988 fell within the six month exclusionary period of her group medical insurance coverage administered by defendant. *Simply stated, the exclusionary period ran from April 18, 1988 to April 18, 1989.* Plaintiff thereafter received treatment by Dr. Papsidero six additional times for the same condition, including two extensive treatments in March, 1989 for which she sought reimbursement from defendant under the group medical insurance policy. Coverage for expenses incurred in

connection with pre-existing conditions did not commence under the terms of the group medical insurance policy *sub judice* until six consecutive months lapsed without undergoing any treatment for the pre-existing condition, or approximately April 18, 1989 at the earliest.

Plaintiff was originally employed at Research Organics, Inc., on August 18, 1988 and completed a group medical insurance enrollment card and individual enrollment supplement which did not refer to the above medical conditions. The group enrollment card, completed and signed by plaintiff August 12, 1988 prior to obtaining coverage under the Research Organics, Inc.'s group medical insurance policy underwritten by Equitable and administered by defendant, stated *inter alia* as follows:

> I hereby request coverage under the policy issued by Cincinnati Equitable Insurance Company and authorize my employer to deduct from my earnings any requested contribution for the insurance to which I am or may be entitled. *** I understand that if the insurance applied for becomes effective, I will be subject to all the terms of the policy, that the agent is not authorized to alter any terms of this application or the policy and that any conflicts will be resolved solely by reference to the policy. (Emphasis added).

Defendant received plaintiff's group enrollment card October 17, 1988 and approved coverage for plaintiff under the Research Organics, Inc. group medical insurance policy underwritten by Equitable effective the following day on October 18, 1988. The group medical policy issued by Equitable to Research Organics, Inc. and administered by defendant contains the following exclusion for

expenses arising from conditions which existed prior to the effective date of the policy (the "Pre-existing Condition Exclusion"):

> Unless specific exception is made, the provisions of this policy do not include as covered charges, or provide benefits for, charges incurred in connection with:
>
> * * *
>
> 19. any charges in connection with a pre-existing condition. Any injury or sickness or a related injury or sickness for which an insured individual has consulted with a licensed physician or dentist or received any medication or dental care or services within the 6 month period immediately preceding the effective date of insurance, unless incurred after the expiration of a period of:
>
> (A) 6 consecutive months after the effective date of insurance during which such insured individual has not consulted with a licensed physician or received any medical care or services for such injury or sickness or related injury or sickness; *** (Emphasis added).

It is undisputed plaintiff had no coverage for pre-existing conditions under the terms of the policy for a period of approximately twelve months beginning April 18, 1988 to April 18, 1989. This Pre-existing Condition Exclusion applies to plaintiff's claim for reimbursement of the March 1989 treatments by Dr. Papsidero since she had received treatment for this same condition within six months prior to obtaining coverage under the group medical policy and six consecutive months without any treatments

for the condition had not elapsed prior to undergoing the subject treatments.

Plaintiff testified generally during deposition that she did not receive notice of this Pre-existing Condition Exclusion. The record demonstrates that neither the group enrollment card nor the individual enrollment supplement completed by plaintiff prior to obtaining coverage under the group medical policy *sub judice* specified the scope of medical insurance coverage under the policy or stated any exclusions from coverage. Moreover, neither party to this action produced a certificate of insurance describing plaintiff's medical insurance coverage or any evidence whether defendant provided such certificate to plaintiff's employer for her in connection with defendant's motion for summary judgment.

Plaintiff testified during deposition that she requested medical insurance information from her employers' personnel officer, Marilyn Garrett. Plaintiff testified that Garrett gave plaintiff only one piece of literature concerning the group medical insurance policy and informed plaintiff that she was given "what you are entitled to have." Plaintiff acknowledged that she had received more extensive literature summarizing the terms of her coverage at her prior employment, but ceased making additional requests for such material from Garrett who had become "very irritable." Plaintiff admitted that she made no request for such materials from defendant, Enterprise, and made no request for material from Equitable the insurance carrier.

The literature received by plaintiff from Garrett is a booklet entitled "Health Care Cost Containment ... Employee Involvement" and bears the service mark "Employers Select Risk." The booklet refers to defendant Enterprise and the "Insurance Company" and contains various modifications to plaintiff's medical insurance coverage under the group policy. The first sentence of the booklet provides as follows:

> A new package of benefits has been added to your medical coverage.

The remainder of the booklet describes an incentive plan for employees to audit medical bills submitted to the insurer and various pre-approval requirements which provide for enhanced reimbursement. The booklet explains that failure to obtain prior approval for specified treatments results in decreased reimbursement levels.

Plaintiff's deposition testimony acknowledged that she knew this booklet did not purport to be a summary of the terms of the master group insurance policy like she had received in connection with her insurance coverage during her prior employment with a different employer and insurance administrator. Plaintiff's affidavit, submitted with her brief in opposition to defendant's motion for summary judgment, states in its entirety as follows:

> Affiant says that at no time during her employment at Research Organics, Inc. was she furnished with a copy of the insurance policy involved in this case; that the booklet, Exhibit A, attached to the Plaintiff's Brief, is the only information furnished to her as to the policy provisions; that she was unaware of the exclusions

> as to coverage claimed by the defendant until after the instant lawsuit was filed.
>
> Affiant further says that she relied on the information furnished to her in the booklet, Exhibit A, as being a correct and complete statement of all pertinent, important information concerning the insurance coverage.

Plaintiff incurred expenses in March, 1989 related to her prior treatment for rhinitis and sinusitis and submitted a comprehensive medical claim form to defendant dated April 17, 1989. Defendant thereafter denied reimbursement for plaintiff's claim under the group medical insurance policy in a letter to plaintiff's employer dated July 28, 1989. Plaintiff's workers' compensation claim relating to the same condition, based on her workers' compensation Form C-1 dated June 30, 1989, was disallowed December 31, 1990.

We note initially defendant did not produce a complete copy of the master group medical insurance policy or certificate of insurance for plaintiff in connection with its motion for summary judgment to demonstrate that it was not liable under the policy as the insurer. Defendant merely argued that plaintiff's expenses were not covered because of various exclusions in the policy and that plaintiff's coverage under the policy was void *ab initio*. However, the group medical insurance application materials completed by plaintiff set forth above demonstrate that Equitable, rather than defendant Enterprise, is the insurance carrier under the group medical policy *sub judice*. As a result, regardless of the terms of the group medical insurance policy in the case *sub*

judice, defendant is not liable for breach of the insurance policy. *See Symczak v. Midwest Premium Finance Co.* (1984), 19 Ohio App. 3d 173, 175 (insurance premium finance company not liable for breach of insurance policy).

Plaintiff contends nevertheless that defendant is liable for breach of fiduciary duty and intentional infliction of emotional distress for failing to disclose the group medical policy exclusions and denying payment of her claim. However, as noted by plaintiff, R.C. 3923.12 governs the delivery of individual certificates of insurance under group medical insurance policies and recognizes the respective duties of a group insurer and employer in this context as follows:

> (C) Each such policy shall contain in substance the following provisions:
>
> * * *
>
> (2) A provision that the insurer will furnish to the policyholder [defined by R.C. 3923.12(A)(1) as the employer], for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable ***

The Franklin County Court of Appeals recognized that this provision imposes the duty of delivering individual certificates of insurance under group insurance policies on the insured's employer, stating as follows:

> R.C. 3923.12 refers to the duty of an employer to deliver to each employee an individual certificate supplied by the insurer explaining

> the essential features of his insurance coverage.

Fraternal Order of Police, Capital City Lodge No. 9 v. Columbus (1985), 24 Ohio App.3d 157, 160 (Emphasis added). R.C. 3923.12(D) likewise mandates that group employers permit individuals covered by a group policy to examine the group policy as follows:

> (D) Each such policy together with any application in connection therewith shall be available for inspection during regular business hours at the office of the policyholder where such policy is on file, by any beneficiary thereunder or by an authorized representative of such beneficiary.

The duties of entities which are not insurers or group employers, such as defendant Enterprise acting as a medical insurance administrator, are not specifically delineated by this provision. However, plaintiff presented absolutely no evidence that defendant as agent for the insurer had a duty and failed in its duty to deliver a certificate of insurance coverage for plaintiff to plaintiff's employer or that defendant undertook the obligation to perform this duty by delivering such information for plaintiff's employer. We note that R.C. Chapter 3959, which specifically regulates third-party medical insurance administrators such as defendant Enterprise in the case *sub judice*, does not create such a duty.

Plaintiff's affidavit and deposition testimony merely indicate that she did not receive an individual certificate of insurance from her employer. Plaintiff stated that she requested explanatory literature from her employer's personnel officer, Marilyn Garrett,

but received only the one "booklet" from her and did not receive a certificate of insurance. Plaintiff acknowledged during her deposition that this "booklet" did not purport to be a complete summary of the terms of the group medical insurance policy. Nevertheless, plaintiff made no additional requests for information, a certificate of insurance or the policy of insurance from her employer, defendant administrator or the insurance carrier although she was aware or should have been aware that Cincinnati Equitable Insurance Company was the insurance carrier. This information was contained at the bottom of the group enrollment card which plaintiff signed when she applied for coverage.

The group enrollment card completed by plaintiff when applying for her medical insurance coverage specifically informed plaintiff that the terms of her insurance coverage were governed solely by the terms of the policy. The Ohio Supreme Court has recognized that a party insured under a group insurance policy is bound by knowledge of such a provision. *See Pedler v. Aetna Life Ins. Co.* (1986), 23 Ohio St. 3d 7. The *Pedler* Court affirmed summary judgment for the group insurer, even where the insured individual subsequently received conflicting documentation contrary to the case *sub judice*, stating as follows:

> Obviously, a party who acts with full knowledge of the truth has not been misled and cannot claim estoppel. Hence, there can be no estoppel where the party claiming it is chargeable with knowledge of the facts, as where he either knows the facts or is in a position to know them; or where the circumstances surrounding the transaction are

> sufficient to put a person of ordinary prudence on inquiry which would have disclosed the facts ***

Id. at 11 (Emphasis in original). Under the circumstances, plaintiff's lack of notice concerning the policy exclusions does not preclude enforcement of the policy exclusions which resulted from her own failure to obtain relevant information. Cf. *Ameritrust Co. Natl. Assn. v. West American Ins. Co.* (1987), 37 Ohio App.3d 182.

Plaintiff's reliance on out-of-state authority precluding the enforcement of exclusions in group policies due to the failure to deliver a individual certificate of insurance under the group policy to an employee is misplaced. As noted above, R.C. 3923.12 imposes the duty of delivering individual certificates of insurance under group medical policies directly on the group policyholder, in this instance plaintiff's employer, and plaintiff has produced no evidence in the case *sub judice* that such duty was delegated to defendant. It is well-established under Ohio law that an employer's participation in the administration of a group health insurance plan does not create an agency relationship between the employer and health insurance administrator or insurance carrier as a matter of law. *Kilbourn v. Henderson, supra* at 45.

Plaintiff's failure to produce any evidence that defendant had a duty to deliver an individual certificate of insurance or other explanatory material to her precludes recovery on her claims for breach of a fiduciary duty and intentional infliction of emotiona[1]

distress. The record contains absolutely no evidence that defendant undertook an obligation to deliver insurance documents to plaintiff on behalf of the insurance carrier or her employer or otherwise directly entered into an agency relationship with plaintiff to give rise to a fiduciary duty toward her. Moreover, since coverage was properly denied under the medical insurance contract in the case *sub judice*, plaintiff's claim for intentional infliction of emotional distress was properly rejected as a matter of law. *See Reamsnyder v. Jaskolski* (1984), 10 Ohio St.3d 150.

Accordingly, plaintiff's sole assignment of error is overruled.

Judgment affirmed.

It is ordered that appellee(s) recover of appellant(s) costs herein taxed.

The Court finds there were reasonable grounds for this appeal.

It is ordered that a special mandate issue out of this Court directing the Common Pleas Court to carry this judgment into execution.

A certified copy of this entry shall constitute the mandate pursuant to Rule 27 of the Rules of Appellate Procedure.

PATTON, P.J., and

PORTER, J., CONCUR

Blanche Krupansky
JUDGE
BLANCHE KRUPANSKY

N.B. This entry is made pursuant to the third sentence of Rule 22(D), Ohio Rules of Appellate Procedure. This is an announcement of decision (see Rule 26). Ten (10) days from the date hereof, this document will be stamped to indicate journalization, at which time it will become the judgment and order of the court and time period for review will begin to run.