IN THE SUPREME COURT
STATE OF SOUTH DAKOTA

No. 28467

IVAN ZOCHERT
Plaintiff/Appellant,

vs.

PROTECTIVE LIFE INSURANCE COMPANY,
Defendant/Appellee.

Appeal from the Circuit Court
Third Judicial Circuit
Moody County, South Dakota

The Honorable Patrick Pardy, Presiding

BRIEF OF APPELLANT IVAN ZOCHERT

Seamus W. Culhane
Nancy J. Turbak Berry
Turbak Law Office, P.C.
26 S. Broadway, Suite 100
Watertown, SD 57201
(605) 886-8361

Attorneys for Appellant

Edwin E. Evans
Ryan W. Redd
Evans Haigh & Hinton, LLP
101 North Main Avenue, Suite 213
P.O. Box 2790
Sioux Falls, SD 57101-2790
(605)275-9599

Attorneys for Appellee

Notice of Appeal filed December 5, 2017

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JURISDICTIONAL STATEMENT

Ivan Zochert appeals from the Order Granting Defendant's Motion for Summary Judgment and Denying Plaintiff's Motion for Summary Judgment entered November 7, 2017 by which the circuit court, the Honorable Patrick Pardy presiding, dismissed all claims against Protective Life Insurance Company, ("Insurer"), entering Judgment in Favor of Insurer on all counts. Notice of Appeal was filed December 5, 2017.

STATEMENT OF LEGAL ISSUES

1. Do undisputed facts show Insurer breached its contract?

Trial court ruled that undisputed facts prove Insurer did not breach the contract.

- *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 NW2d 752, 754 (S.D. 1994) (Duty of good faith is term of every insurance policy);
- *Stene v. State Farm Mut. Auto Ins.*, 1998 SD 95, ¶19 (Violation of duty of good faith is a breach of contract);
- *Eide v. Southern Sur. Co.*, 55 SD 405, 409 (1929) (Insured is not required to elect clauses in policy upon which claim is made);
- *Hein v. Acuity*, 2007 SD 40, ¶10, 731 N.W.2d 231, 235 (Unfair processing of insurance claim can be a breach of duty of good faith whether benefits are eventually paid or not).

2. Does South Dakota recognize the independent tort of insurance bad faith?

Trial court ruled it does not.

- *Stene v. State Farm Mut. Auto Ins.*, 1998 SD 95, ¶19 (A cause of action against an insurance company for bad faith failure to pay a claim is recognized in South Dakota);
- *Bertelsen v. Allstate Ins. Co.*, 2011 S.D. 13 ¶ 46 (First-party bad faith occurs "when an insurance company consciously engages in wrongdoing during its processing or paying of policy benefits to its insured.")

3. Could reasonable jurors conclude Insurer violated duties of good faith?

Trial court ruled they could not.

- *Bertelsen v. Allstate Ins. Co.* ("*Bertelsen III*"), 2013 SD 44, ¶ 17 (Question of whether insurer has acted in bad faith is generally a question of fact).

- *Champion v. United States Fidelity & Guaranty Co.*, 399 N.W.2d 320, 324 (Lack of reasonable basis for denial of insurance claim may be inferred and imputed to insurer where there is reckless indifference to facts or proofs submitted by insured);

- *Dakota, Minn. & E.R.R. Corp. v. Acuity*, 2009 SD 69, ¶19 (Bad faith conduct may include the failure to conduct a reasonable investigation concerning the claim).

STATEMENT OF THE CASE

Ivan Zochert brought this action against Insurer, an Alabama insurance company that sold Ivan and his wife Lenore a "Cancer Policy" in 1990, which Zocherts maintained for 22 years. When Lenore got cancer in 2012, Zocherts made a claim for benefits. While Lenore was treating for cancer, Ivan tried to get Insurer to investigate, process, and pay the resulting claim for benefits. He continued to try to get benefits for two years. Eventually, Lenore passed away, and Ivan sued Insurer for breach of contract and insurance bad faith.

The parties brought cross-motions for summary judgment. Ivan asked the trial court to rule that undisputed facts show Insurer breached contractual duties of good faith and fair dealing and its contractual duty to pay benefits when due.[1] (SR 835-836, 863-874) Insurer asked the trial court to rule that undisputed facts entitled it to judgment as a

[1] Plaintiff also asked the trial court to interpret certain policy provisions, but the trial court's ruling on that issue is not part of this appeal.

matter of law on the breach of contract claim and the tort claim. The trial court denied Ivan's motion, granted Insurer's motion, and dismissed the lawsuit.

STATEMENT OF THE FACTS

In 1990, Lenore and Ivan Zochert buy a "Cancer Policy" from Insurer. (Policy, SR 1011-1032, App. 72-95) The policy promises "benefits for losses due to Hospital confinement and certain other expenses resulting from treatment for Cancer of an Insured." (SR 1017, App. 78) Benefits are payable for expenses incurred from 10 days preceding the date of a positive cancer diagnosis. (Schedule of Benefits. SR 1018, App. 79).

Most policy benefits are tied to actual expenses incurred, which are subject in some cases to dollar limitations specific to the nature of the charge and in all cases, must be within the "usual and customary charge". (SR 1018, App. 79) For example, "In-Hospital Room and Board" benefits for the first 10 days of confinement are limited to $160/day and "In-Hospital Attending Physician" benefits are limited to $25/day for personal visits by attending Physicians other than surgeons. (SR 1018, App. 79). "Surgical Expense" benefits include benefits for both surgery and anesthesia charges, with a maximum benefit of $2500 for surgery and $630 for anesthesia.[2] (SR 1019, App. 80) Other benefits are not tied to actual expenses; for example, "Home Recovery Benefit" promises $14.28/day while an insured is confined at home immediately following

[2] The specific amounts of surgery and anesthesia benefits due depend on the 1969 California Relative Value Schedule ("CRVS"). The CRVS assigns a specific "Unit Value" to surgeries and accompanying anesthesia, identified by surgical billing code. *See* excerpts from CRVS. (SR 1312-1315) Insurer promises $50 for each "Surgical Value" unit and $42 for each "Anesthesia Value" unit under CRVS. (SR 1019)

hospital confinement,[3] though insureds obviously do not receive a bill from anyone for recovering at home. (SR 1018, App. 79) Besides the basic policy for cancer-related benefits, Zocherts also bought a rider to pay benefits if they were ever placed in intensive care, whether that care is related to cancer or not. (SR 1024-1025)

For 22 years, Zocherts pay premiums for their policy, expecting that if Ivan or Lenore gets cancer, the policy will pay resulting medical bills. (Zochert deposition p. 17:23-24,[4] SR 942) Then, during a medical exam in 2012, a lump is found in Lenore's breast. (SR 960).

On July 5, 2012, Sanford surgeon Alan Christensen, MD performs Lenore's first cancer-related surgery, a biopsy to confirm the suspected diagnosis of cancer. (SR 960, 969). Tissue samples are sent to a pathology lab and by July 11, 2012, the microscopic exam has yielded a report that 81-year old Lenore has invasive ductal carcinoma. (SR970-975). Dr. Christensen assembles a medical team to consider treatment options, including partial mastectomy (or "lumpectomy") versus total mastectomy and nodal dissection. (SR 976)

On August 14, 2012, Lenore has a partial mastectomy/lumpectomy under general anesthesia at Prairie Lakes Hospital in Watertown. (SR 992-993) Lenore is hospitalized until August 16, 2012. (SR 1308). The next day, August 17, Ivan contacts Insurer and requests claim forms. (SR 996) As he begins working on the forms, Lenore's cancer treatment becomes complicated by infection.

[3] The number of days for which a "Home Recovery Benefit" is supposed to be paid is equal to the days of the hospital confinement preceding home recovery.

[4] See Excerpt of deposition of Ivan Zochert, p. 17, lines 23-24 (SR 942).

When Dr. Christensen examines the surgical incision from Lenore's partial mastectomy on August 28, 2012, he is concerned about signs of infection. (SR 994) He begins treating Lenore with antibiotics, then sees her again on August 31, 2012. (SR 995) Dr. Christensen is still concerned about infection and notes the possibility of internal bleeding, so he re-admits Lenore to the hospital. Lenore spends seven days in the hospital on this second occasion, including three nights in intensive care. (SR 1310).

Meanwhile, Ivan is working on the paperwork Insurer sent him. He corrects his name on the letter Insurer sent with the claim forms. (SR 1323, App 103). He completes and signs the release Insurer requested to authorize the company to obtain Lenore's medical records. (SR 1328, App. 104) He fills out and signs Insurer's general proof of loss form. (SR 1325) He takes the Physician Statement to Dr. Christensen, who completes the form and attaches a billing document that shows surgical charges for the partial mastectomy performed on August 14, 2012. (SR 1324, 1326, App. 106, 107) Dr. Christensen notes in the Physician Statement that Lenore's cancer was initially diagnosed July 11, 2012, informs Progressive Life that Lenore was hospitalized for several days for the surgery, provides the hospital's name and address, confirms the surgical procedures (partial lumpectomy and layered closure) he performed on August 14, and signs the form. (SR 1324). On September 14, 2012, 87-year-old Ivan Zochert puts all those things in an envelope, hand addresses the envelope, and sends them to Insurer. (SR 1323-28, App. 102-107)

Insurer is a large insurer based in Alabama with about 8.3 million policies in force. Insurer sells a variety of insurance products and handles claims arising from those products, like the claim for cancer insurance benefits Zocherts filed with the company.

The manager of Insurer's claims department, Debra Turner, estimates that although Insurer's claims department consists of only about twenty claims handlers, it handles 1,700 to 1,800 insurance claims each month. (Turner deposition, 17:9-10, SR 1752).

By September 21, 2012, Insurer knows that its insured, Lenore Zochert, has cancer because her elderly husband, Ivan, contacted the company wanting to make a claim under their policy. (SR 1323. App. 103). Because of the September 14th, 2012 mailing that Ivan sent Insurer, Insurer knows the name, address, phone number and fax number of Lenore's doctor/surgeon; knows Lenore has had a partial mastectomy; knows she was hospitalized for several days at the time of surgery; and knows the name and address of the hospital where she was hospitalized. (SR 1324, App. 106). Insurer has a billing document that shows some of Lenore's treatment expenses – i.e., $3,383 in surgical charges consisting of $2,371 for the partial mastectomy and $1,012 for the layered closure. (SR 1326, App. 107) Insurer also has a signed authorization allowing it to obtain whatever medical records and additional bills are necessary to understand and document Lenore's cancer treatment. (SR 1328, App.104)

Insurer has also banked 22 years' worth of premiums from Zocherts to pay for the service element of handling its insureds' claim. It knows Zocherts' policy offers several different benefits *besides* surgical benefits for the mastectomy and layered closure on August 14, 2012, but does not communicate anything to the Zocherts about various other benefits available. Insurer chooses to not assist its insureds in identifying the coverage and benefits to which the insureds are likely entitled. Insurer also chooses to not investigate the claim. Instead, Insurer's sole response to the claim is to look at the billing statement for surgical charges Dr. Christensen attached to his Physician Statement, and

look no further. Insurer then sends an Explanation of Benefits ("EOB") reporting "$ 0.00" in benefits; the EOB says Insurer processed $3,383 of charges on September 21, 2012, but those charges are for "non-covered service" and tell Ivan that he should submit a pathology report. (SR 1001, App. 109).

Ivan goes to Dr. Christensen's clinic, Sanford Health, and requests a pathology report. Sanford Clinic mails Insurer the report generated after the mastectomy, confirming once again Lenore's cancer. (SR 1002-1003). On November 13, 2012, Insurer sends a check for benefits. The check is solely related to the surgical expenses Lenore incurred on August 14, 2012, the day of her partial mastectomy. (SR 1126, App. 110) Insurer still has made no effort to obtain any of Lenore's records or other bills.

Insurer has made no investigation of Lenore's overall treatment or the expenses she was incurring – by then, including not only treatment and expenses that obviously *preceded* Lenore's mastectomy in the first place (such as the biopsy that led to the initial diagnosis of cancer July 11, 2012, as Dr. Christensen reported) – but also *subsequent* treatment and expenses arising from Lenore's post-surgical infection (including a seven-day hospitalization including three days of intensive care). The company has not investigated any other circumstances entitling Lenore to benefits (like her post-hospitalization recuperation at home, which would trigger "Home Recovery" benefits), and still has not advised Zocherts of other benefits they are entitled to under the coverages they purchased.

Insurer already knows, but does not tell Lenore or Ivan, that *besides the surgical expenses for the partial mastectomy and layered closure on August 12, 2012,* there is coverage in the policy for many other benefits Lenore is entitled to, including:

- "Surgical Expense Benefit" for the biopsy surgery on July 5, 2012;
- "Surgical Expense Benefit" for the anesthesia on August 14, 2012;
- "In-Hospital Room and Board Benefit" for her first hospitalization, at the time of her mastectomy; and,
- "Home Recovery Benefit" for the first three days recuperating at home, following her first hospitalization. (*See* SR 1018-1019)

Had Insurer made even a cursory investigation of Lenore's claim, it also would know Lenore is entitled to *even more* benefits – benefits related to treatment of the post-surgical infection Dr. Christensen discovered shortly after her mastectomy, including:

- "In-Hospital Room and Board Benefit" for her second hospitalization; and,
- "Home Recovery Benefit" for the seven days recuperating at home, following her second hospitalization; and
- "Hospital Intensive Care Benefit" for three days of intensive care received during her second hospitalization.

However, Insurer has done nothing with the pathology report and other information it already has about Lenore, has done nothing with the signed authorization it requested so it could obtain medical records and bills, and has made no further inquiry about Lenore's situation. It is willfully ignorant of those particular benefits due under its policy. Later, the manager of Insurer's claims department will admit under oath that the company does not even investigate claims its insureds submit, saying "[W]e don't investigate a claim." (Turner deposition, p. 15, line 8, SR 1750, App. 130)

With respect to the portion of the claim the company *does* process – surgeon's charges incurred for the partial mastectomy and layered closure on August 14, 2012 (which happened to show up on the document Dr. Christensen attached to his Physician Statement), Insurer sends a check for $420 with an EOB saying nothing more is owed because the surgical charges "exceed the amount which can be considered as a covered charge." (SR 1126, App. 110)

Ivan is puzzled, so he calls Insurer. On phone calls December 12 and December 13, 2012, Insurer's claim handlers recognize that Ivan is elderly, is not understanding how the claim is being paid, and has difficulty hearing. (SR 1006, App. 115) So, claims handler Lia Velez follows up with a letter to Ivan on December 18, 2012. It offers little more explanation, except to say that the surgical expense benefit is "payable in accordance with California Relative Value Schedule." (SR 1007, App.108)[5] The letter does not mention any other benefits owed under the policy, much less explain why they are not being paid. E.g., there is no mention of benefits for the anesthesia obviously used during the mastectomy that was paid, for hospital room and board charges, for nursing or physician care during hospitalization, or for the "home recovery" that followed Lenore's hospitalization. (SR 1007, App. 108)

A year after the claim was made, Ivan will learn Insurer takes the position it need not investigate any claims, insisting it is up to the insured cancer patient (or, in this case, her 88-year old husband) to know what benefits an insured may be entitled to, figure out what information the company requires to process a claim, and gather all the evidence the company wants as documentation (SR 1130, SR 1576). However, in December 2012 when Ivan contacts Insurer to ask for help understanding what is going on with the claim arising from Lenore's cancer, the company's response does not disclose any of that. Insurer does not tell Ivan the company is doing nothing to investigate the claim and will do nothing to investigate. The letter does not explain that, despite requiring a signed

[5] While the policy says surgical benefits are determined by the 1969 California Relative Value Schedule ("CRVS"), *see* fn. 2, communications from Insurer eventually reveal that Protective does not even have access to and cannot produce the CRVS. According to one claims handler, CRVS values supposedly were programmed into the company's computer system when the system was set up. (SR 1145)

authorization for the release of medical records, Insurer is not procuring Lenore's bills or records, but is waiting for *Ivan* to collect all Lenore's information. It also does not say that Insurer is assuming, common sense notwithstanding, that Lenore's treatment entailed nothing before or after Dr. Christensen removed the lump from Lenore's breast, unless Zocherts specifically prove otherwise.

Ivan knows no more after receiving Insurer's December 18, 2012 letter than he knew the week before, when he called the company to express his confusion and ask for clarity. Despite collecting the Zocherts' premiums for decades, the company offers no help with the claim. Insurer's practice is to delegate its duty to investigate an insured's claim to the insured, the insured's spouse, or an attorney hired by the insured at their own expense, and to delegate its duty to inform an insured of applicable coverage to the insured's attorney should an insured be able to find an attorney to get involved given relatively modest claim amounts.

Exasperated, Ivan finds an attorney to help.

At Ivan's expense, his attorney begins reviewing the Insurer policy and asking Insurer pointed questions about benefits. On March 13, 2013, Ivan's attorney asks why benefits have not been paid under provisions in the policy like the "In-Hospital Room and Board Benefit" or the "In-Hospital Attending Physician Benefit." (SR 1008) The company responds by saying those benefits have not been paid because *Ivan* has not submitted Lenore's bills from the hospital and physicians who treated her there. (SR 1009) Ivan and his attorney gather those bills and forward them to the company, along with hospital records showing Lenore was hospitalized from August 14-16, 2012. (SR 420-429)

Though Insurer has not been willing to use the signed medical release to get billing information or medical records that might *support* paying benefits, it does briefly investigate for the purpose of *limiting* benefits. Namely, once Insurer has hospital records further confirming what the Physician's Statement had already informed it, Lenore's stay at Prairie Lakes Hospital in Watertown from August 14 – 16, 2012. Insurer contacts the hospital to see if Lenore was confined for three days of hospitalization, or only two. (SR 1579, App. 116) Although Lenore's hospitalization lasted portions of three days, if Insurer can confirm the hospital only charged Lenore for two days, Insurer will save $174.28 ($160 in room and board benefits and $14.28 in home recovery benefits). (SR 1018, App. 79)

In May of 2013, nine months after Ivan first submits the claim, Insurer finally issues a second benefit payment, sending Ivan directly a check for $474.56. (SR 1127, App. 111) The payment includes $126 as an anesthesia benefit related to Lenore's mastectomy, $320 for two days of hospital room and board, and $28.56 for two days of corresponding home recovery. (SR 1127, App. 111) Still, the company has done nothing to investigate, process, or pay other benefits, such as "Surgery Benefits" for the biopsy surgery or benefits related to Lenore's second hospitalization.

Ivan finally learns why his claim was not being fairly processed from the beginning. On August 26, 2013, almost a year since Zocherts first submitted their claim, Ivan's counsel asks Insurer what it *has* done to determine what benefits are due, and specifically asks if the company has requested an itemized billing from Lenore's physician; Insurer responds by admitting it has not requested any billings, saying "it is the insured's responsibility to submit any/all itemized bills…."(SR 1130) By then,

Lenore has passed away.[6] In the following months, Ivan and his counsel work to identify applicable coverage, continue to question Insurer about why it is not paying additional benefits, and gather and submit additional information about Lenore's treatment and expenses (e.g., see SR 485-490) Claims handlers continue an extended game of cat-and-mouse in which they pay benefits only if Ivan can identify the right coverage and what document Insurer requires for payment under that coverage.

On August 26, 2014, Ivan sues Insurer for breach of contract and insurance bad faith, contending that Insurer's unfair insurance claims processing system prejudices cancer-stricken policyholders and their families. Within the next two weeks, Insurer processes and pays $1,850 more in benefits. (SR 1128-29, 1311, App. 112-113, 114)

Additional facts will be provided as relevant below.

ARGUMENT

I. Undisputed Facts Show Insurer Breached Its Contract

Once material facts are determined to be undisputed, reviewing a trial court's action in granting summary judgment is limited to whether the law was correctly applied. *Hoglund v. Dakota Fire Ins. Co.*, 2007 S.D. 123 ¶7, 742 N.W.2d 853, 856. Questions of law are reviewed *de novo*, with no deference given to the trial court's decision. *Id.*

Elements necessary to prove breach of contract in South Dakota are "(1) an enforceable promise; (2) breach of the promise; and (3) resulting damages." *Bowes Constr., Inc. v. S.D. DOT*, 2010 SD 99, 793 N.W.2d 36, 43 (S.D. 2010). There is no dispute here about an enforceable promise; both sides agree Insurer's policy was in effect when Lenore was diagnosed with cancer. The issue is whether undisputed facts prove

[6] Lenore died August 2, 2013.

Insurer breached contractual promises, as Ivan contends, or whether no jury could reasonably conclude it had done so, as Insurer argued.

Given the undisputed material facts, the question of whether Insurer breached its promise can only be answered affirmatively, entitling Ivan to summary judgment on that issue. SDCL 15-6-56(c) The trial court should have granted Ivan's motion. Instead, the trial court ruled that even if all facts and inferences are viewed in Ivan's favor, no reasonable jury could conclude Insurer had breached the contract. The trial court erred, and should be reversed.

A. Insurer breached the implied contractual duty of good faith

1. Insurer owed its insureds the duty of good faith

Every contract contains an implied covenant of good faith and fair dealing that prohibits a contracting party from injuring the other party's right to receive contract benefits. *Garrett v. Bankwest, Inc.*, 459 N.W.2d 833, 841 (S.D. 1990), citing *Restatement (Second) of Contracts,* §205 (1981). Because good faith duties are contractual, violating them constitutes a breach of contract, as well as a tort. While South Dakota law recognizes tort liability for a breach of good faith duties, contract liability remains. *Stene v. State Farm Mut. Auto Ins.*, 1998 SD 95, ¶19 ("An insurer's violation of its duty of good faith and fair dealing … is also a breach of contract.")

Since at least 1969, the duty of an insurer to act in good faith toward its insured has been recognized as an implied term of every insurance contract in South Dakota. *Kunkel v. United Sec. Ins. Co.*, 168 N.W.2d 723 (S.D. 1969); *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 NW2d 752, 754 (S.D. 1994); *Stene* at ¶19. In *Kunkel*, the court held that insurers have a "duty to exercise good faith" and noted, "Good faith is a broad and

comprehensive term." *Kunkel* at 726. Except in workers compensation, the issue is not simply whether an insurer ultimately pays benefits, as an insurer can breach its duty in the way it *processes* benefits, whether or not benefits eventually are paid. *Hein v. Acuity,* 2007 SD 40, ¶10, 731 N.W.2d 231, 235.

The variety of cases involving breach of an insurer's duty of good faith illustrates that the duty is broad. An insurer's contractual duty of good faith and fair dealing specifically includes the duty to conduct a reasonable investigation concerning a claim made under the policy. *Dakota, Minn. & E.R.R. Corp. v. Acuity,* 2009 SD 69, ¶19, 771 N.W.2d 623, 629, citing *Walz v Firemen's Fund Ins. Co.,*1996 SD 135, ¶8, 556 N.W.2d 68, 70. ("Bad faith conduct may include the failure to conduct a reasonable investigation concerning the claim."); *Hanson v. Mut. of Omaha Ins Co*, 2003 US Dist LEXIS 28242, 10-12 (DSD Apr 29, 2003) (Schreier, J) (Insurer has the duty of gathering the necessary information to determine whether to pay benefits.)

The specific good faith duty *Kunkel* announced was the "duty to exercise good faith and give equal consideration" to an insured's interests. *Kunkel* at 726. The duty also requires the insurer to consider evidence supportive of an insured's claim, not just evidence seeming to contradict the claim. *Dakota, Minn. & E.R.R. Corp,* 2009 S.D. 69 at ¶22-24, 27. The good faith duty further requires there not be "unreasonable delay in performing under a contract…" *Champion v. United States Fidelity & Guaranty Co.,* 399 N.W.2d 320, 322, quoting 16A J.A. Appleman & J. Appleman, *Insurance Law and Practice,* §8878.15, at 422-24 (1981).

An insurer's good faith duty to its insured is so substantial, insurers often are referred to as fiduciaries. See *Crabb v. National Indem. Co.,* 205 N.W.2d 633, 637 (SD

1973) (refers to insurer's "fiduciary relationship" with insured); *Bertelsen v. Allstate Ins. Co.*, 2011 S.D. 13 ¶ 47, 796 N.W.2d 685, 700 (describes insurer's role as "like that of a fiduciary"); *Helmbolt v. LeMars,*, 404 N.W.2d 55, 58 (S.D. 1987) (refers to insurer's "fiduciary relationship" to insureds).

In *Trouten v. Heritage Mutual*, the Court explained:

> "The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary. Insurers hold themselves out as fiduciaries, and with the public's trust must go private responsibility consonant with that trust." 2001 SD 106, ¶31, 632 N.W.2d 856, 863.

Whether an insurer fulfills its fiduciary duty of good faith is *not* determined simply by whether the insurer ultimately pays benefits. That is because when consumers buy insurance, they are paying for more than just the right to eventually be paid benefits; they also are paying for *service* in the event of a claim. (SR 1747, App. 129) Basic insurance industry standards, confirmed by undisputed expert evidence, hold that among the services policyholders purchase with their premiums are assistance to help policyholders identify coverage and understand what triggers coverage, and active investigation by claims handlers, including reasonable efforts to obtain bills and other documents concerning a loss. (SR 1139, Flood declaration ¶22.) Insurer's manager of the claims department agrees.

2. Insurer breached the duty of good faith

- ***Duty to conduct reasonable investigation***

Insurer breaches its good faith duty to conduct a reasonable investigation of the claim arising from Lenore's cancer. The Insurer knows that when insureds pay

premiums, they are entitled to service in the event of a claim and that service includes investigating the insured's claim. Insurer's claims manager testified:

> Q. Well, the insurance company [is] being prepaid by the policyholder every month when every policyholder pays premiums to provide service, right?
>
> A. Correct.
>
> Q. And that service includes providing investigation when a claim is made?
> …
>
> A. Right. (SR 1750, App. 130)

However, when Lenore gets cancer and her husband tells Insurer they want to claim benefits, undisputed evidence shows Insurer *does not* investigate the claim. Insurer has everything necessary to obtain any documents it needs to determine what benefits should be paid: names, addresses, and phone numbers of Lenore's doctor and hospital, dates of her diagnosis, initial hospitalization, and her mastectomy, and a signed release allowing it to get her records and bills. (SR 1323-1328, App. 102-107) Insurer nevertheless does *nothing* to investigate, making no effort whatsoever – much less reasonable effort – to investigate facts supporting the claim. (SR 1009, App.144; SR 1130, App.145)

Insurer claims it discharged its duty to investigate by delegating that duty to Lenore's husband – supposedly making it Ivan's job to figure out what treatment expenses and other losses were covered, identify what documents were available to prove losses, and gather the documentation for claim handlers. That argument fails for several reasons. First, insurers know they cannot avoid the duty of good faith in South Dakota by delegating the duty to an independent adjuster. *Eldridge v. Northwest G.F. Mut. Ins. Co.*, 221 N.W.2d 16, 21 (SD 1974). If an insurer cannot avoid responsibility for good faith by

delegating its duties to a professional adjuster or to an attorney (see *Dakota, Minn. & E.R.R. Corp.* 2009 S.D. 69 at ¶22-27), it makes little sense to suggest an insurer can absolve itself of responsibility for good faith by delegating its duties *back to the insured*.

Neither eighty-one-year-old Lenore Zochert, cancer-stricken and living in a nursing home (SR 944, Zochert deposition, 25:21 – 26:11) nor her 87-year-old husband were employed by Insurer to handle claims. They were policyholders who had *paid for claim handling* by sending premiums year after year – people whose premiums helped fund Insurer's payroll. Neither they nor other insureds can be expected to have claims handling skills or expertise. There is no basis for contending insureds should provide the service an insurer was supposed to perform for them in exchange for premiums. (SR 1138 ¶17, SR 1139 ¶22, Flood Declaration)

Insurer's claim handler admits insureds should not have to hire an attorney to provide services necessary to get a claim paid:

> Q. Insureds and policyholders shouldn't have to hire a lawyer to get their benefits under their policy, should they?
>
> A. Absolutely not. (SR 930, App.143, Henry deposition)

Zocherts' circumstances demonstrate why it is ludicrous to say that policyholders who pay for decades for cancer insurance should relieve Insurer of its legal duty to investigate claims *by investigating their own claims at their own expense*. If Lenore or some other insured cancer patient happened to be a widow, would the insurer seriously contend she had to either investigate the claim herself or forego policy benefits? The fact that Lenore happened to have a husband surely cannot disqualify her for services insurers generally owe their insureds. Especially considering that insureds making claims under *this* policy are by definition dealing with cancer so serious it requires surgery and

hospitalization, Insurer's approach appears intended to obtain windfalls by impeding and minimizing claims from the most vulnerable policyholders. In no way does such an approach "encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary," which *Trouten* describes as qualities of an insurer's duty.

Insurer essentially delegates the duty to investigate back to insureds by including language in its proof of loss form telling them to submit bills (SR 1325, App. 105), but even if circular delegation back to insureds were allowed to contradict established principles of bad faith law, contract law makes it clear there was no such agreement here. The insureds' obligations stated in the contract are to give written notice of the claim within 60 days and file a written proof of loss within 90 days. (SR 1021, App 82) Nothing in the policy says policyholders must investigate their own claims – or even that they are responsible to gather and submit bills concerning their claim. Basic principles of contract law prohibit Insurer from unilaterally adding terms to the parties' agreement after the fact. Zocherts did not contract away their right to have the insurer conduct a reasonable investigation of the claim arising from Lenore's cancer treatment, much less agree to take on themselves the duty to investigate, and Insurer has no power to unilaterally amend the insurance contract.

- ***Duties to disclose coverage, give insured equal consideration, and consider reasons to pay claims***

Insurer breaches various other duties of good faith and fair dealing, evidenced especially by how the company disregards information it *does* have and by its lack of meaningful communication with its insureds. The fiduciary-like duty of good faith does not allow an insurer to play a game of hide-and-seek that makes insureds figure out where coverage exists and then set out to find what the company demands as proof before

benefits can be paid. As noted above, the good faith duty requires an insurer to disclose applicable coverages – not require insureds to identify coverages and elect which coverage to apply to the claim. This is not the first time an insurer in South Dakota has tried to use this type of excuse to avoid extra contractual liability.

This Court found it "particularly egregious" when an insurer failed to tell its insured that particular coverage would be available if the insured provided certain information. *Biegler v American Family Mut. Ins. Co.*, 2001 SD 13, P33-P34. The impropriety of expecting insureds to figure out which coverages they qualify for and want to claim has been known for nearly 90 years. "An insured is "not obliged . . . to elect upon which of the clauses in the policy the claim might be made." *Eide v. Southern Sur. Co.*, 55 SD 405, 409 (1929). In *Isaac.*, a bad faith verdict was upheld where the insurer failed to disclose UIM coverage, then tried later to excuse the nondisclosure by arguing that workers comp benefits were to be set off against it. 522 NW2d 752, 754 (SD 1994) In the landmark case relied on in *Trouten*, 632 N.W. 2d at 863, the court held, "To protect [the insured's] interests it is essential that an insurer fully inquire into possible bases that might support the insured's claim." *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 819 (1979).

When Lenore's claim is submitted, Insurer does essentially nothing to identify various coverages under which her claim could yield benefits or otherwise inquire into possible bases supporting the claim. (See SR 1137, App.122), Flood Declaration, ¶14) Not once in Insurer's communications to Ivan does it ever disclose the many different coverages Lenore qualified for. Not once do claims handlers initiate even a telephone interview of Lenore, Ivan, or Lenore's doctor to determine the scope of Lenore's

treatment or nature of any ongoing treatment or recovery. Not once do claim handlers use the authorization the company has to obtain Lenore's medical records, which would disclose triggers for many additional benefits.

Insurer even disregards the information it *does* have. For example:

- Insurer knows its insured had a mastectomy surgery, but does not tell its policyholder there are anesthesia benefits or look for evidence supporting payment of anesthesia benefits.

- Insurer knows its insured has been hospitalized because of cancer, but does not inquire about or look for evidence supporting paying hospital in-room benefits.

- The policy provides benefits for "home recovery" following cancer-related hospitalization, but Insurer does not tell its policyholder about that benefit or voluntarily just pay it when they know an insured has been hospitalized.

Such a head-in-the-sand approach by an insurer trying to avoid claim payments by willful ignorance is inconsistent with the affirmative duties recognized in *Biegler, Isaac, and Egan.* It is also undisputed that this type of passive claims handling does not meet industry standards (SR1134-1141, Flood declaration App. 119-126).

Both in its refusal to identify applicable coverages and in how it handled factual information about Lenore's claim, Insurer failed to give its insured's interest in *having the claim paid* equal weight to the company's interest in *not paying the claim.* It is particularly telling that on the *one* occasion Insurer used the authorization it had for release of Lenore's medical information, it was to check with the hospital to see if Lenore is owed for *three days* of hospitalization and home recovery, since the company has documents referring to Lenore's hospitalization from August 14-16, 2012, *or just two days*. (SR1138, App. 123, Flood declaration, ¶17) Saving less than $200 *for the insurance company* was a sufficient interest to prompt claims handlers to use the signed release, pick up the phone, and contact the hospital for information – but never did the

company use the release to further *the insured's interests* by requesting treatment records that would give a more complete picture of her cancer treatment and therefore reveal a duty various other benefits.

Insurer also breached the duty of good faith requiring no "unreasonable delay in performing under a contract," *Champion*, 399 N.W.2d at 322. That aspect of the good faith duty essentially duplicates an express contractual duty here, so discussion of that breach is handled immediately below.

Undisputed facts show Insurer breached the contract by breaching one or more of the implied duties of good faith – the promises to conduct a reasonable investigation, to give an insured's interests equal weight, and to consider evidence supporting payment of a claim, not just reasons to deny it. Ivan was entitled to summary judgment on breach of contract based on the breach of any or all of those promises, and the trial court erred by denying the motion. The trial court erred further by not only denying Ivan's motion, but granting Defendant's motion to dismiss by finding that *even when the facts are viewed most favorably to Ivan,* no reasonable jury could conclude the company had breached any of its contractual duties of good faith.

B. Insurer breached its contractual duty to pay benefits when due

1. Insurer owed a duty to pay benefits in a timely manner.

The insurance policy states:

- "**Notice of Claim** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. [. . .]";
- "**Claim Forms.** When we receive a notice of claim we will send you forms for filing proof of loss. [. . .]"

- **"Proofs of Loss.** Written proof of loss must be given to use within 90 days after the occurrence or commencement of any loss covered by the policy. [. . .]"

The policy promises that once the company receives written proof of loss, it will pay *all benefits then due:*

> **"After we receive written proof of loss, and subject to the terms of this policy, we will pay benefits then due under this policy." (SR 1022, App. 83)**

At the trial court, Insurer argued it was necessary for Zocherts to gather and submit Lenore's itemized bills because, it contended, the itemized bills themselves were the only "proofs of loss" that could trigger coverage. However, nothing in the policy says "written proof of loss" refers to a collection of every itemized bill incurred related to the loss, nor otherwise says the *insured* will be required to undertake an ongoing effort to gather and submit all billings or other document relating to the loss. In fact, nowhere does the policy *ever* even mention the word "bill."

Meanwhile, insurance law makes it clear that proof of loss is effectively *a notice requirement* that allows the insurer to prepare a defense. The requirement of proof of loss is to cue the insurer to do the investigation, an investigation that protects both insurer and insured. *Auto-Owners Ins. Co. v. Hansen Housing, Inc.* 2000 S.D. 13, ¶ 31, 604 N.W. 2d 504, (2000) citing *City of Ft. Pierre v. United Fire and Casualty Co.*, 463 N.W. 2d 845 (S.D. 1990). Notice and proofs of loss are not supposed to be some technical escape hatch for insurers to use to avoid paying claims. *Id.* In this case, Insurer never did the investigation once it received notice and proofs of loss. Yet, it argues it is not responsible for paying Zocherts' claim because neither Lenore nor her husband provided each and every "itemized billing."

Insurer also argues because neither Lenore nor Ivan said that they wanted to be paid for Lenore's hospitalization, Insurer was justified in not paying it. The *Eide* Court put that kind of argument to rest nearly 90 years ago in South Dakota. More recently another court has further elaborated. In the Kansas decision of *Bartlett v. CNA*, 104 P.3d 1011, 1017 (Kan. App. 2005) the insurer made the same kind of argument Insurer makes here: that its insured had not specifically requested the coverage, so the accident notice was insufficient to make an under-insured motorist claim. The Court disagreed, concluding that: "[t]he [insurer's] argument is unsupported by law, contract, or common sense."

> The notice provisions of the policy *do not require the insured to identify for his or her company the coverage provision which will be applicable* to the claim. One would expect the insurance company, which drafted the insurance policy, to have a greater knowledge of the applicability of the various coverages contained in the policy than a person who purchases the policy.
>
> *To suggest that the insured has to identify the precise coverage that will apply to an accident is totally unpersuasive. Upon being notified of an accident, it is incumbent on the insurance company to investigate the applicability of its insurance policy provisions. Bartlett*, 104 P3d 1011, 1017 (Kan. App. 2005) (emphasis added).

The same applies here: Insurer knows Lenore had cancer, knows cancer was diagnosed via biopsy, knows cancer was surgically operated on, knows who the surgeon was that performed the operation, knows where Lenore was hospitalized and treated, and knows the dates of the initial hospitalization. Insurer even required Ivan to complete and return a medical release authorization that would allow claims handler to get whatever additional information Insurer needed. Yet, Insurer *chooses* to do nothing with this information and prefers to put the burden on the 87-year-old husband of a cancer-stricken policy holder, instead of allowing him to be with his wife while she recovers.

2. Insurer breached its duty to pay benefits when they were due.

Ivan promptly notifies the company of Lenore's cancer and the resulting claim for benefits. Well within 90 days, Ivan submits written proof of loss, returning every form Insurer provides, including the medical release authorization, Physician Statement, and general proof of loss form. By October 24, 2012, Ivan also has a pathology report submitted confirming Lenore's diagnosis. (SR 1323-1328, App. 102-107) Ivan gives Insurer everything it needs to proceed with reasonable investigation and processing. Knowing nothing more than it already knows, if Insurer had made reasonable inquiry, it would find Lenore entitled to at least these benefits: surgical benefits for the biopsy; surgical benefits for the partial mastectomy; anesthesia benefits for the mastectomy; in-hospital benefits for room and board; home recovery benefits following the first hospitalization; in-hospital benefits for room and board during the second hospitalization; intensive care benefits; and home recovery benefits following the second hospitalization and ICU stay. All those losses were incurred by early September of 2012 and subject to documentation soon after, had claim handlers made reasonable inquiry. Instead, Insurer pays a single benefit on November 13, 2012: surgery benefits for the partial mastectomy.

Another six months later, only after Ivan hires an attorney who works to get Insurer to pay additional benefits, Insurer finally pays more benefits. May 13, 2013, it pays $474.56 in benefits for anesthesia and room and board charges during Lenore's first hospitalization and two days of post-hospitalization recovery. (SR 1127) Insurer has known of the surgery and initial hospitalization triggering those benefits since September of 2012.

For over 15 months, Insurer again pays nothing. Only then – a week after Ivan sues the company, a year after Lenore dies, and two years after Ivan first notifies it of Lenore's cancer and files a claim –does Insurer start paying additional benefits. Finally, the company resumes paying benefits. Beginning August 29, 2014, it starts issuing checks totaling $1,850, all representing benefits for losses occurring two years earlier, including payment for Lenore's July 5, 2012 biopsy. (SR 1309-1311)

These undisputed facts prove breach of the implied and express duties to pay benefits when due without unreasonable delay. Insurer argues that because once Ivan or his counsel identified coverage for Ivan and then submitted the itemized bills, they were paid within 30 days. However, that misses the point. Had insurer done the necessary investigation and coverage disclosure when it was supposed to, the bills would have been paid as much as two years earlier and Ivan would not have had to hire an attorney to process and investigate their claim. He had already paid Insurer for 22 years to do exactly that.

II. The Trial Court Erred in Dismissing the Bad Faith Tort Claim

A. South Dakota recognizes the tort of insurance bad faith.

The trial court erred when finding that insurance bad faith is not a tort. Since at least 1969, this Court has ruled that in cases of a contract between an insurer and its policyholder, breach of the universally implied contractual duty of good faith[7] gives rise

[7] Every contract includes an implied contractual term requiring good faith and fair dealing. *Garrett*, 459 N.W.2d at 841. While every contract does not allow a breach of good faith and fair dealing claim despite the implied term, such a claim does exist when it arises in an insurance claim.

to a *tort* claim. *Kunkel,* 168 N.W.2d 723 (S.D. 1969); *Isaac* at 754; *Stene* at ¶19. The trial court is unquestionably wrong.

Insurer argued that "South Dakota does not recognize the tort of breach of duty of good faith and fair dealing." (SR 1215) Ignoring more than a dozen published South Dakota Supreme Court opinions recognizing tortious breach of the duty of good faith and faith dealing in insurance contracts, Insurer brazenly claimed no such claim exists. (SR 1215). The company's contention was particularly alarming, considering it had cited several published opinions to the contrary in its own briefing. Nevertheless, overlooking nearly 50 years of caselaw, the trial court adopted the falsehood on its way to granting Insurer's motion to dismiss, finding that "South Dakota's not recognized that action" (SR 1724, lines 18-22).

B. <u>Jurors reasonably could find Insurer liable for the tort of bad faith.</u>

1. Bad faith requires an insurer to know of, or have reckless disregard for, the lack of reasonable basis for its conduct.

For an insurer's breach of the good faith duty to be tortious, the insurer must lack a reasonable basis for its conduct and know of the lack of reasonable basis or recklessly disregard whether a reasonable basis exists. *Mordhorst v. Dakota Truck Underwriters,* 2016 SD 70, ¶9, 886 N.W.2d 322; *Bertelsen v. Allstate Ins. Co.* ("*Bertelsen III*"), 2013 SD 44, ¶ 17, 833 N.W.2d 545, 554. An insurer's knowledge of the lack of a reasonable basis to deny benefits "may be inferred and imputed to an insurance company where there is a …reckless indifference to facts or to proofs submitted by the insured." *Mordhorst,* 2016 SD 70, ¶9, quoting *Champion,* 399 N.W.2d at 324.

2. Bad faith is a question of fact, appropriate for summary judgment *only* if reasonable jurors could reach but one conclusion.

Insurer was required to show there is no genuine issue of material fact regarding the tort claim and that undisputed material facts entitled the company to judgment as a matter of law. SDCL 15-6-56(c); *Schliem v State*, 2016 SD 90, ¶ 7. *Wildeboer v. SD Junior Chamber of Comm.*, 1997 SD 33, ¶10, 561 N.W.2d 666, 668-69. Whether an insurer has acted in bad faith is generally a question of fact. *Bertelsen III*, 2013 SD 44, ¶ 17. A party moving for summary judgment is entitled to judgment as a matter of law on factual questions *only* when the evidence is such that reasonable jurors could "draw but one conclusion from facts and inferences." *Wilson v. Great Northern Ry. Co.*, 83 SD 207, 213, 157 N.W.2d 19, 222 (1968). Furthermore, the evidence must be viewed most favorably to the non-moving party, with reasonable doubts resolved against the movant. *Wilson*, 157 N.W.2d at 21. Insurer cannot meet that burden. Instead, all insurer offers is the argument that once Ivan and his counsel performed the investigation and claim processing at the Zochert's expense, Insurer paid the benefits within 30 days.

3. Jurors could find that Insurer knew of, or had reckless disregard for, the lack of reasonable basis for its conduct.

The discussions above that establish breach of contract will not be repeated here for purposes of arguing the related tort of bad faith; set out below are particular facts that show the *tortious nature* of the insurer's conduct.

There are at least three examples showing the tortious nature of Insurer's conduct toward its insureds: how the company handles Lenore's biopsy and otherwise fudge facts to try to shrink coverage, the company's general nondisclosure of coverages, and how the company incentivizes its claims handlers. Ivan consulted an insurance expert, Elliott S. Flood, who spent a career handling such matters for insurers. After reviewing the entire

claim file, Flood confirms that Insurer lacked a reasonable basis when it denied and failed to fairly and properly process and pay the claim. (SR 1134-1141, App. 119-126), Flood declaration) Flood's conclusions are undisputed by any other insurance claims handling expert.

- ***Handling of Lenore's biopsy shows bad faith***

It cannot be surprising that when a doctor meets with a patient believed to have breast cancer, one of the first steps in treating the patient is to perform diagnostic tests, likely including a biopsy, to confirm diagnosis and determine the nature of the cancer. Claims handlers know cancer must be "diagnosed" before it is treated, and claims handlers assigned to claims under Insurer's cancer policy should know that diagnosis of breast cancer often is done by biopsy. The policy nowhere excludes coverage for diagnosis; in fact, it *requires* that cancer be diagnosed by microscopic pathology and *allows payment for expenses incurred up to 10 days before diagnosis.* (SR 1018, App. 79)

When Insurer gets notice of Lenore's cancer, its claim handlers do not request any record documenting the biopsy or when it occurred so they can pay benefits for the procedure. They do not tell the insureds that a biopsy triggers entitlement to a Surgical Expense Benefit. More than two years after Lenore's biopsy, Insurer finally pays $30 for the biopsy as a surgical expense. (SR 1128, App. 112) In the meantime, claim handlers fail to pay for Lenore's biopsy, apparently engaging in a game of Catch-22, refusing to acknowledge a biopsy as surgery for purposes of Surgical Expense Benefits, later insisting it *is* surgery when some other argument arises:

> Q. And "treatment" could mean just surgery or just chemotherapy, or it could also mean diagnosis, like a biopsy, a needle that gets pushed into

somebody's breast to take a tissue sample. Now, one of those favors the policyholder and one doesn't. Were you ever trained that you have to use the one that favors the policyholder?

MS. WEBER: Object to form.

A. No, because we have to go off of what the word "treatment" means. Having a biopsy isn't treatment."

…

It's surgery.

…

So it's not a form of treatment, because it's not -- a biopsy is for the purposes of diagnosis only, not necessarily to treat or remove their cancer.

….

A. That's a separate surgery.

Q. So you don't think the word "treatment" includes things like a biopsy or mammogram, things that are used before chemotherapy might start?

A. Those are for -- for me personally the way I would view it, and the way the policy dictates from my understanding, is that those are for laboratory purposes.

…

A. Because we are not -- they are not treating the cancer. A form of treatment would be chemotherapy or radiation.

Q. Is surgery treatment?

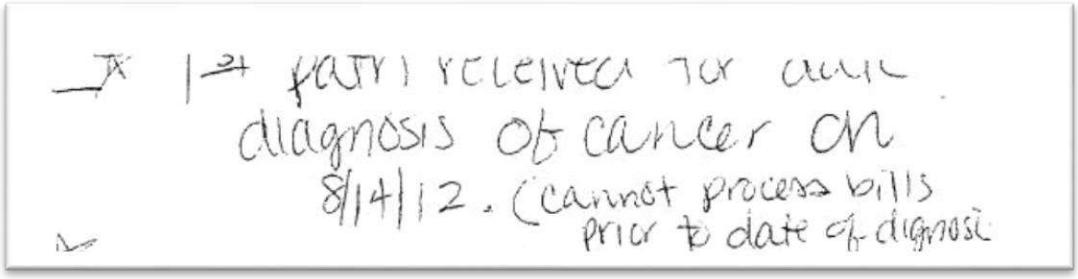
A. Yes, it can be, if it's going to fully remove their cancer, depending on what type of cancer they have. [. . .]

Q. So, in your mind as you handle claims, surgery is treatment for cancer?

A. Yes, it can be." (SR 842-1144)

While the claim handler demands that a biopsy is surgery, not treatment which is absurd and beside the point, what is on-point is that the claims handler in this case did not

pay the biopsy under the surgical expense benefit despite *knowing* a biopsy is surgery. If that were not enough to avoid paying for biopsies, one claim handler further narrows eligibility criteria by blatantly disregarding policy terms, as indicated on this note found in the claim file. (SR 1154) The claim handler refuses to process bills prior to the date of diagnosis of cancer – *even though the policy expressly says it will cover expenses* incurred within "10 days preceding the date of positive diagnosis of Cancer."



To make matters worse, the claims handler not only misstates the policy provision regarding onset of eligibility, but focuses on an August 14, 2012 pathology report, unrelated to the initial date of diagnosis. Insurer knows Lenore's cancer was diagnosed as of July 11, 2012; the Physician's Statement expressly stated that. But the claims handler chooses instead to use a date from the pathology report generated *after* Lenore's mastectomy.

Claim handlers assigned cancer policy claims know there are often multiple pathology reports during any course of cancer treatment, and that mastectomies likely do not occur unless cancer was diagnosed prior to surgery. Yet, rather than using the initial diagnosis date Dr. Christensen provided, Insurer chooses to focus on a later pathology report concerning tissue taken during the mastectomy. By pretending August 14, 2012 was the "first diagnosis" of cancer and by ignoring that the policy covers expenses

incurred even 10 days prior to diagnosis, Insurer pushes back considerably the period for which benefits will be owed, avoiding payment for earlier charges.

- ***Efforts to avoid applicable coverage shows bad faith***

Discovery reveals that how Lenore's claim was handled is a consequence of specifically designed company mechanisms and practices happening over and over in thousands of cases. It is an *unfair claims practice* for an insurer to fail to adopt and implement reasonable standards for claim investigations and settlement. SDCL 58-12-34(3). Yet, despite being a billion-dollar insurance company handling 1,700 to 1,800 claims a month, Insurer has no standards that guarantee the fair and prompt investigation of insurance claims. (SR1140, App. 125, ¶23-24 Flood declaration) The only standard for performing fair and prompt investigation is the standard that the claims manager testified to, "We don't investigate a claim." (SR 1750, App.30)

The harmful effects on insureds is evident. For example, although Insurer *requires* that insured claimants sign a medical release authorization form allowing the company to obtain protected health information and requires a doctor to confirm diagnosis of cancer, dates of hospitalization and surgery, and the name and address of the relevant health care facility, Insurer does not use the releases to obtain any medical information to support claims payments. Requiring insureds complete and return an authorization to medical records gives insureds the idea that Insurer is going to do something with the authorization. Insurer does nothing except protect its self.

Instead, when a claim is submitted, Insurer just tells policy holders things like, "Charges excluded exceed the amount which can be considered as a covered charge" or "Please Submit Pathology Report for 1st Diagnosis of Breast Cancer." Insurer never tells

policyholders about additional benefits they qualify for. Insurer does not divulge that additional coverages apply, nor does it tell policy holders what is necessary to trigger benefits under those coverages. (Valez deposition p. 48-50, SR 1158-1160, App.138-140)

- ***Incentive programs promote bad faith claim handling***

The claim handling displayed in this case is no accident or anomaly. It is designed to operate as it did. Insurer uses employee incentive plans to promote individual adherence to practices that promote the company's profitability. Employees from top earners down to claims handlers have a personal financial stake in the company reaching certain financial goals, with claims payments being the biggest variable affecting an insurance company's bottom line and the only thing the claims handlers have the ability to substantially affect. Insurer's incentive plan for top tier employees; the "annual incentive plan" or "AIP," is "directly linked to the company's performance" and has a maximum payout to an executive of millions of dollars. (SR 1730-1731).

In most business settings, incentives and bonuses are common and there is nothing illicit about incentivizing profitability. Insurance is different. As the Court explained in *Trouten:*

> "The insurer's obligations are ... rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements.... [A]s a supplier of a public service rather than a manufactured product, the obligations of insurers go beyond meeting reasonable expectations of coverage. The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary. Insurers hold themselves out as fiduciaries, and with the public's trust must go private responsibility consonant with that trust." 2001 SD 106, ¶31 citing *Egan,* 24 Cal. 3d 809 (1979).

Fiduciaries are not supposed to put their interests ahead of the interests of those they serve, and that is what renders suspect any insurance company incentive program that encourages claims handling practices that promote minimization of claims payments. Programs that incentivize avoiding claims payments make insureds into adversaries.

A fiduciary is the *opposite* of an adversary. "A fiduciary is a person with a duty to *act primarily for the benefit of another.*" (Emphasis in original) *Garrett* 459 N.W.2d at 837. "A fiduciary is defined as a 'person who is required to act for the benefit of another person on *all matters within the scope of their relationship.'"* (Emphasis in original) *Dykstra v. Page Holding Co.,* 2009 SD 38, ¶ 27, 766 N.W.2d 491, 497 (quoting *Black's Law Dictionary* (8th ed. 2004)). In *Hein v. Zoss,* the court reiterated the Black's Law definition and went on to note that "A fiduciary must act with utmost good faith and avoid any act of self-dealing that places [his] personal interest in conflict with [his] obligations to the beneficiaries." 2016 SD 73, ¶8.

Insurer puts claims handling staff and supervisors in an adversarial relationship with insured claimants. Claim handlers should pay what is owed – no more, no less – without regard to the effect on corporate profit. (SR 1761, App. 132) The insurance policy should govern the transaction, and an insurance claims department should not be a profit center for insurers. (SR 1756, App. 131) But Insurer's claims handlers are tasked with either processing and paying claims fairly *and receiving smaller bonuses*, or diverting dollars to corporate profits by avoiding claims payments *and receiving larger bonuses.*

The employee incentive program for claims handlers is administered by Insurer's CEO.(SR 1587, App. 99) Funding that incentive plan is based on overall performance

results for the company, compared to goals established for the plan year, with incentives of up to as much as several percent of an employee's annual salary.(SR 1586, App.98) In 2012, the year of Lenore's claim, Insurer surpassed its goal and funded the pool from which claims handlers' bonuses were paid at a level of multiple percent of employees' salaries.(SR1729).

The incentive plan utilized for claims handlers is based on audit results, rewarding employees based on "value of results delivered to organization" and "overall corporate performance." (SR 1585, App. 97) How does the company determine the "value of results" a claims handler has "delivered to [the] organization" and whether the claims handler has furthered "overall corporate performance"? Claims handlers are supervised by managers, who submit claims to be audited by internal auditors. When a claim is audited, the auditors review pre-set criteria.

The audit forms reveal what is valued by Insurer, and what is disregarded when evaluating claims handling performance. (SR 1583-1584, App. 100-101) Notably, the auditor *never checks whether the claims handler told the insured about other potential coverages.* (SR 1780, App 133, SR 1797 -1798, App. 134-135) Even though cancer is often a complex condition with extended and varied treatment, claim handlers are *never asked if they investigated other possible medical providers or other possible hospitalizations.* The auditor *never considers whether a claim handler contacted a doctor, hospital or other medical provider*. The only real question auditors ask is whether the claim handler paid the bills in the file. Of course, as Insurer's claims manager testified, the company "never investigates claims" (Turner deposition, SR 1750, App.130). Thus, the only bills in the file are ones the insured submitted.

Linking bonus payment for claims personnel to the amount of corporate performance pits claims handlers directly against their insureds. If the claims handlers look for coverages and information that supports paying claims, corporate profits go down because more claims get fully and fairly paid. Thus, so does overall funding for the incentive pools. It is no wonder claims handlers do not help insureds find coverage or facts that support payment of benefits. This process not only allows, but systemically encourages, Insurer's violation of its fiduciary-like duty.

CONCLUSION

There is only one answer to the question of whether Insurer breached the contract: yes. Insurer breached its contractual good faith duty to investigate an insured's claim, advise its insured of applicable coverages, fairly process the claim as required by its good faith duties, and by failing to pay benefits in a timely manner. The court's rulings to the contrary must be reversed. Summary judgment for Insurer on the breach of contract claim should be reversed, and the trial court instructed to enter partial summary judgment for Ivan Zochert on that issue.

Insurer is not entitled to judgment as a matter of law on bad faith. South Dakota recognizes the tort of bad faith. Reasonable jurors could conclude this insurer acted in bad faith. Summary judgment should be reversed, and the parties allowed to proceed to trial on the entire tort claim.

January 25, 2018 TURBAK LAW OFFICE, P.C.

By: Seamus W. Culhane
Nancy J. Turbak Berry
Attorneys for Plaintiff
26 S. Broadway, Suite 1100
Watertown, SD 57201

CERTIFICATE OF COMPLIANCE

The above brief complies with the type-volume limitation imposed by SDCL 15-26A-66(b)(2) by containing only 9,752 words.

January 25, 2018 TURBAK LAW OFFICE, P.C.

By: Seamus W. Culhane
Nancy J. Turbak Berry
Attorneys for Plaintiff
26 S. Broadway, Suite 1100
Watertown, SD 57201

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STATE OF SOUTH DAKOTA IN CIRCUIT COURT

COUNTY OF MOODY THIRD JUDICIAL CIRCUIT

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert,
Plaintiff,

vs.

Protective Life Insurance Company,
Defendant.

CIV: 14-61

COMPLAINT

Plaintiff, for his complaint against Defendant Protective Life Insurance Company ("Protective Life"), states as follows:

1. Ivan Zochert is a resident of South Dakota.

2. Protective Life Insurance Company, ("Protective Life") is a corporate entity with its principal place of business outside the State of Dakota.

3. Protective Life Insurance Company, ("Protective Life") is an "Authorized Insuraer" under the laws of South Dakota.

4. Protective Life sold Ivan Zochert and his wife Lenore Zochert ("the Zocherts") a cancer insurance policy ("policy") numbered D00054903 on or about March 1, 1990.

5. At all times relevant to this action, Ivan Zochert and his wife Lenore Zochert paid premiums to Protective Life and were insured under the cancer insurance policy Protective Life sold them.

6. The policy Protective Life sold Ivan Zochert and Lenore Zochert included a **Schedule of Benefits** that reads as follows:

"Benefits are payable for those expenses incurred by an Insured from 10 days preceding the date of positive diagnosis of Cancer or from the first day of a period of Hospital confinement during which the positive diagnosis is made, whichever is more favorable to you. Such expenses will consist of the actual charges by the Hospital, Physician, or other providers subject to the limitations stated herein. No benefit will be paid in excess of the Usual and Customary Charge made by the provider of services or treatment."

7. The **Schedule of Benefits** includes benefits for:

   a. "**In-Hospital Room and Board Benefit.** We will pay $160 per day for each of the first 10 days of each period of Hospital confinement and $200 per day for each day thereafter."

   b. "**In-Hospital Special Nursing Benefit.** We will pay up to $100 per day for special nursing services (other than those regularly furnished by the Hospital) received from a full-time private duty registered nurse (R.N.) or licensed practical nurse (L.P.N.), while an Insured is Hospital confined. Such nursing care must be required and authorized by the attending Physician and be given by a person not related to you."

   c. "**In-Hospital Attending Physician Benefit.** We will pay up to $25 per day for all personal visits by attending Physicians, other than a surgeon, while an Insured is confined in a Hospital."

   d. "**Home Recovery Benefit.** We will pay $100 per week ($14.28 per day) while an Insured is confined at home immediately following a Hospital

confinement. The maximum period this benefit will be paid is equal to the number of consecutive days of the prior Hospital confinement."

e. **"Surgical Expense Benefit.** When a surgical operation for the treatment of Cancer is performed on an Insured, we will pay for charges incurred for such operation and anesthesia in accordance with the 1969 California Relative Value Schedule with a unit value of $50 for surgery and $42 for anesthesia. Examples of various type operations are listed in the Schedule of Operations. To determine the maximum surgical benefit multiplied the S.V. by $50. To determine the maximum anesthesia benefit multiplied the A.V. by $42. Two or more surgical procedures performed through the same incision will be treated as one operation, and the benefit paid will be that for the procedure providing the greater benefit. Maximum benefit is $2,500 for surgery and $630 for the anesthesia."

8. On or about July 5, 2012 Lenore, Dr. Alan Christensen performed surgery to collect samples from a lump identified within Lenore's left breast.

9. On or about July 5, 2012 a pathology lab test at Prairie Lakes Healthcare confirmed that the samples gathered from Lenore's breast were carcinoma.

10. On or about July 18, 2012 Lenore underwent pre-operative stress and blood testing to verify that she was a candidate for surgery including blood testing and

11. On or about August 14, 2012 Lenore was admitted to Prairie Lakes Healthcare System for a left breast lumpectomy. Lenore was anesthetized, given antibiotic treatment, and Dr. Alan Christensen completed a left breast partial mastectomy and intermediate closure of the partial mastectomy site.

12. Lenore stayed in the hospital two nights and was discharged from the hospital on August 16, 2012.

13. On or about August 31, 2012 Lenore began to have ongoing erythematous change and hematoma to the breast tissue and was forced to be re-admitted to the hospital.

14. In total, for the surgery to gather the sample, the pathology testing of the sample, the doctors' visits, stress testing to qualify Lenore for surgery, anesthesia, the cancer removal surgery, the first hospital stay, surgery, pathology testing of the removed breast tissue, prescription medication, a second subsequent related hospitalization, and follow up doctors' visits, the Zocherts incurred a total of $25,606.00 in expenses from the Hospital, Physicians, and other providers for cancer related diagnosis, treatment, and post-surgical care.

15. After policy limitations are applied to the surgery, anesthesia, and hospital room and board charges, Protective Life should pay the Zocherts at least $10,688.00.

16. The Zocherts made a claim to Protective Life for expenses incurred during the surgery, anesthesia, hospital stay, and other cancer related treatment.

17. On or about November 13, 2012, Protective Life issued payment of $420 under the Surgical Expense Benefit provision.

18. On or about March 13, 2013 the Defendants were asked why they did not issue payment for the In-Hospital Room and Board Benefit, or the In-Hospital Physician Benefit.

19. On or about May 13, 2013 the Defendants responded by issuing another payment for $474.56, meanwhile denying the remaining charges incurred which were related to cancer diagnosis, treatment and follow up care.

20. On August 2, 2013, Lenore Zochert passed away.

21. Under the policy Protective Life sold the Zocherts, Ivan Zochert is entitled to insurance benefits equal to the difference between the amount charged by the providers relating to the diagnosis, treatment and post-operative care of cancer less the restrictions the policy places on some of the charges.

Count 1- Breach of Contract

22. Paragraphs 1 through 21 are incorporated by reference as if set forth again.

23. The insurance policy that Protective Life sold the Zocherts combined with the Zocherts payment of premiums amounted to a legally enforceable promise.

24. When Protective Life failed to make full payment under the policy, they breached their promise to the Zocherts.

25. The breach of Protective Life's promise in the ordinary course of things caused the Zocherts clearly ascertainable damages.

26. Those damages clearly ascertainable amount to at least $10,688.00.

Count 2 - *Statutory Entitlement to Attorney's Fees*

27. Paragraphs 1 through 26 are incorporated by reference as if set forth again.

28. Protective Life's failure to pay insurance benefits under the Zocherts' insurance policy was unreasonable and vexatious, such that Ivan Zochert is entitled under SDCL §58-12-3 to recover his reasonable attorney's fees.

29. Protective Life misrepresented its cancer insurance policy benefits by ignoring policy provisions and the law in South Dakota by denying payment of insurance benefits to the Zocherts, even after Protective Life knew or reasonably should have known that such benefits were owed to the Zocherts, making attorney's fees appropriate under SDCL §58-33-5 and §58-33-46.1.

Count 3 – *Tortious Breach of Duty of Good Faith and Fair Dealing*

30. Paragraphs 1 through 28 are incorporated by reference as if set forth again.

31. Protective Life had no reasonable basis to deny or withhold payment of cancer related treatment expense benefits under the policy.

32. Protective Life has a series of deficient and unfair claim handling practices designed to reduce claim payouts at the expense of the cancer battling policy holders.

33. Those deficient claim handling practices include but are not limited failing to perform a full and fair claim investigation, using claim handling software that is processing claims contrary to the policy provisions, ignoring policy holders' request for information about their claims, shifting the burden to the claimants to investigate and document their own claims, and only processing payment for some charges and not other charges.

34. Protective Life knew, or through a reasonable investigation would have known, that there was no reasonable basis to deny or withhold payment of insurance benefits.

35. Protective Life did not conduct a reasonable investigation of The Zocherts' claim before Ivan Zochert was forced to file suit.

36. Protective Life did not conduct a reasonable evaluation of the Zocherts' insurance claim.

37. Protective Life conduct was in breach of the duty of good faith and fair dealing that it owed to The Zocherts as its insureds.

38. Protective Life's conduct as described above caused Ivan Zochert financial harm, as well as emotional upset, frustration, aggravation, distress, wasted time, annoyance, and other harms.

39. Protective Life's conduct in ignoring or misapplying its own policy provisions not only caused damage to Ivan Zochert, but also has harmed and continues to harmother policyholders by increasing Protective Life's claim denials and reducing the amounts Protective Life pays in claims, and such conduct amounts to oppression, fraud, or malice, and amounts to willful and wonton reckless disregard to the rights of policy holders such that punitive and exemplary damages are necessary to punish Protective Life and deter Protective Life and other insurers from employing these tactics on other policyholders.

THEREFORE, Plaintiff requests that the Court enter Judgment against the Defendant as follows:

1. Compensatory damages in an amount to be determined at trial;
2. Prejudgment interest as allowed by law;
3. Punitive damages an amount to be determined at trial;
4. Other relief as deemed appropriate and necessary, including nominal damages; and
5. Attorney's fees as allowed by law pursuant to SDCL§58-12-3 and SDCL §58-33-46.1.

Dated this 25st day of August, 2014.

TURBAK LAW OFFICE, P.C.

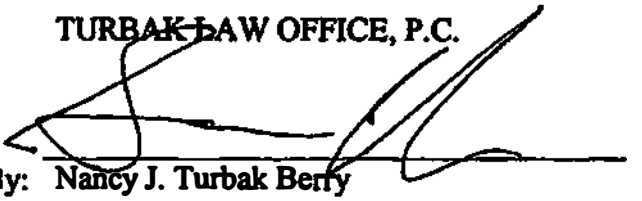
By: Nancy J. Turbak Berry
Seamus W. Culhane
Attorneys for Plaintiffs
26 S. Broadway STE 100
Watertown, SD 57201
605-886-8361
Nancy@turbaklaw.com
Seamus@turbaklaw.com

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand trial by jury on all the issues in this action.

Dated this 25st day of Augut, 2014.

TURBAK LAW OFFICE, P.C.



By: Nancy J. Turbak Berry
Seamus W. Culhane
Attorneys for Plaintiffs
26 S. Broadway STE 100
Watertown, SD 57201
605-886-8361
Seamus@turbaklaw.com
Nancy@turbaklaw.com

STATE OF SOUTH DAKOTA) : SS		IN CIRCUIT COURT
COUNTY OF MOODY)		THIRD JUDICIAL CIRCUIT
IVAN ZOCHERT individually and as Administrator for the Estate of Lenore Zochert,	*	50CIV14-000061
Plaintiff,	*	
vs.	*	**AMENDED ANSWER**
PROTECTIVE LIFE INSURANCE COMPANY,	*	
Defendant.	*	

COMES NOW Defendant Protective Life Insurance Company ("Defendant") by and through its attorney of record, and for its Amended Answer to Plaintiff's Complaint, state and allege as follows:

1. Plaintiffs Complaint fails to state a claim upon which relief can be granted.

2. Defendant denies the allegations in Plaintiff's Complaint unless expressly admitted or qualified herein.

3. Defendant admits paragraphs 1, 2, 3, 4 and 5 of Plaintiff's Complaint.

4. Concerning paragraphs 6 and 7 of Plaintiff's Complaint, Defendant states that it appears Plaintiff has accurately quoted portions of policy number D00054903, but Plaintiff has omitted important parts of the policy, and Defendant pleads that the best evidence of the language of the policy is the policy itself and refers to the policy.

5. Concerning paragraphs 8-14 of Plaintiff's Complaint, Defendant is without sufficient information to either admit or deny the allegations contained therein and therefore denies

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the same.

6. Defendant denies the allegations contained in paragraph 15 of Plaintiff's Complaint.

7. Concerning paragraph 16 of Plaintiff's Complaint, Defendant admits that Ivan Zochert made a claim for benefits under their Protective Life policy but allege that they failed to submit necessary information for the processing of the claims.

8. Concerning paragraph 17 of Plaintiff's Complaint, Defendant admits the allegation contained therein.

9. Concerning paragraph 18 of Plaintiff's Complaint, Defendant is without sufficient information at this time to either admit or deny the allegations contained in this paragraph and therefore denies the same.

10. Concerning paragraph 19 of Plaintiff's Complaint, Defendant admits that it made a payment of $474.56 on or about May 13, 2013, but denies the remaining allegations contained in this paragraph.

11. Concerning paragraph 20 of Plaintiff's Complaint, Defendant is without sufficient information to either admit or deny the allegation contained therein and therefore denies the same.

12. Defendant denies the allegations contained in paragraph 21 of Plaintiff's Complaint.

13. Concerning paragraph 23 of Plaintiff's Complaint, Defendant admits that the issuance of policy number 000054903 created a contract between Plaintiff and Defendant.

14. Defendant denies the remaining allegations of the Complaint.

15. Defendant specifically denies that Plaintiff is entitled to attorney's fees and punitive damages.

16. Defendant alleges that it complied with the terms of the insurance policy it had with Plaintiff and further alleges that it complied with all laws in the payment or denial of claims to Plaintiff.

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AFFIRMATIVE DEFENSES

Plaintiff's Complaint may be barred, in whole or in part, by these affirmative defenses:

1. Plaintiff's Complaint is barred by the doctrines of waiver and estoppel.

2. Plaintiff breached his duty of good faith and fair dealing in the performance of his duties under the insurance agreement.

WHEREFORE, Defendant prays that the Complaint of the Plaintiff be dismissed upon the merits, with prejudice, and that Plaintiff recover nothing thereunder; and, further, that Defendant recover its costs and disbursements herein, together with such other and further relief as the Court deems just and proper.

Dated at Sioux Falls, South Dakota, this 11th day of October, 2017.

EVANS HAIGH & HINTON LLP

/s/ Edwin E. Evans
Edwin E. Evans
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599
Facsimile: (605) 275-9602
Email: eevans@ehhlawyers.com

and

Katharine A. Weber
MAYNARD, COOPER & GALE, P.C.
1901 Sixth Avenue North
2400 Regions Harbert Plaza
Birmingham, AL 35203
Telephone: 205-254-1000
Email: kweber@maynardcooper.com

Attorneys for Defendant

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DEMAND FOR JURY TRIAL

Defendant demands trial by jury on all issues of fact.

/s/ Edwin E. Evans
Edwin E. Evans

CERTIFICATE OF SERVICE

The undersigned, one of the attorneys for Defendant, hereby certifies that a true and correct copy of the foregoing "Amended Answer" was filed electronically with the Clerk of Court using Odyssey File and Serve system which will send notification of such filing to the following:

Nancy J. Turbak Berry
Seamus W. Culhane
Turbak Law Office, P.C.
26 South Broadway, Suite 100
Watertown, SD 57201
nancy@turbaklaw.com
seamus@turbaklaw.com
Attorneys for Plaintiff

on this 11th day of October, 2017.

/s/ Edwin E. Evans
Edwin E. Evans

Filed: 10/11/2017 1:35:59 PM CST Moody County, South Dakota 50CIV14-000061

STATE OF SOUTH DAKOTA	IN CIRCUIT COURT
COUNTY OF MOODY	THIRD JUDICIAL CIRCUIT
Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert, Plaintiff, vs. Protective Life Insurance Company, Defendant.	50CIV14-000061 PLAINTIFF'S AMENDED NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT

TO THE ABOVE-NAMED DEFENDANT, PROTECTIVE LIFE INSURANCE COMPANY, AND ITS ATTORNEYS OF RECORD: ED EVANS OF EVANS, HAIGH, & HINTON, LLP, AND KATHARINE WEBER OF MAYNARD, COOPER & GALE, P.C.:

PLEASE TAKE NOTICE that on November 6, 2017 at 1:15 PM, or as soon thereafter as counsel can be heard, at the Moody County Courthouse in Flandreau, South Dakota, Plaintiff will move the Honorable Patrick Pardy pursuant to SDCL § 15-6-56 to grant summary judgment in favor of the Plaintiff as follows:

1. Interpreting the insurance policy the Defendant issued to Ivan and Lenore Zochert so as to rule that:

    a. the policy provides broad coverage for expenses resulting from an insured's treatment for cancer (not to exceed usual and customary charges for such expenses as defined in the policy); and

    b. certain categories of benefits are limited by various limits and rules specifically expressed on page 7 and 8 of the policy with regard to those respective categories of benefits; but

    c. the categories of benefits for which specific limits and rules are expressed on page 7 and 8 of the policy do not define the scope of policy's coverage; and

    d. expenses resulting from treatment for cancer are not beyond the scope of policy coverage simply because they are not included in the categories of benefits for which specific limits and rules are set out on page 7 and 8 of the policy.

2. Finding that the Defendant breached its contract of insurance with Ivan and Lenore Zochert by:

Filed: 10/6/2017 11:25:13 AM CST Moody County, South Dakota 50CIV14-000061

a. Breaching its contractual duty to make timely payment of insurance policy benefits;
b. Breaching its contractual duty pay policy benefits still due and owing; and
c. Breaching it contractual duty of good faith and fair dealing.

Dated October 6th, 2017

TURBAK LAW OFFICE, P.C.
Attorneys for Plaintiff

By: Seamus W. Culhane
26 S. Broadway, Suite 100
Watertown, SD 57201
(605) 886-8361
seamus@turbaklaw.com

STATE OF SOUTH DAKOTA	IN CIRCUIT COURT
COUNTY OF MOODY	THIRD JUDICIAL CIRCUIT

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert,
Plaintiff,

vs.

Protective Life Insurance Company,
Defendant.

50CIV14-000061

PLAINTIFF'S STATEMENT OF UNDISPUTED MATERIAL FACTS

Plaintiff states the following undisputed material facts:

1. At all times relevant to this action, Ivan and Lenore Zochert were insured under an insurance policy they purchased in 1990 from Protective Life Insurance Company ("Protective Life"), which Protective Life called a "Cancer Policy."

2. A copy of the Protective Life Cancer Policy is attached to the *Second Affidavit of Seamus W. Culhane* as Exhibit 55, supporting *Plaintiff's Motion for Partial Summary Judgment.*

3. Beginning in 1990 and continuing through 2012, Ivan and Lenore Zochert paid Protective Life premiums on the Cancer Policy, which Ivan Zochert believed was supposed to pay for "everything cancer" – specifically, the medical bills incurred as a result of either Ivan or Lenore Zochert getting cancer. See *Second Affidavit of Seamus W. Culhane,* Exhibit 32: Deposition of Ivan Zochert, page 54, line 22; and page 24, lines 19-20.

4. In 2012, Lenore Zochert had a lump in her left breast that was suspected to be cancer.

5. On July 5, 2012 at the Watertown Surgery Center, surgeon Alan Christensen, MD performed a biopsy on the lump in Lenore Zochert's left breast to confirm whether Lenore had

cancer. See *Second Affidavit of Seamus W. Culhane,* Exhibit 33: Sanford Clinic Record, 7/5/2012, Supporting *Plaintiff's Motion for Partial Summary Judgment.*

6. On July 9, 2012, the biopsy tissue sample that Dr. Christensen had removed during the surgery was confirmed by pathology to be cancer. See *Second Affidavit of Seamus W. Culhane.* Exhibit 34: Prairie Lakes Healthcare System, Inc. Department of Surgical Pathology Report, 7/11/2012, supporting *Plaintiff's Motion for Partial Summary Judgment.*

7. Dr. Christensen referred Lenore to a local cancer doctor and to Dr. Anu, an medical doctor, to obtain anesthesia clearance for further surgery.[1]

8. Dr. Anu ordered an EKG to help confirm whether Lenore could tolerate surgical treatment of her cancer, concluded that Lenore was a high risk for anesthesia, and referred her to Dr. Garcia, a cardiologist, for clearance.[2]

9. On August 14, 2012, Dr. Christensen performed a partial mastectomy of Lenore Zochert's left breast at Prairie Lakes Hospital in Watertown,[3] where Lenore was hospitalized until August 16, 2012.

10. By August 28, 2012, Dr. Christensen became concerned that Lenore's surgical incision was showing signs of infection; began treating Lenore with antibiotics,[4] saw her again

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[1] See *Second Affidavit of Seamus W. Culhane*, Exhibit 35: Sanford Clinic Record, Dr. Anuradaha Gonuguntla, M.D. "Dr. Anu" 7/19/2012.

[2] See *Second Affidavit of Seamus W. Culhane*, Exhibit 36: "Dr. Anu," excerpt page 6; and Exhibit 36: Dr. Garcia report, 7/24/2012.

[3] See *Second Affidavit of Seamus W. Culhane*, Exhibit 37: Prairie Lakes Healthcare System, Inc. Christensen Report of Operation. 8/14/2012.

[4] See *Second Affidavit of Seamus W. Culhane*, Exhibit 38: an excerpt of the Christensen Record, 8/28/12.

on August 31, 2012[5], and re-admitted her to Prairie Lakes Hospital to treat complications of her mastectomy, including possible infection and internal bleeding.[6]

11. Upon readmission to Prairie Lakes Hospital, Lenore spent seven days in the hospital, including three nights in intensive care, during which time the Zocherts incurred a variety of charges resulting from treatment of the complications of Lenore's partial mastectomy.

12. On August 17, 2012, Ivan called Protective Life and requested claim forms.[7]

13. In response to Ivan's request, Protective Life provided Ivan with three forms to be completed: a general proof of loss form, a Medical "Authorization to Obtain and Disclose Information for Evaluation of Claim;" and a Physician's Statement.

14. Ivan completed and signed the general proof of loss form.[8]

15. Ivan completed and signed the Medical Authorization form allowing Protective Life to obtain and use health and medical information needed to evaluate the claim for benefits.[9]

16. Dr. Christensen completed and signed the Physician's Statement, attesting that Lenore was diagnosed with cancer on July 11, 2012, that Lenore had been hospitalized at Prairie Lakes Hospital, and that Dr. Christensen had performed surgical procedures.[10]

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[5] See *Second Affidavit of Seamus W. Culhane*, Exhibit 39: an excerpt of the Christensen Record, 8/31/12.

[6] See *Second Affidavit of Seamus W. Culhane*, Exhibit 39: an excerpt of the Christensen Record, 8/31/12; and Exhibit 74: an excerpt from Prairie Lakes Healthcare System Admission, 8/31/2012.

[7] See *Second Affidavit of Seamus W. Culhane*, Exhibit 40: Protective Life Bates No. 0181.

[8] See *Second Affidavit of Seamus W. Culhane*, Exhibit 43: Protective Life Bates No. 0183.

[9] See *Second Affidavit of Seamus W. Culhane*, Exhibit 41: Protective Life Bates No. 0180.

[10] See *Second Affidavit of Seamus W. Culhane*, Exhibit 42: Protective Life Bates No. 0182.

17. On September 14, 2012, Ivan returned by U.S. Mail all three completed and signed forms to Protective Life, along with a hospital bill confirming that Lenore had had surgical procedures including a partial mastectomy and closure.[11]

18. On September 17, 2012, Protective Life received the items Ivan had mailed three days earlier.

19. By September 21, 2012, Protective Life had denied Ivan's claim because he had not submitted "pathological diagnosis" of cancer.[12]

20. Ivan went to Sanford Clinic and requested a pathology report, which Sanford mailed to Protective Life on October 24, 2012.[13]

21. By November 1, 2012, Protective Life had what it needed in its possession to pay benefits for surgery charges for the partial mastectomy, in the amount of $2,491.00.

22. By November 1, 2012, Protective Life had what it needed in its possession to pay benefits for anesthesia during the partial mastectomy, in the amount of $120.00.

23. By November 1, 2012, Protective Life had what it needed in its possession to pay benefits for hospital room and board charges, in the amount of $320.00.

24. By November 1, 2012, Protective Life had what it needed in its possession to pay benefits for in-hospital doctor visits, in the amount of $50.00.

25. By November 1, 2012, Protective Life had what it needed in its possession to pay benefits for in-hospital nurse visits, in the amount of $200.00.

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[11] See *Second Affidavit of Seamus W. Culhane*, Exhibit 44: Protective Life Bates No. 0184.

[12] See *Second Affidavit of Seamus W. Culhane*, Exhibit 45: Protective Life Bates No. 0201.

[13] See *Second Affidavit of Seamus W. Culhane*, Exhibits 46 and 47: Protective Life Bates No. 0202; 204; See *Second Affidavit of Seamus W. Culhane*, Exhibit 32: Deposition of Ivan Zochert, p. 35 lines 3-17.

26. By November 1, 2012, Protective Life had what it needed in its possession to pay benefits for home recovery following discharge from the hospital, in the amount of $28.56.

27. On November 13, 2012, Protective Life sent Ivan a check for $420 in benefits to cover a portion of the surgical charges for Lenore's partial mastectomy, but denied any other benefits, including benefits for remaining charges for Lenore's partial mastectomy, which Protective Life claimed exceeded the surgery benefits in the policy.[14]

28. Protective Life did not tell Zocherts that their Cancer Policy covered charges resulting from the surgical biopsy.[15]

29. Protective Life did not tell Zocherts that their Cancer Policy covered charges resulting from anesthesia during the biopsy or anesthesia during the partial mastectomy.[16]

30. Protective Life did not tell Zocherts that their Cancer Policy covered charges for hospital room and board.[17]

31. Protective Life did not tell Zocherts that their Cancer Policy covered charges resulting from hospital doctor and nurse visits.[18]

32. Protective Life did not tell Zocherts that their Cancer Policy provided benefits for time Lenore spent at home in recovery, following discharge from the hospital.[19]

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[14] See *Second Affidavit of Seamus W. Culhane*, Exhibit 49: Protective Life Bates No. 0031.

[15] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.

[16] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.

[17] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.

[18] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.

[19] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.

33. Protective Life did not tell Zocherts there was coverage under the Intensive Care rider they had purchased for charges resulting specifically from Lenore's stay in intensive care.

34. Protective Life did not use information from the hospital bill Ivan had sent or from the pathology report Sanford Clinic had sent to investigate the Zocherts' claim or process additional benefits resulting from the treatment of Lenore's cancer.[20]

35. Protective Life did not use information obtained from Dr. Christensen to investigate the Zocherts' claim or process any additional benefits resulting from the treatment of Lenore's cancer.[21]

36. Protective Life did not use the Medical Authorization in its possession to procure any medical bills or other medical records concerning the treatment of Lenore's cancer.[22]

37. On December 13, 2012, Protective Life claim handler Lia Velez had a telephone conversation with Ivan prompted by Ivan's questions about why only $420 of benefits had been paid, during which Ms. Velez recognized that Ivan Zochert was elderly, was having difficulty hearing her, and did not understand how his claim was being paid.[23]

38. Following Ms. Velez' telephone conversation with Ivan, Protective Life sent a letter confirming that Protective Life had calculated the benefits due to total $420 as a surgical benefit for the partial mastectomy, but the letter did not indicate why other benefits – such as the anesthesia required during the partial mastectomy – were *not* being paid. [24]

[20] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.
[21] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.
[22] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of LIA VALEZ, p. 48, line 8 – p. 51, line 14.
[23] See *Second Affidavit of Seamus W. Culhane*, Exhibit 50: Protective Life Bates No. 0215.
[24] See *Second Affidavit of Seamus W. Culhane*, Exhibit 51: Protective Life Bates No. 0216.

39. When an attorney Ivan eventually hired questioned Protective Life about why additional benefits had not been paid under the Cancer Policy, Protective Life claimed the reason additional benefits had not been paid was because Protective Life did not have the bills from the hospital or physicians who treated Lenore's cancer.[25]

40. On May 13, 2013, after the attorney Ivan hired had intervened on Ivan's behalf to fight for additional benefits owed, Protective Life eventually issued a second payment, in the amount of $474.56, representing $126.00 of anesthesia benefits for the mastectomy, $300.00 for hospital room and board benefits related to Lenore's first hospitalization, and $28.56 for "home recovery" benefits.[26]

41. Had Protective Life used the Medical Authorization in its possession to procure medical bills and other records concerning the treatment of Lenore's cancer, Protective Life would have had in its possession what it needed to pay benefits for hospital room and board charges related to Lenore's readmission to Prairie Lakes Hospital to treat the complications of her partial mastectomy, in the amount of $1,120.00.

42. Had Protective Life used the Medical Authorization in its possession to procure medical bills and other records concerning the treatment of Lenore's cancer, Protective Life also would have had in its possession what it needed to pay benefits for in hospital doctor visits during Lenore's readmission to Prairie Lakes Hospital, in the amount of $175.00.

43. Had Protective Life used the Medical Authorization in its possession to procure medical bills and other records concerning the treatment of Lenore's cancer, Protective Life also

[25] See *Second Affidavit of Seamus W. Culhane*, Exhibit 53: Protective Life Bates No. 0221.

[26] See *Second Affidavit of Seamus W. Culhane*, Exhibit 54: Protective Life Bates No. 0032.

would have had in its possession what it needed to pay benefits for in hospital nurse visits during Lenore's readmission to Prairie Lakes Hospital, in the amount of $700.00.

44. Had Protective Life used the Medical Authorization in its possession to procure medical bills and other records concerning the treatment of Lenore's cancer, Protective Life also would have had in its possession what it needed to pay benefits for home recovery after Lenore's discharge from her second admission to Prairie Lakes Hospital, in the amount of $99.96.

45. Had Protective Life used the Medical Authorization in its possession to procure medical bills and other records concerning the treatment of Lenore's cancer, Protective Life also would have had in its possession what it needed to pay benefits for intensive care charges incurred during Lenore's readmission to Prairie Lakes Hospital, in the amount of $600.00.

46. For the next 15 months, from May of 2013 until August of 2014, Protective Life paid no additional benefits beyond the payments described above for $420 and $474.56.[27]

47. On August 25, 2014, Ivan filed this lawsuit.[28]

48. About one week after being sued, and approximately two years after Ivan had first notified Protective Life of Lenore's cancer and filed a claim, Protective Life paid additional benefits in September of 2014 totaling $1,850: hospital room and board charges of $1,120 related to Lenore's second hospitalization in August of 2012; $600 for intensive care benefits related to

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[27] See *Second Affidavit of Seamus W. Culhane*, Exhibits 49 and 54: Protective Life Bates No. 0031, 0032.

[28] Ivan's bad faith claim, which is a matter for trial and not before the court at this time, alleges that Protective Life had no reasonable basis for denying Ivan's claim to begin with; acted unreasonably and unfairly as it processed Ivan's claim for benefits; acted recklessly in disregarding the initial information Ivan provided that would have led the company to discover all of the Zocherts' cancer related losses and make full payments under the policy, had simply investigated and adjusted the way insurers must investigate and adjust claims.

that second hospitalization; $100 for "home recovery" benefits following that second hospitalization; and $30 for the surgical biopsy in July 2012. [29]

49. To date, Protective Life still has not paid benefits for several expenses related to Lenore's treatment of cancer, including benefits resulting from the surgery charges for the biopsy, benefits for the anesthesia required during the biopsy, and benefits for doctor visits and nurse visits during either of Lenore's hospitalizations.

Dated October 6, 2017

TURBAK LAW OFFICE, P.C.
Attorneys for Plaintiff

By: Nancy J. Turbak Berry
Seamus W. Culhane
26 S. Broadway, Suite 100
Watertown, SD 57201
(605) 886-8361
nancy@turbaklaw.com
seamus@turbaklaw.com

[29] See *Second Affidavit of Seamus W. Culhane*, Exhibits 68, 69 and 70: Protective Life Bates No. 0033, 0034, 0035.

STATE OF SOUTH DAKOTA) : SS		IN CIRCUIT COURT
COUNTY OF MOODY)		THIRD JUDICIAL CIRCUIT

IVAN ZOCHERT individually and as Administrator for the Estate of Lenore Zochert, Plaintiff, vs. PROTECTIVE LIFE INSURANCE COMPANY, Defendant.	*	50CIV14-000061 **DEFENDANT'S OBJECTIONS AND RESPONSES TO PLAINTIFF'S STATEMENT OF MATERIAL FACTS**

Pursuant to SDCL ¶ 15-6-56(c), Defendant, Protective Life Insurance Company ("Protective Life"), by and through their counsel of record, respectfully submit the following Responses to Plaintiff Ivan Zochert's ("Mr. Zochert"), Statement of Undisputed Material Facts.

1. Admit that Ivan and Lenore Zochert were insured under an insurance policy they purchased in 1990 from Protective Life Insurance Company which is titled "**CANCER POLICY**" on page 1 of the Policy. Evans Aff. ¶ 4, Exhibit B (the Policy at 1). It is further stated on page 1 that the Policy "Provides Benefits For Hospital Services And Other Expenses Caused By Cancer To The Extent Herein Provided." *Id.*

2. Admitted.

3. Denied. Beginning in 1990 and continuing through 2012, Mr. Zochert and his wife, Lenore Zochert ("Ms. Zochert") (collectively referred to as "the Zocherts") paid Protective Life premiums on a Cancer Insurance Policy (hereinafter "the Policy") issued to the Zocherts by Protective Life in 1990. Ivan Zochert's subjective belief as to what the Policy covered is

immaterial to any issue in this case. Regardless of whether Mr. Zochert believed the Policy was supposed to pay for "everything cancer," the Policy only paid for "loss resulting from definitive Cancer treatment, including only direct extension, metastatic spread or recurrence," and did not pay for "any other disease, sickness or incapacity." Evans Aff. ¶ 4, Exhibit B (the Policy at 10). The Policy only provided for "Benefits For Hospital Services And Other Expenses Caused By Cancer To The Extent Herein Provided." *Id.* at 1.

4. Admitted.

5. Admitted.

6. Denied. The biopsy tissue sample collected by surgeon Alan Christensen, M.D. (Dr. Christensen) was confirmed by pathology to be cancer on July 11, 2012, as indicated by the pathology report cited by the Plaintiff. *See* Second Affidavit of Seamus W. Culhane, Exhibit 34, Prairie Lakes Healthcare System, Inc. Department of Surgical Pathology Report, 7/11/2012. The results of this pathology report were submitted to Protective Life on August 4, 2014. *Id.* at ProtectiveLife 0455-0458.

7. Admitted that Dr. Christensen referred Lenore to Dr. Anuradha Gonuguntla but deny that Dr. Gonuguntla is a "cancer doctor." She is a family practitioner. Second Affidavit of Seamus W. Culhane, Exhibit 35 (Dr. Gonuguntla worked at Sanford Family Medicine as a Physician); *see* AMERICAN BOARD OF FAMILY MEDICINE, https://www.theabfm.org/diplomate/find.aspx?ts=636440982.

8. Admitted.

9. Admitted.

10. Denied. Dr. Christensen became concerned that Ms. Zochert may have had an infection within the area of the incision site and he began treating her with antibiotics. Dr.

Christensen also saw Ms. Zochert again on August 31, 2012, admitted her to Prairie Lakes Hospital to treat an infection and a possible abscess within the area of the incision site. The statement that Ms. Zochert's hospitalization was to treat complications of her mastectomy is not supported by the evidentiary citation in Plaintiff's Statement of Undisputed Facts, and is therefore denied pursuant to SDLC 15-6-56(c)(1).

11. Admitted.

12. Admitted.

13. Denied. Protective Life mailed Mr. Zochert a Patient Information form, Physician Statement form, and a Medical Information Release form. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179.

14. Denied. Mr. Zochert signed a Patient Information form. Mr. Zochert did not "complete" the form because he did not follow instructions listed on the form—Mr. Zochert did not include a pathology report diagnosing cancer and did not submit Ms. Zochert's itemized bills related to his cancer claim. Evans Aff. ¶ 4, Exhibit B (the Policy at 10); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0181-0185. The Patient Information form explicitly states "A PATHOLOGY REPORT diagnosing cancer MUST accompany your first claim." *See* Second Affidavit of Seamus W. Culhane, Exhibit 43, ProtectiveLife 0183. Further, it states, "Submit all bills related to this cancer claim. All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.*

15. Denied. Mr. Zochert completed and signed a Medical Information Release form. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0181-0185.

16. Admitted.

17. Denied. On September 14, 2012, Mr. Zochert returned by U.S. Mail a signed Patient Information form, a signed Medical Information Release, a signed Physician Statement, and a Professional Hospital Account Summary ("PHAS") containing the billing summary for two items: (1) partial left mastectomy; and (2) layered closure. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0181-0185. Deny that Mr. Zochert followed the instructions of the forms because he did not submit a pathology report and all itemized bills relating to his cancer claim. *Id.* Mr. Zochert did not complete the pathology report requirement until October 24, 2012. *Id.* at ProtectiveLife 0202-0204. Further, Plaintiff did not submit all itemized bills until August 4, 2014. *Id.* at ProtectiveLife 0455-0468.

18. Admitted that on September 17, 2012 Protective Life received Mr. Zochert's claim with the limited information he provided. Evans Aff, ¶ 6, Exhibit D at ProtectiveLife 0199, 0201.

19. Denied. Protective Life did not deny Mr. Zochert's claim. On September 21, 2012, Protective Life provided Mr. Zochert with an "Explanation of Benefits," informing him that he needed to supply Protective Life with a pathology report so Protective Life could verify Ms. Zochert's cancer diagnosis. *Id.* at ProtectiveLife 0201.

20. Admitted.

21. Denied. This statement has no evidentiary citation to support it, and is therefore denied pursuant to SDLC 15-6-56(c)(1). Additionally, as of November 1, 2012, Protective Life had received a bill containing charges only for Ms. Zochert's partial mastectomy and closure. *Id.* at ProtectiveLife 0184. It had also received a pathology report diagnosing cancer on August 14, 2012. *Id.* at ProtectiveLife 0202-0203. Therefore, Protective Life had sufficient information to pay benefits for surgery charges for the partial mastectomy in the amount of $300. The Surgical

Benefit for the partial mastectomy was $300 based on the procedure code the physician used, CPT 19301. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 37-38); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0031, 0221. The Schedule of Benefits provides: "When a surgical operation for the treatment of Cancer is performed on an insured, we will pay for charges incurred for such operation and anesthesia in accordance with the 1969 California Relative Value Schedule with a unit value of $50 for surgery and $42 for anesthesia." Evans Aff. ¶ 4, Exhibit B (the Policy at 8). The unit value for CPT 19301 reads "BR," which instructs the claims processor to look at the procedure performed to determine the nearest similar procedure number. *See* Evans Aff. ¶ 6, Exhibit D, at Protective Life 0062, 72. In this case, the claims adjuster properly applied CPT 19160, "partial mastectomy (quadrectomy or more), unilateral," which has a unit value of 6.0, as the nearest similar procedure number. *Id.* at Protective Life 0071. Denied that the amount of benefits for Ms. Zochert's surgery charges for the partial mastectomy was $2,491. *Id.* at ProtectiveLife 0184. The amount listed on the Professional Hospital Account Summary, the only bills provided by Plaintiff, for Ms. Zochert's partial mastectomy was $2,371. *Id.* Thus, Protective Life did not have what the Policy required and what it needed in its possession as of November 1, 2012, to pay benefits for surgery charges for Ms. Zochert's partial mastectomy in the amount of $2,491.

22. Denied. This statement has no evidentiary citation to support it and is therefore denied pursuant to SDLC 15-6-56(c)(1). On November 1, 2012, Protective Life had not received a bill listing any charges for anesthesia during Ms. Zochert's partial mastectomy. The PHAS, submitted by Plaintiff, did not contain any charges for anesthesia. *See Id.* Billing records for anesthesia during the partial mastectomy were not submitted by Mr. Zochert until May 6, 2013. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 40-

41); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0235-0294. Mr. Zochert was promptly reimbursed on May 13, 2013, in the sum of $126.00 for anesthesia that was administered to Ms. Zochert on August 14, 2012. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 42-44); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0032, 0366-0370. Therefore, Protective Life did not have what was required by the Policy and what it needed in its possession by November 1, 2012, to pay benefits for anesthesia during the partial mastectomy in the amount of $120.00.

23. Denied. This statement has no evidentiary citation to support it and is therefore denied pursuant to SDLC 15-6-56(c)(1). By November 1, 2012, Protective Life had not received any bills containing charges for in-hospital room and board. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184. Further, in-hospital room and board benefits are only payable for each day of hospital confinement. Evans Aff. ¶ 4, Exhibit B (the Policy at 7). According to the information provided by Plaintiff to Protective Life, as of November 1, 2012, Ms. Zochert was never confined overnight in a hospital. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184. Rather, the bill submitted indicated that Ms. Zochert was discharged on the same date as her surgery. *Id.* Additionally, billing records for Ms. Zochert's two-night hospital stay, beginning August 14, 2012, were not submitted by Mr. Zochert until May 6, 2013. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 40-41); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0235-0294. On May 13, 2012, Mr. Zochert was promptly reimbursed $320 for Ms. Zochert's two-night hospital stay, commencing August 14, 2012. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 42-44); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0032, 0366-0370). Therefore, Protective Life did not have what was required by the Policy and what it needed in its possession by November

1, 2012, to pay benefits for Ms. Zochert's two-night hospital stay, beginning on August 14, 2012, in the amount of $320.

24. Denied. This statement has no evidentiary citation to support it and is therefore denied pursuant to SDLC 15-6-56(c)(1). By November 1, 2012, Protective Life had not received any bills containing charges for in-hospital doctor visits. *Id.* Further, in-hospital attending physician benefits are only payable for each day of hospital confinement.[1] Evans Aff. ¶ 4, Exhibit B (the Policy at 7). According to the information provided by Plaintiff to Protective Life, as of November 1, 2012, Ms. Zochert was never confined in a hospital. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184. Rather, the bill submitted indicated Ms. Zochert was discharged on the same date as her surgery. *Id.* Therefore, Protective Life did not have what was required by the Policy and what it needed in its possession by November 1, 2012, to pay benefits for in-hospital doctor visits in the amount of $50.

25. Denied. This statement has no evidentiary citation to support it and is therefore denied pursuant to SDLC 15-6-56(c)(1). By November 1, 2012, Protective Life had not received any bills containing charges for in-hospital nurse visits. *Id.* Further, in-hospital special nursing benefits are only payable for each day of hospital confinement.[2] Evans Aff. ¶ 4, Exhibit B (the Policy at 7). According to the information provided by Plaintiff to Protective Life, as of November 1, 2012, Ms. Zochert was never confined in a hospital. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184. Rather, the bill submitted indicates Ms. Zochert was discharged on the same date as her surgery. *Id.* Therefore, Protective Life did not have what was required by the

[1] To be clear, in-hospital doctor visits, during the time of confinement to the hospital, are covered under the Policy. Evans Aff. ¶ 4, Exhibit B (the Policy at 7). The Policy, however, does not cover office visits, when not confined to the hospital. *See id.* (nowhere in the Policy does it say that office visits are covered).

[2] To be clear, in-hospital nursing benefits, during the time of confinement to the hospital, are covered under the Policy. Evans Aff. ¶ 4, Exhibit B (the Policy at 7). The Policy, however, does not cover nursing expenses during regular office visits, when not confined to the hospital. *See id.* (nowhere in the Policy does it say that office visits are covered).

Policy and what it needed in its possession by November 1, 2012, to pay benefits for in-hospital nurse visits in the amount of $200.

26. Denied. This statement has no evidentiary citation to support it and is therefore denied pursuant to SDLC 15-6-56(c)(1). By November 1, 2012, Protective Life had not received any bills qualifying Ms. Zochert for home recovery benefits. *Id.* Home recovery benefits are only payable for each day of hospital confinement. Evans Aff. ¶ 4, Exhibit B (the Policy at 7). According to the information provided by Mr. Zochert to Protective Life, as of November 1, 2012, Ms. Zochert was never confined to a hospital. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184. Rather, the bill submitted indicated that Ms. Zochert was discharged on the same date as her surgery. *Id.* Additionally, billing records for Ms. Zochert's two days of home recovery commencing August 17, 2012, were not submitted by Mr. Zochert until May 6, 2013. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 40-41); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0235-0294. On May 13, 2013, Mr. Zochert was promptly reimbursed $28.56 for Ms. Zochert's two days of home recovery commencing August 17, 2012. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 42-44); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0032, 0366-0370. Therefore, Protective Life did not have what was required by the Policy and what it needed in its possession by November 1, 2012, to pay benefits for Ms. Zochert's two days of home recovery commencing August 17, 2012, in the amount of $28.56.

27. Denied. On November 13, 2012, Protective Life issued Mr. Zochert a check for the covered benefits under the Policy as supported by the PHAS (the only bills submitted by Mr. Zochert as of that date) in the amount of $420. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0031. The statement that Protective Life denied any other benefits is not supported by the

evidentiary citation and is denied pursuant to SDLC 15-6-56(c)(1).

28. Denied. The Policy provided an explanation to the Zocherts of what charges the Policy covered. *See* Evans Aff. ¶ 4, Exhibit B (the Policy); *see Castello v. Gamache,* 593 F.2d 358, 361 (8th Cir. 1979) (applying the general rule that the insured is charged with knowledge of the terms and conditions of his policy); *Lazzara v. Howard A. Esser, Inc.*, 802 F.2d 260, 275, 6 Fed. R. Serv. 3d 54 (7th Cir. 1986) (same); *Western World Ins. Co. v. Stack Oil, Inc.*, 922 F.2d 118, 122 (2d Cir. 1990) (same). Further, as of November 13, 2012, Plaintiff had not submitted any bills that included charges resulting from Ms. Zochert's biopsy. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183. When Plaintiff inquired as to additional coverage, Protective Life told Plaintiff that it had fully processed the bills he had submitted and to contact them if he had any questions. *Id.* at ProtectiveLife 0215-2016. Protective Life continuously informed Plaintiff that he could submit any additional bills and Protective Life would process them. *Id.* at ProtectiveLife 0215, 0221, 0304, 0383, 0448. There are no South Dakota statutes or case law that impose an affirmative duty on insurers to advise insureds about benefits. *See* SDCL ¶ 58-12-34 (South Dakota's statute setting forth "Acts Constituting Unfair Claims Practices" does not create affirmative duty to disclose benefits); *see Harts v. Farmers Ins. Exchange*, 597 N.W.2d 47, 52 (Mich. 1999) (reviewing Michigan's Unfair Trade Practices Act to find that insurer does not have an affirmative duty to disclose benefits).

29. Denied. The Policy provided an explanation to the Zocherts of what charges the Policy covered. *See* Evans Aff. ¶ 4, Exhibit B (the Policy). Further, as of November 13, 2012, Plaintiff had not submitted any bills, as required by the Policy, that included charges resulting from anesthesia during Ms. Zochert's biopsy or partial mastectomy. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184; *see* Defendant's Response to Undisputed Fact ¶ 28.

30. Denied. The Policy provided an explanation to the Zocherts of what charges the Policy covered. *See* Evans Aff. ¶ 4, Exhibit B (the Policy). Further, as of November 13, 2012, Plaintiff had not submitted any bills, as required by the Policy, indicating Ms. Zochert was confined to the hospital for any period of time, as required for coverage under the In-Hospital Room and Board Benefit. Evans Aff. ¶ 4, Exhibit B (the Policy at 7); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184; *see* Defendant's Response to Undisputed Fact ¶ 28.

31. Denied. The Policy provided an explanation to the Zocherts of what charges the Policy covered. *See* Evans Aff. ¶ 4, Exhibit B (the Policy). Further, as of November 13, 2012, Plaintiff had not submitted any bills indicating Ms. Zochert was confined to the hospital for any period of time, as required for coverage under the In-Hospital Special Nursing Benefit and Attending Physician Benefit. Evans Aff. ¶ 4, Exhibit B (the Policy at 7); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184; *see* Defendant's Response to Undisputed Fact ¶ 28.

32. Denied. The Policy provided an explanation to the Zocherts of what charges the Policy covered. *See* Evans Aff. ¶ 4, Exhibit B (the Policy). Further, as of November 13, 2012, Plaintiff had not submitted any bills, as required by the Policy, indicating Ms. Zochert was confined to the hospital for any period of time, as required for coverage under the Home Recovery Benefit. Evans Aff. ¶ 4, Exhibit B (the Policy at 7); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184; *see* Defendant's Response to Undisputed Fact ¶ 28.

33. Denied. The Policy provided an explanation to the Zocherts of what charges the Policy covered. *See* Evans Aff. ¶ 4, Exhibit B (the Policy). Further, as of November 13, 2012, Plaintiff had not submitted any bills, as required by the Policy, indicating Ms. Zochert was confined to the intensive care unit. Evans Aff. ¶ 6, Exhibit D, at Protective Life 0184, 0466. It was not until August 4, 2014, that Plaintiff submitted bills that indicated Ms. Zochert was

admitted to the ICU). *See* Defendant's Response to Undisputed Fact ¶ 28.

34. Denied. Mr. Zochert did not submit a "hospital bill." He submitted a Professional Hospital Account Summary (PHAS). Protective Life did not use the PHAS, containing the billing summary for Ms. Zochert's partial left mastectomy and layered closure to investigate ***potential*** claims for benefits for which Mr. Zochert did not submit an itemized bill pursuant to the Patient Information form. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184. The Patient Information form states Mr. Zochert is to "submit all bills related to this cancer claim" and that "[a]ll bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.* at ProtectiveLife 0174-0179. Protective Life used the pathology report to determine that Ms. Zochert was diagnosed with cancer on August 14, 2012. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0441-0442. Accordingly, Protective Life used the cancer diagnosis date to process the PHAS Mr. Zochert submitted. *Id.* Protective Life continuously informed Plaintiff that he could submit any additional bills and Protective Life would process them accordingly. *Id.* at ProtectiveLife 0215, 0221, 0304, 0383, 0448.

35. Denied. Protective Life did not use the Physician Statement completed by Dr. Christensen to investigate ***potential*** claims for benefits for which Mr. Zochert did not submit an itemized bill pursuant to the Patient Information form. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0182. The Patient Information form states Mr. Zochert is to "submit all bills related to this cancer claim" and that "[a]ll bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.* at ProtectiveLife 0174-0179. Protective Life relied on the date of diagnosis listed on the pathology report. The Policy informed Plaintiff

that the pathology report must be submitted to determine coverage under the Policy. Evans Aff. ¶ 4, Exhibit B (the Policy at 10); *see* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183 (the Patient Information form informed Plaintiff of the necessity of a pathology report). Protective Life used the pathology report to determine that Ms. Zochert was diagnosed with cancer on August 14, 2012. *Id.* at ProtectiveLife 0202-0203. Accordingly, Protective Life used the cancer diagnosis date to process the bills that Mr. Zochert submitted.

36. Denied. Plaintiff had a duty to submit pathology reports and all itemized bills relating to Ms. Zochert's cancer as a part of his proof of loss. Evans Aff. ¶ 4, Exhibit B (the Policy at 10); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183. Plaintiff's characterization wrongfully suggests, or infers, that Protective Life incorrectly required Plaintiff to submit a proof of loss. This assertion is contrary to the duties established by the Policy. Before any claim is investigated, and processed, including Protective Life obtaining and reviewing medical records and bills from the healthcare providers, Mr. Zochert was required to submit a claim for benefits which included the pathology report and all itemized bills that he was seeking benefits for under the terms of the Policy. Evans Aff. ¶ 4, Exhibit B (the Policy at 10). Further, Protective Life continuously informed Plaintiff that he could submit any additional bills and Protective Life would process them accordingly. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0215, 0221, 0304, 0383, 0448. Not disputed that Protective Life did not use the Medical Information Release form to investigate **potential** claims for benefits beyond the two procedures documented in the PHAS. *See* Second Affidavit of Seamus W. Culhane, Exhibit 75, Deposition of Lia Valez, at 45:8-51:14.

37. Admitted that Ms. Valez had a telephone conversation with Mr. Zochert regarding the benefits Protective Life paid. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 215. Dispute that the remaining assertion is material.

38. Denied. It is not disputed that, based on a telephone inquiry by Mr. Zochert regarding an explanation of benefits he had received, Protective Life sent a letter explaining the surgery charges were paid according to the Cancer Policy based on the procedure codes indicated on the surgery bill from Watertown Surgery for services on August 14, 2012. *See* Second Aff. Of Seamus W. Culhane, Exhibit 50, ProtectiveLife 0216. The purpose of the letter was to address Mr. Zochert's inquiry for an explanation of his benefits, not to inform Mr. Zochert of every **potential** claim for benefits he may have. Denied that the letter states that $420 was for Ms. Zochert's partial mastectomy. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 215. The letter informed Mr. Zochert that benefits were calculated according to the California Relative Value Schedule with a unit value of $50 for surgical procedures. *Id.* Further, Plaintiff's characterization of Protective Life's response is misleading and irrelevant. Plaintiff continuously informed Plaintiff that he could submit any and all additional itemized bills relating to Ms. Zochert's cancer and Protective Life would process them. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0215, 0221, 0304, 0383, 0448.

39. Denied. When Mr. Zochert's Attorney, Seamus Culhane, questioned Protective Life about why additional benefits had not been paid under the Cancer Policy, Protective Life informed Attorney Culhane that Mr. Zochert had not submitted bills for In-Hospital Room and Board Benefit and Attending Physician Benefit for Protective Life to process per Mr. Zochert's obligations under the Policy. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0221. Protective Life's response simply stated the requirements under the Policy. *Id.* at ProtectiveLife 0221.

40. Denied. On May 13, 2013, Protective Life issued a second payment in the amount of $474.56. *Id.* at ProtectiveLife 0032. But the Explanation of Benefits states that $320, not $300, was paid for hospital room and board benefits. *Id.* The second payment also included

$126 for anesthesia benefits and $28.46 in home recovery benefits in accordance with the terms of the Policy. *Id.* The fact that Mr. Zochert hired an attorney had no impact on Protective Life's distribution. Protective Life distributed this second payment after Attorney Culhane sent Protective Life a letter on May 6, 2013, transmitting copies of additional bills for services performed in accordance with the terms of the Policy and not in response to the appearance of an attorney. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 40-44); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0032, 0235-0294, 0366-0370. If Plaintiff had submitted the same materials, Protective Life would have distributed the exact same payment. Plaintiff's attorney prolonged the claims process by not submitting the itemized bills that Protective Life requested. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife at 0309-0314, 0317-0321, 0324-0326, 0333-0335, 0340-0343, 0346-0357.

41. Denied. Plaintiff's characterization misconstrues the duties and obligations under the Policy. It was Plaintiff's duty, under express terms of the Policy, to file a "proof of loss." Evans Aff. ¶ 4, Exhibit B (the Policy at 10); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179. The proof of loss contained the following requirement: "All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.* Protective Life had no duty to investigate and process a claim until Mr. Zochert submitted a claim, including a pathology report diagnosing cancer and itemized bills. *Id.* Mr. Zochert's attorney sent Protective Life a letter on August 4, 2014, transmitting records and bills from Ms. Zochert's readmission to Prairie Lakes Healthcare System. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 56-57, 61); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0455-0468. The August 4, 2014 Submission was the

first time these claims (bills) were provided by Mr. Zochert or Attorney Culhane to Protective Life. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 58). In response to the August 4, 2014 Submission, on August 29, 2014, Protective Life issued a check to Mr. Zochert for $1,720.00, which included $1,120.00 for the seven days Ms. Zochert was confined to Prairie Lakes Healthcare System from August 31, 2012 through September 7, 2012. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0033-34.

42. Denied. Plaintiff's characterization misconstrues the duties and obligations under the Policy. It was Plaintiff's duty, under express terms of the Policy, to file a "proof of loss." Evans Aff. ¶ 4, Exhibit B (the Policy at 10); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183. The proof of loss contained the following requirement: "All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.* Protective Life would not have investigated or processed any claims for benefits related to hospital doctor visits during Ms. Zochert's cancer treatment at Prairie Lakes Hospital until Mr. Zochert submitted claims (bills) related thereto. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179. Further, Plaintiff has never submitted any itemized bills that include charges for in-hospital doctor visits[3] during Ms. Zochert's readmission to the hospital. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0237 (Plaintiff submitted Medicare claims forms, but did not submit any bills from the hospital).

43. Denied. Plaintiff's characterization misconstrues the duties and obligations under the Policy. It was Plaintiff's duty, under express terms of the Policy, to file a "proof of loss." Evans Aff. ¶ 4, Exhibit B (the Policy at 10); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183. The proof of loss contained the following requirement: "All bills should be itemized and should

[3] *See supra* note 1.

include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.* Protective Life would not have investigated or processed any claims for benefits related to hospital nurse visits during Ms. Zochert's cancer treatment at Prairie Lakes Hospital until Mr. Zochert submitted claims (bills) relating thereto. See Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179. Protective Life had no duty to investigate until Mr. Zochert submitted a claim, including a pathology report diagnosing cancer and itemized bills. *Id.* Plaintiff has never submitted any itemized bills that included charges for in-hospital nurse visits[4] during Ms. Zochert's readmission to the hospital. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0238 (Plaintiff submitted Medicare claims forms, but did not submit any bills from the hospital).

44. Denied. Plaintiff's characterization misconstrues the benefits and obligations under the Policy. It was Plaintiff's duty, under express terms of the Policy, to file a "proof of loss." Evans Aff. ¶ 4, Exhibit B (the Policy at 10); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183. The proof of loss contained the following requirements: "All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.* Protective Life would not have investigated or processed any claims for benefits related to home recovery after Ms. Zochert's readmission to Prairie Lakes Hospital until Mr. Zochert submitted claims (bills) supporting such a claim. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179. Protective Life had no duty to investigate until Mr. Zochert submitted a claim, including a pathology report diagnosing cancer and itemized bills. *Id.* Mr. Zochert's attorney sent Protective Life a letter on August 4, 2014, transmitting records and bills from Ms. Zochert's readmission to Prairie Lakes

[4] *See supra* note 2.

Healthcare System. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 56-57, 61); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0455-0468. The August 4, 2014 Submission was the first time these bills were provided by Mr. Zochert or Attorney Culhane to Protective Life. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 58). In response to the August 4, 2014 Submission, Protective Life promptly distributed payment according to the Policy in the amount of $100.00 to cover Ms. Zochert's home recovery benefits for September 8 through September 14, 2012. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0446, 0035 (Protective Life distributed payment on September 2, 2014, less than 30 days after receiving the August 4, 2014 Submission).

45. Denied. Plaintiff's characterization misconstrues the duties and obligations under the Policy. It was Plaintiff's duty, under express terms of the Policy, to file a "proof of loss." Evans Aff. ¶ 4, Exhibit B (the Policy at 10); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0183. The proof of loss contained the following requirement: "All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.* Protective Life would not have investigated or processed any claims for benefits related to intensive care charges during Ms. Zochert's readmission to Prairie Lakes Hospital until Mr. Zochert submitted claims (bills) relating thereto. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179. Mr. Zochert's attorney sent Protective Life a letter on August 4, 2014, transmitting records and bills from Ms. Zochert's readmission to Prairie Lakes Healthcare System. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 56-57, 61); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0455-0468. The August 4, 2014 Submission was the first time these bills were provided by Mr. Zochert or Attorney Culhane to Protective Life. Evans Aff. ¶ 3, Exhibit A

(Plaintiff's Answers to Defendant's Request for Admissions at ¶ 58). In response to the August 4, 2014 Submission, on August 29, 2014, Protective Life issued a check to Mr. Zochert for $1,720.00, which included $600.00 for three days Ms. Zochert was confined in the ICU from August 31 through September 2, 2012. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0446, 0034 (Plaintiff submitted bills for Ms. Zochert's hospital confinement on August 4, 2014. Protective Life distributed payment less than 30 days later).

46. Admitted. During that time, Plaintiff's attorney did not submit itemized bills relating to Ms. Zochert's cancer, as required by the Policy and Protective Life's instructions. *See id.* at ProtectiveLife 0309-0314, 0317-0321, 0324-0326, 0333-0335, 0340-0343, 0346-0357.

47. Admitted.

48. Denied. Plaintiff implies that filing suit resulted in payment of benefits. In fact, filing suit had no impact on Protective Life processing his claim. Protective Life received a submission of medical bills and medical records on August 11, 2014. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0455. On August 29, 2014, Protective Life issued two checks to Mr. Zochert, one in the amount of $30.00 for a biopsy performed on July 10, 2012, and the other for $1,720.00—$1,120.00 for the seven days Ms. Zochert was confined to Prairie Lakes Hospital from August 31, 2012 through September 7, 2012, and $600.00 for three days Ms. Zochert was confined in the ICU from August 31 through September 2, 2012. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0033-34. Further, on September 2, 2014, Protective Life issued Mr. Zochert a check for $100.00 to cover Ms. Zochert's home benefits for September 8 through September 14, 2012. *Id.* at ProtectiveLife 0035. These checks were in response to a letter Attorney Culhane sent Protective Life on August 4, 2012, transmitting a pathology report for Ms. Zochert dated July 5, 2012, as well as copies of certain medical records and bills from Watertown Family

Medicine, Prairie Lakes Healthcare System, and Sanford Health Services, all as required by the Policy and the instructions in the Patient Information form. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 56-57, 61); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0455-0468. The August 4, 2014 Submission was the first time these bills were provided by Mr. Zochert or Attorney Culhane to Protective Life, and their submission allowed Protective Life to process Mr. Zochert's claims. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 58). It is also denied that Protective Life distributed $1,850 in benefits in September 2014. Protective Life distributed $1,750 in benefits on August 29, 2014. *Id.* at ProtectiveLife 0033-0034. Protective Life distributed $100 in benefits on September 2, 2014. *Id.* at ProtectiveLife 0035. The amounts distributed are not disputed. *Id.* at ProtectiveLife 0033-0035.

49. Denied. To date, Protective Life has processed all claims (bills) Plaintiff has submitted and distributed payment in accordance with the terms of the Policy. *See* Protective Life 0183, 0031, 0235-0294, 0032, 0455-0467, 0033-0035. The expenses Plaintiff refers to are not covered under the Policy or have not been submitted to Protective Life. *Id.*; *see* Evans Aff. ¶ 4, Exhibit B (the Policy at 7-8).

Dated at Sioux Falls, South Dakota this 20th day of October, 2017.

EVANS HAIGH & HINTON LLP

/s/ Edwin E. Evans

Edwin E. Evans
Ryan W.W. Redd
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599
Facsimile: (605) 275-9602
Email: eevans@ehhlawyers.com
Email: rredd@ehhlawyers.com

and

Katharine A. Weber
MAYNARD, COOPER & GALE, P.C.
1901 Sixth Avenue North
2400 Regions Harbert Plaza
Birmingham, AL 35203
Telephone: 205-254-1000
Email: kweber@maynardcooper.com

Attorneys for Defendant

CERTIFICATE OF SERVICE

The undersigned, one of the attorneys for Defendant, hereby certifies that a true and correct copy of the foregoing "Defendant's Objections and Reponses to Plaintiff's Statement of Material Facts" was filed electronically with the Clerk of Court using the Odyssey File and Serve system which will send notification of such filing to the following:

Nancy J. Turbak Berry
Seamus W. Culhane
Turbak Law Office, P.C.
26 South Broadway, Suite 100
Watertown, SD 57201
nancy@turbaklaw.com
seamus@turbaklaw.com

Attorneys for Plaintiff

on this 20th day of October, 2017.

/s/ Edwin E. Evans
Edwin E. Evans

Filed: 10/20/2017 2:21:10 PM CST Moody County, South Dakota 50CIV14-000061

STATE OF SOUTH DAKOTA) : SS		IN CIRCUIT COURT
COUNTY OF MOODY)		THIRD JUDICIAL CIRCUIT
IVAN ZOCHERT individually and as Administrator for the Estate of Lenore Zochert, Plaintiff, vs. PROTECTIVE LIFE INSURANCE COMPANY, Defendant.	*	50CIV14-000061 **DEFENDANT'S MOTION FOR SUMMARY JUDGMENT**

Defendant, Protective Life Insurance Company, by and through its attorneys of record, respectfully moves this Court for entry of Summary Judgment in its favor pursuant to SDCL § 15-6-56 for the reason that, based upon all the files and records herein, and Defendant's Statement of Undisputed Facts and Brief submitted in support of this Motion, there is no genuine issue as to any material fact and Defendant is entitled to judgment as a matter of law.

Dated at Sioux Falls, South Dakota, this 6th day of October, 20177.

EVANS HAIGH & HINTON LLP

/s/ Edwin E. Evans
Edwin E. Evans
101 N. Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599
Facsimile: (605) 275-9602
Email: eevans@ehhlawyers.com

Filed: 10/6/2017 4:28:52 PM CST Moody County, South Dakota 50CIV14-000061

and

Katharine A. Weber
MAYNARD, COOPER & GALE, P.C.
1901 Sixth Avenue North
2400 Regions Harbert Plaza
Birmingham, AL 35203
Telephone: 205-254-1000
Email: kweber@maynardcooper.com

Attorneys for Defendant

CERTIFICATE OF SERVICE

The undersigned, one of the attorneys for Defendant, hereby certifies that a true and correct copy of the foregoing "Defendant's Motion for Summary Judgment" was filed electronically with the Clerk of Court using the Odyssey File and Serve system which will send notification of such filing to the following:

Nancy J. Turbak Berry
Seamus W. Culhane
Turbak Law Office, P.C.
26 South Broadway, Suite 100
Watertown, SD 57201
nancy@turbaklaw.com
seamus@turbaklaw.com

Attorneys for Plaintiff

on this 6th day of October, 2017.

/s/ Edwin E. Evans
Edwin E. Evans

STATE OF SOUTH DAKOTA) : SS		IN CIRCUIT COURT
COUNTY OF MOODY)		THIRD JUDICIAL CIRCUIT
IVAN ZOCHERT individually and as Administrator for the Estate of Lenore Zochert, Plaintiff, vs. PROTECTIVE LIFE INSURANCE COMPANY, Defendant.	*	50CIV14-000061 **DEFENDANT'S STATEMENT OF UNDISPUTED MATERIAL FACTS**

Pursuant to SDCL 15-6-56(c), Defendant, Protective Life Insurance Company, by and through their counsel of record, respectfully submit the following Statement of Undisputed Material Facts in support of its Motion for Summary Judgment.

1. This action arises out of the claims process and handling of a Cancer Insurance Policy (hereinafter "the Policy"), numbered D00054903, issued by Defendant, Protective Life Insurance Company (hereinafter "Protective Life") to Ivan Zochert ("Mr. Zochert") and Lenore Zochert ("Ms. Zochert") (collectively referred to as "the Zocherts") on March 1, 1990. Compl. ¶ 4; Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 1); Evans Aff. ¶ 4, Exhibit B (the Policy).

2. The Policy included an endorsement entitled Hospital Intensive Care Benefit Rider. Evans Aff. ¶ 5, Exhibit C.

3. The Zocherts were the beneficiaries under the Policy and the endorsement. Evans Aff. ¶ 4, Exhibit B (the Policy).

4. The Policy is a limited policy. Evans Aff. ¶ 4, Exhibit B (the Policy at 1).

5. On the first page of the Policy, it states in bold lettering: "**THIS IS A LIMITED POLICY – PLEASE READ CAREFULLY.**" Evans Aff. ¶ 4, Exhibit B (the Policy at 1).

6. Because it was a limited policy, the Policy only covered losses under the benefits listed in the Schedule of Benefits. Evans Aff. ¶ 4, Exhibit B (the Policy at 7) ("We will, subject to the terms of this policy, pay the benefits provided by this policy.").

7. The Policy is a "Cancer" policy, which provided coverage for listed benefits that derived from "definitive Cancer treatment, including only direct extension, metastatic spread or recurrence." Evans Aff. ¶ 4, Exhibit B (the Policy at 10).

8. The Policy states, "This Policy pays only for loss resulting from definitive Cancer treatment, including only direct extension, metastatic spread or recurrence. Pathologic proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness or incapacity." Evans Aff. ¶ 4, Exhibit B (the Policy at 10).

9. The Policy contains procedures necessary to file a claim:

Claim Provisions

> **Notice of Claim.** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice must be given to us at our Home Office or to any authorized agent.
>
> **Claim Forms.** When we receive a notice of claim we will send you forms for filing proof of loss. If the forms are not mailed or given to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of your loss within the time limit stated in the Proof of Loss provision.
>
> **Proof of Loss.** Written proof of loss must be given to us within 90 days after the occurrence or commencement of any loss covered by the policy. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. Unless you were legally incapable, this proof must be given within 1 year from the time specified.

Evans Aff. ¶ 4, Exhibit B (the Policy at 10).

10. Under the Policy, the beneficiary is responsible for filing a claim and providing the information necessary for Protective Life to determine the appropriate coverage. Evans Aff. ¶ 4, Exhibit B (the Policy at 10).

11. The beneficiary is responsible for giving Protective Life notice of its claim within 60 days of a covered loss or as soon as reasonably possible. Evans Aff. ¶ 4, Exhibit B (the Policy at 10).

12. Once Protective Life received notice of a claim, the Policy states, "[Protective Life] will send [insured] forms for filing proof of loss." Evans Aff. ¶ 4, Exhibit B (the Policy at 10).

13. In addition, the Policy states, "Written proof of loss must be given to [Protective Life] within 90 days after the occurrence or commencement of any loss covered by the policy." Evans Aff. ¶ 4, Exhibit B (the Policy at 10).

14. The Policy provides, "**Time of Payment of Claims.** After we receive written proof of loss, and subject to the terms of this policy, we will pay all benefits due under this policy." Evans Aff. ¶ 4, Exhibit B (the Policy at 10)

15. Once coverage is determined, the Policy, states that payments of covered claims will be made directly to the beneficiary. Evans Aff. ¶ 4, Exhibit B (the Policy at 11).

16. Further, the Policy states, "[Protective Life] will be discharged to the extent of any such payments made in good faith." Evans Aff. ¶ 4, Exhibit B (the Policy at 11).

17. On July 5, 2012, Dr. Alan Christensen performed a needle core biopsy to collect samples from a lump identified within Ms. Zochert's left breast. Compl. ¶ 8.

18. Also on July 5, 2012, Dr. Christensen performed pathology testing of the lump, confirming that the samples gathered from Ms. Zochert's breast were carcinoma. Compl. ¶ 8.

19. On July 18, 2012, Dr. Christensen conducted laboratory tests and x-rays on Ms. Zochert. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0462.

20. On August 14, 2012, Ms. Zochert was admitted to Prairie Lakes Healthcare Systems for a left breast lumpectomy. Compl. ¶ 11; Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0184.

21. Ms. Zochert was anesthetized, given antibiotic treatment, and Dr. Alan Christensen completed a partial left breast mastectomy and intermediate closure of the partial mastectomy site. Compl. ¶ 11; Evans Aff. ¶ 6, Exhibit D, at PrtoectiveLife 0184.

22. On August 17, 2012, Mr. Zochert requested a claim form from Protective Life to file a claim or claims under the Policy. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 4).

23. On that same day, August, 17, 2012, Protective Life mailed Mr. Zochert the claims forms required to file a claim under the Policy. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 4); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179.

24. The claims forms included a Patient Information form, Physician Statement form, and a Medical Information Release form (collectively "Claims Forms"). Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0174-0179.

25. The Patient Information form stated, in bold letters, "**A PATHOLOGY REPORT diagnosing cancer MUST accompany your first claim.**" *Id.*

26. In addition, the Patient Information form required Mr. Zochert to "submit all bills related to this cancer claim." *Id.*

27. It further stated, "All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Tax Identification Number." *Id.*

28. On September 14, 2012, Mr. Zochert mailed the executed Claims Forms to Protective Life. *Id.* at ProtectiveLife 0180-0185.

29. Dr. Christensen completed the Physician Statement, stating that Ms. Zochert was first diagnosed with cancer on July 11, 2012. *Id.* at ProtectiveLife 0182.

30. Mr. Zochert also provided Protective Life with a Professional Hospital Account Summary ("PHAS"), which summarized Ms. Zochert's bills for her August 14, 2012, procedure. *Id.* at ProtectiveLife 0184.

31. The PHAS contained the billing summary for two items: (1) partial left mastectomy; and (2) layer closure. *Id.*

32. According to the PHAS, Ms. Zochert was discharged from the hospital on August 14, 2012. *Id.*

33. The total amount owed, as reflected on the PHAS, was $3,383.00, the sum of $2,371.00 for the lumpectomy and $1,012.00 for the layered closure. *Id.*

34. The PHAS provided that Ms. Zochert's admission date was August 14, 2012 and her discharge date was August 14, 2012. *Id.*

35. Mr. Zochert did not include a pathology report when he submitted these documents, as required by the instructions on the Patient Information form. Evans Aff. ¶ 3,

Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 14); *see* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0182-0185.

36. On September 17, 2012, Protective Life received Mr. Zochert's claim with the information Mr. Zochert provided. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0199, 0201.

37. Protective Life responded to Mr. Zochert with an Explanation of Benefits, informing Mr. Zochert that he needed to supply Protective Life with a pathology report so Protective Life could verify Ms. Zochert's cancer diagnosis. *Id.* at ProtectiveLife 0201.

38. The pathology report for Ms. Zochert was supplied to Protective Life on October 24, 2012, by Sanford Health. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 22); *see* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0202-0204.

39. The pathology report did not contain a diagnosis date from July 2012. *See* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0202-0203.

40. On November 13, 2012, Protective Life processed Mr. Zochert's claim, based on of the Policy and the PHAS provided by Mr. Zochert, and issued a check for the covered benefits in the amount of $420.00. *Id.* at ProtectiveLife 0031.

41. Protective Life provided Mr. Zochert with an Explanation of Benefits, which stated that benefits payable under the Policy for the partial left breast mastectomy was $300.00, and benefits payable under the Policy for the layered closure was $120.00. *Id.*

42. At that time, Protective Life was not provided with any other bills nor an itemized bill from Ms. Zochert's August 14, 2012, procedure. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 58-61).

43. The first time additional itemized bills were provided to Protective Life was on August 4, 2014. *Id.*; *see* Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0182-85, 0194, 0201-04, 0221.

44. The only documents sent to Protective Life by Mr. Zochert were the Patient Information form, Physician Statement form, Medical Information Release form, and the PHAS. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0181-0185.

45. The check issued on November 13, 2012, correctly reflected the appropriate amount of benefits under the Policy for the listed items, based on the PHSA provided to Protective Life by Mr. Zochert. *Id.* at ProtectiveLife 0031, 0221, 0367-0368.

46. On December 12, 2012, Mr. Zochert called Protective Life to inquire about how benefits were determined under the Policy and ask about the "P1" code on the Explanation of Benefits he received with his $420.00 payment. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 32); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0215-0216.

47. The explanation of benefits stated: "P1 Charges excluded exceed the amount which can be considered as a covered charge." Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0031.

48. On December 13, 2012, Protective Life called Mr. Zochert back to answer his questions. *Id.* at ProtectiveLife 0215.

49. Mr. Zochert informed Protective Life that he would be sending additional bills. *Id.*

50. In response to the December 12 and 13, 2012, phone calls, on December 18, 2012, Protective Life sent Mr. Zochert a letter explaining how the $420 in benefits were

determined. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 33-34); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0216.

51. Mr. Zochert was informed that the surgical expense benefit was payable in accordance with 1969 California Relative Value Schedule with a unit value of $50 for surgical procedures. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0216.

52. The Schedule of Benefits in the Policy provides:

> **Surgical Expense Benefit.** When a surgical operation for the treatment of Cancer is performed on an insured, we will pay for charges incurred for such operation and anesthesia in accordance with the 1969 California Relative Value Schedule with a unit value of $50 for surgery and $42 for anesthesia. . . . [T]o determine the maximum surgical benefit multiply the S.V. by $50. To determine the maximum anesthesia benefit multiply the A.V. by $42.

Evans Aff. ¶ 4, Exhibit B (the Policy at 8).

53. According to the 1969 California Relative Value Schedule, the S.V. for the lumpectomy and layered closure is 6.0 and 2.4, respectfully. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0068, 0071.[1]

54. The CPT for the layered closure was 12035, the comparable code under the 1969 California Relative Value Schedule is 13140, which has a unit value of 2.4. *See id.* at ProtectiveLife 0068.

55. Mr. Zochert was informed the surgery charges were paid according to the Policy, using the procedure codes indicated on the August 14, 2012 PHAS. *Id.* at ProtectiveLife 0216.

[1] The unit value for CPT 19301 reads "BR," which instructs the claims processor to look at the procedure performed to determine the nearest similar procedure number. *See* Evans Aff. ¶ 6, Exhibit D, at Protective Life 0062, 72. In this case, the claims adjuster applied CPT 19160, "partial mastectomy (quadrectomy or more), unilateral," which has a unit value of 6.0, as the nearest similar procedure number. *Id.* at Protective Life 0071.

56. After this communication, Mr. Zochert did not personally contact Protective Life with further questions or inquire as to additional coverage. Evans Aff. ¶ 7, Exhibit E (Ivan Zochert Dep. at 37:8-25, 38:1-25, 39:1-14).

57. On March 13, 2013, Mr. Zochert's attorney, Seamus Culhane, sent Protective Life a letter, questioning how the benefits were determined, why only $300 in surgical benefits were paid and not $400, and why "In-Hospital Room and Board" or "In-Hospital Attending Physician Benefit" expenses were not paid. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 35-36); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0219.

58. Protective Life received Attorney Culhane's letter on March 15, 2013. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0219.

59. Protective Life responded to Attorney Culhane in a letter dated March 22, 2013, stating "the Surgical Benefit was paid at $300.00 due to the procedure code the physician used, CPT 19301." Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 37-38); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0221.

60. Further, Protective Life informed Attorney Culhane that Mr. Zochert had not submitted bills for In-Hospital Room, Board benefit, and Attending Physician benefit for Protective Life to process. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0221.

61. Protective Life stated, "in order to review for these benefits, we will need a hospital bill (UB04) and bills from the treating physicians while confined due to the treatment of cancer." *Id.*

62. On May 6, 2013, Attorney Culhane sent Protective Life a letter transmitting copies of additional bills for services performed on Ms. Zochert commencing on August 14,

2012 ("May 2013 Submission"). Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 40-41); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0235-0294.

63. The May 2013 Submission included billing records for a two-night hospital stay beginning August 14, 2012, pathology lab charges in the amount of $267.00, pharmacy charges in the amount of $110.00. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 41); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0236-0294.

64. On May 13, 2013, Protective Life reimbursed Mr. Zochert for the amount due for these items under the Policy: $320.00 for Ms. Zochert's two-night hospital stay, commencing August 14, 2012; $28.56 for Ms. Zochert's two days of home recovery commencing August 17, 2012; and $126.00 for anesthesia that was administered to Ms. Zochert on August 14, 2012. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 42-44); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0032, 0366-0370.

65. The payment for the two-night hospital stay, home recovery, and anesthesia are not in dispute. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 43-44); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0368.

66. On August 22, 2013, Protective Life received another letter from Attorney Culhane requesting the status and response from his March 22, 2013 letter and May 2013 Submission. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0301-0302.

67. Protective Life responded via email, on August 26, 2013, providing Attorney Culhane with another copy of its March 26, 2013, letter responding to the questions Attorney Culhane's asked in his March 13, 2013 letter. *Id.* at ProtectiveLife 0304.

68. Protective Life further stated,

> [s]ince this [March 26, 2013] letter we have processed the room and board benefit on May 13, 2013 when the itemized bills were

> presented on May 9, 2013. We have not processed any Attending Physician Benefits because we have yet to receive any itemized bills for August 12, 2012, through August 16, 2012 from the physician.
>
> There is no timely filing for a cancer claim, once we have received any/all itemized bills pertaining to cancer treatment, we will process according to policy provision. If you have any further questions, please do not hesitate to contact us at 800-866-3808.

Id.

69. Protective Life told Attorney Culhane again that they would process "any/all" itemized bills pertaining to cancer treatment once those bills were submitted. *Id.*

70. Attorney Culhane responded to Protective Life's email by asking if Protective Life had requested any itemized billing from the physician. *Id.* at ProtectiveLife 0305.

71. Attorney Culhane asked, "what else have you done to determine what other benefits Ivan would be eligible for? How did you determine the amount of money that the Zocherts were eligible for under the policy?" *Id.*

72. Protective Life replied to Attorney Culhane's email by stating, "Protective life has not requested billing from the physician, it is the insured's responsibility to submit any/all itemized bills pertaining to cancer treatment." *Id.*

73. Protective Life continued, "Benefits eligibility are based on itemized bills submitted for review by the insured or providers. We based benefits according to the policy provisions." *Id.*

74. Protective Life also attached the relevant policy provisions in its response. *Id.* (attachments omitted).

75. Attorney Culhane responded, via email, asking "Can you point me to where in the policy it says that the insured has to submit the bills?" *Id.* at ProtectiveLife 0307.

76. Attorney Culhane also inquired about whether "the policy holder [has] to figure out what coverage might apply or does Protective Life do that for the policy holder?" *Id.*

77. He also inquired about "what formula and code" Protective Life used to calculate the payments made to the Zocherts, so that he could explain to Mr. Zochert how they were being paid. *Id.*

78. Protective Life responded the next day by providing the Claims Provision from the Policy which requires the insured to supply written notice to Protective Life; that the Policy was "an independent cancer policy that provides for the first day confined due to accident or second day for illness and pays $600.00 per day and reduces by 50% after age 65;" and providing the clause from page 8 of the Policy, under Surgical Expense Benefit, "we will pay for charges incurred for such operation and anesthesia in accordance with the California Relative Value Schedule." *Id.*

79. Further email exchange and inquiry persisted from August 27, 2013, through November 20, 2013. *See id.*, at ProtectiveLife 0309-0314, 0317-0321, 0324-0326, 0333-0335, 0340-0343, 0346-0357 (email exchange).

80. In a November 20, 2013 email, Protective Life provided Attorney Culhane with a link to resources used to calculate the benefits paid in accordance to the 1969 California Relative Value Schedule. *Id.* at ProtectiveLife 0346.

81. On July 21, 2014, Attorney Culhane sent a letter to Protective Life, which transmitted a copy of a spreadsheet, which purported to set forth all of Ms. Zochert's medical procedures, costs, benefit limits, benefits paid, and benefits owed the Policy ("the Spreadsheet"), and a draft copy of the complaint (collectively referred to as the "July 21, 2014 Submission").

Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 53-54); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0365-0378.

82. In response to receiving the July 21, 2014 Submission, on July 25, 2014, Protective Life sent Attorney Culhane an email stating the only pathology report it had received for Ms. Zochert was for a diagnosis made on August 14, 2012, yet the Spreadsheet listed charges for services performed prior to that date; that Protective Life had not received any medical records or bills aside from those associated with services performed on August 14, 2012; and requesting that Mr. Zochert provide "all itemized bills to include the diagnosis, procedure codes and charges" for the dates of service noted in his Spreadsheet. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 55); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0383.

83. Attorney Culhane replied to Protective Life's request for the itemized bills included in his Spreadsheet, stating "We will happily provide you with the itemized billings." Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0448.

84. Further, Attorney Culhane inquired why Protective Life had "not previously requested these billings or records while processing and adjusting the claim directly from the providers?" *Id.*

85. Protective Life responded to Attorney Culhane's inquiry by email dated July 29, 2014, again informing him, "as indicated by [Protective Life's] claim form, [Protective Life] rel[ies] on the insured to send the bills and other pertinent records to [Protective Life]." *Id.* at ProtectiveLife 0447-0448.

86. Protective Life informed Attorney Culhane, "[Protective Life is] not in a position to know all of the providers that may have billed the insured, nor would [Protective Life] know

the pertinent dates of services as relates to the particular diagnosis. For example, in this case, [Protective Life] did not know until you referenced some of the bills that there was a biopsy performed prior to the date of the pathology report [Protective Life] had previously been sent." *Id.* at ProtectiveLife 0448.

87. Protective Life further informed Attorney Culhane, "If the insured has difficulty obtaining a bill, [Protective Life] will assist the insured, but, in this case, [Protective Life was] not aware of any difficulty the insured was having." *Id.*

88. Protective Life concluded, by reiterating, "Upon receipt of the additional pathology report and itemized bills, [Protective Life] will be more than happy to review and process them according to the policy provisions." *Id.*

89. On August 4, 2014, Attorney Culhane sent Protective Life a letter transmitting a pathology report for Ms. Zochert dated July 5, 2012, as well as copies of certain records and bills from Watertown Family Medicine, Prairie Lakes Healthcare System, and Sanford Health Services (collectively referred to as the "August 4, 2014 Submission"). Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶¶ 56-57, 61); Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0455-0468.

90. The August 4, 2014 Submission was the first time these bills were provided by Mr. Zochert or Attorney Culhane to Protective Life. Evans Aff. ¶ 3, Exhibit A (Plaintiff's Answers to Defendant's Request for Admissions at ¶ 58).

91. Prior to the August 4, 2014 Submission, Mr. Zochert and Attorney Culhane had not provided Protective Life the pathology report for Ms. Zochert dated July 5, 2012. *Id.* at ¶ 59.

92. Prior to the August 4, 2014 Submission, Mr. Zochert and Attorney Culhane had not provided to Protective Life any pathology report predating the August 14, 2012 pathology report. *Id.* at ¶ 60.

93. Likewise, prior to the August 4, 2014 Submission, Mr. Zochert and Attorney Culhane had not provided to Protective Life the reports of charges from Watertown Family Medicine, Prairie Lakes, and Sanford Health. *Id.* at ¶ 61.

94. In response to the August 4, 2014 Submission, on August 29, 2014, Protective Life issued two checks to Mr. Zochert, one in the amount of $30.00 for a biopsy performed on July 10, 2012, and the other for $1,720.00—$1,120.00 for the seven days Ms. Zochert was confined to Prairie Lakes Hospital from August 31, 2012 through September 7, 2012, and $600.00 for three days Mrs. Zochert was confined in the ICU from August 31 through September 2, 2012. Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0033-34.

95. Further, on September 2, 2014, Protective Life issued Mr. Zochert a check for $100.00 to cover Ms. Zochert's home benefits for September 8 through September 14, 2012. *Id.* at ProtectiveLife 0035.

96. In total, Protective Life issued Mr. Zochert five checks, totaling $2,744.56. *Id.* at ProtectiveLife 0031-35.

97. Protective Life processed each bill and paid covered benefits according to the Policy within 30 days of their submission. *See supra* ¶¶ 22, 23, 36, 39, 41, 62, 64, 83, 88, 89.

98. Mr. Zochert was a farmer, who has dealt with insurance for most of his life. Evans Aff. ¶ 7, Exhibit E, at 18:2-5.

99. He has made insurance claims in the past which required him to submit bills and other information before the insurer would process the claim and pay any covered benefits. Evans Aff. ¶ 7, Exhibit E, at 20:21-25; 21:1-12.

100. Mr. Zochert did not have any problem with complying with Protective Life's requests. Evans Aff. ¶ 7, Exhibit E, at 35:12-25; 36:1-5; 43:15-25; 44:1-17.

101. At no point did Mr. Zochert or Attorney Culhane object to having to provide Protective Life with the information Protective Life requested or claim that Protective Life was being unreasonable by requesting such information before paying benefits under the Policy. Evans Aff. ¶ 7, Exhibit E, at 35:12-25; 36:1-5; 43:15-25; 44:1-17; Evans Aff. ¶ 6, Exhibit D, at ProtectiveLife 0448.

Dated at Sioux Falls, South Dakota this 6th day of October, 2017.

EVANS HAIGH & HINTON LLP

/s/ Edwin E. Evans

Edwin E. Evans
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599
Facsimile: (605) 275-9602
Email: eevans@ehhlawyers.com

and

Katharine A. Weber
MAYNARD, COOPER & GALE, P.C.
1901 Sixth Avenue North
2400 Regions Harbert Plaza
Birmingham, AL 35203
Telephone: 205-254-1000
Email: kweber@maynardcooper.com

Attorneys for Defendant

CERTIFICATE OF SERVICE

The undersigned, one of the attorneys for Defendant, hereby certifies that a true and correct copy of the foregoing "Defendant's Statement of Undisputed Material Facts" was filed electronically with the Clerk of Court using the Odyssey File and Serve system which will send notification of such filing to the following:

Nancy J. Turbak Berry
Seamus W. Culhane
Turbak Law Office, P.C.
26 South Broadway, Suite 100
Watertown, SD 57201
nancy@turbaklaw.com
seamus@turbaklaw.com

Attorneys for Plaintiff

on this 6th day of October, 2017.

/s/ Edwin E. Evans
Edwin E. Evans

Filed: 10/6/2017 4:28:52 PM CST Moody County, South Dakota 50CIV14-000061

STATE OF SOUTH DAKOTA | IN CIRCUIT COURT

COUNTY OF MOODY | THIRD JUDICIAL CIRCUIT

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert,

Plaintiff,

vs.

Protective Life Insurance Company,

Defendant.

50CIV14-000061

PLAINTIFF'S RESPONSES TO DEFENDANT'S STATEMENT OF UNDISPUTED MATERIAL FACTS

Plaintiff, Ivan Zochert, individually and as Administrator for the Estate of Lenore Zochert, by and through his attorney, makes the following responses to Defendant's Statement of Undisputed Material Facts.

1.) Undisputed.
2.) Undisputed that one endorsement was for Hospital Intensive Care. There is/was an additional endorsement amending some terms of the policy at Bates Protective Life 0017.
3.) Undisputed.
4.) Undisputed that the policy is limited to Cancer.
5.) Undisputed.
6.) DISPUTED. The Schedule of Benefits did not contain the full expanse of coverage actually contained within in "the policy." Both the insuring clause, (p.6 of policy), and the Endorsement(s) (Bates 0017 and Exhibit C to Affidavit of Ed Evans) contained grants of coverage that expanded the scope of the schedule of benefits. Undisputed, that except for the Intensive Care Rider, the cancer policy was limited to "Benefits For Cancer Only."
7.) Undisputed except as the policy language was expanded by the Endorsement(s) described above to cover other diseases/incidents resulting ICU confinement.
8.) Undisputed except as the policy language was expanded by the Endorsement(s) described above to cover other diseases/incidents resulting ICU confinement.
9.) Undisputed.
10.) DISPUTED. The insured/claimant is responsible for providing "written notice of claim" notifying the insurer within 60 days of the start of the covered loss, completing claim forms, and providing written proof of loss. Nowhere does the policy state the claimant "is responsible for providing the information necessary for Protective Life to determine the appropriate coverage."
11.) DISPUTED. The insured/claimant is responsible for giving Protective Life notice within 60 days of the *start* of the covered loss i.e. 60 days from the diagnosis of Cancer.
12.) Undisputed.
13.) Undisputed.
14.) Undisputed. (The cited provision is on p. 11, not p. 10.)

15.) DISPUTED. The policy says, "All benefits will be paid to you [. . .]" "You" is defined on p.1 of the policy as the "insured." Ivan Zochert and Lenore Zochert are/were both insureds under the policy. Anything regarding a "beneficiary" is beside the point and not at issue.

16.) Undisputed.

17.) Undisputed.

18.) DISPUTED. Dr. Christensen ordered the testing, however, the pathology lab at Prairie Lakes Hospital confirmed the samples were cancerous.

19.) DISPUTED. Dr. Christen ordered said exams and tests, but Dr. Christensen did not "conduct" said exams and tests.

20.) Undisputed.

21.) Undisputed.

22.) Undisputed ON OR ABOUT, August 17th, Ivan requested claims forms for filing a claim.

23.) Undisputed that Protective Life mailed what it calls, "claims forms." DISPUTED that the claims forms were appropriate given the policy, industry standard, and otherwise "required" to the extent that the claims forms purported to shift the burden to investigate and document the claim onto Ivan. (See Plaintiff's Brief in Support of Summary Judgment, and Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment for full explanation and documentation.)

24.) Undisputed.

25.) Undisputed.

26.) Undisputed that the claim form attempted to required Ivan to "submit all bills" DISPUTE that is appropriate given the policy agreement that had been in place for more than 20 years, South Dakota law, and Industry Standard. (See Plaintiff's Brief in Support of Summary Judgment, and Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment for full explanation and documentation.)

27.) Undisputed that the claim form attempted to required Ivan to "itemized bills" DISPUTE that is appropriate given the policy agreement that had been in place for more than 20 years said nothing about "bills" nor "itemized bills," South Dakota law, and Industry Standard. (See Plaintiff's Brief in Support of Summary Judgment, and Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment for full explanation and documentation.)

28.) Undisputed.

29.) Undisputed.

30.) Undisputed.

31.) DISPUTED. The document speaks for its self and does not say "(1) partial left mastectomy, and (2) layer closure." The actual document said, "MAS PAR LUMP LT" and "LAYER CLOSUR 51" the procedure codes were 19301 and 12035 respectively.

32.) DISPUTED. According to the PHAS, Lenore was discharged from the Watertown Surgery Department on August 14th - not from the hospital.

33.) Undisputed that the total amount owed for these two procedures was $3,383.00.

34.) DISPUTED. According to the PHAS, Lenore was discharged from the Watertown Surgery Department on August 14th - not from the hospital.

35.) Undisputed that Ivan did not include a pathology report with the initial submission.

36.) Undisputed.

37.) Undisputed.
38.) Undisputed.
39.) Undisputed.
40.) Undisputed that Protective Life paid $420. DISPUTED that Protective Life "processed" Ivan's claim. Protective Life did not appear to "process" much, if anything., DISPUTED that was the full extent of the covered benefits, even as applied to the PHAS at Bates No 184. (See Plaintiff's Brief in Support of Summary Judgment at pp. 29-31, and Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment for full explanation and documentation for full detail of the failed processing.)
41.) Undisputed that is what the Explanation of Benefits said. DISPUTED that the benefits were calculated correctly. (See Plaintiff's Brief in Support of Summary Judgment at pp. 29-31, and Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment for full explanation and documentation for full detail of the failed processing.)
42.) Undisputed.
43.) DISPUTED. Extensive billings were provided to Protective Life on or about May 6, 2013 (Bates No. 235).
44.) DISPUTED. Ivan Zochert arranged for, at Protective Life's request, Sanford Clinic sending a pathology report to Protective Life on or about October 24, 2014.
45.) DISPUTED. (See Plaintiff's Brief in Support of Summary Judgment at pp. 29-31).
46.) DISPUTED that any "P1" Code was discussed. Ivan was having difficulty hearing (See Protective Life Bates No. 215). The idea that the claims handler and Ivan had any meaningful conversation about any benefit eligibility code that Protective Life printed on the Explanation of Benefits form is a false.
47.) Undisputed that Protective Life *claimed* the charges exceed the covered amount. DISPUTED because there should have been another $2,071 paid toward the surgical benefit and PHAS billing.
48.) Undisputed.
49.) Undisputed that Protective Life attempted to make Ivan send additional bills, DISPUTED that Ivan agreed to send additional bills, or even heard or comprehended the conversation well enough to make such an agreement.
50.) Undisputed that Protective Life send Ivan a letter that appears at Bates No. 0216. DISPUTED that the letter is factually correct, in fact it is blatantly misleading and intentionally so. Protective Life *did not* use the procedure code from the PHAS to calculate the benefits, nor did Protective Life use the California Relative Value Schedule. (See Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment pp. 22-24 for full explanation and cites to documents disproving this misleading statement.)
51.) Undisputed.
52.) Undisputed.
53.) DISPUTED. The procedure code cited by the surgeon, Dr. Alan Christensen was 19301. That procedure code had a unit value of, "By Report" or "BR." Protective Life did not seek out the surgeon's report. Protective Life did not use that procedure code. Instead, Protective Life picked a different procedure code with a unit value of 6. (See Plaintiff's Brief in Support of Summary Judgment at pp. 29-31 and Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment pp. 22-24 for full explanation and cites to documents disproving this.)
54.) Undisputed.

55.) Undisputed that is what Ivan was told. DISPUTE that it was factually correct.
56.) Undisputed.
57.) Undisputed.
58.) Undisputed.
59.) Undisputed that Protective Life said that. DISPUTED that Protective Life used procedure code 19301. Protective Life admitted that it *did not* use the procedure code from the PHAS to calculate the benefits, nor did Protective Life use the California Relative Value Schedule at the time. (See Plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment pp. 22-24 for full explanation and cites to documents disproving this misleading statement.)
60.) Undisputed.
61.) Undisputed.
62.) Undisputed.
63.) Undisputed that the May 2013 submission included said bills. DISPUTED that two-night's hospital stay, pathology charges, and pharmacy charges were the full extent of the bills contained within the submission at Bates No. 236 – 294.
64.) Undisputed that Protective Life paid for some items contained within the billing due under the policy. DISPUTED that Protective Life paid all items due under the policy. Ivan has submitted two briefs, totaling nearly 80 pages that explain why this allegation is incorrect.
65.) Undisputed that the items are not in dispute for purposes of the breach of contract. DISPUTED that they are not relevant for purposes of determining insurance bad faith, because of the failed investigation, and failed claims processing procedure(s).
66.) Undisputed that when Attorney Culhane submitted questions in March and billings in May, Protective Life followed by communicating directly with Ivan to the exclusion of Attorney Culhane.
67.) Undisputed.
68.) Undisputed.
69.) Undisputed that is what Protective Life said.
70.) Undisputed.
71.) Undisputed.
72.) Undisputed.
73.) Undisputed that is what Protective Life said. DISPUTE that that approach is appropriate per State Law and Industry Standards.
74.) Undisputed Protective Life attached relevant policy provisions. DISPUTE that the relevant policy provisions say what Protective Life interprets them to mean.
75.) Undisputed.
76.) Undisputed.
77.) Undisputed.
78.) Undisputed.
79.) Undisputed.
80.) Undisputed that Protective Life provided links. DISPUTED that these links were appropriate or proper under the policy conditions.
81.) DISPUTED that the spreadsheet "purported to set forth all of Ms. Zochert's benefits owed [sic] the policy." The purpose of the spreadsheet was to point out a variety of discrepancies between what Ivan should have been paid had Protective Life done its job,

and what Ivan was actually paid.

82.) Undisputed.

83.) Undisputed.

84.) Undisputed.

85.) Undisputed.

86.) Undisputed that Protective Life makes this claim in writing, dispute that it is factually correct or complaint with South Dakota law and industry standards. See for example, *Biegler v American Family Mut. Ins. Co.*, 2001 SD 13, P33-P34, (the Court found it "particularly egregious" when the insurer failed to tell the insured that coverage would be available if he provided certain information to the insurer.); *Hanson v. Mut. of Omaha Ins Co*, 2003 US Dist LEXIS 28242, 10-12 (DSD Apr 29, 2003) (Schreier, J) ("Mutual of Omaha has the duty of gathering the necessary information to determine whether to pay benefits."); *Eide v. Southern Sur. Co.*, 55 SD 405, 409 (1929): (An insured is "not obliged . . . to elect upon which of the clauses in the policy the claim might be made."); *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 NW2d 752, 754 (SD 1994) (bad faith verdict upheld where the insurer failed to disclose UIM coverage but, 3 years later, said the reason they didn't disclose the coverage was that workers compensation benefits were set off against it.) *See also: Egan v. Mutual of Omaha Ins. Co.*, 2 Cal 3d 809, 819 (relied on by the South Dakota Supreme Court in *Trouten v. Heritage Mut. Ins. Co, 632 N.W. 2d 856 (S.D. 2001), holding that "[to protect these [insured's] interests it is essential that an insurer fully inquire into possible bases that might support the insured's claim."; Athey v. Farmers Ins. Exchange*, 234 f3d 357 (8th Cir. 2000) (applying South Dakota law and finding sufficient evidence to support the jury's verdict of bad faith and punitive damages where there was ample evidence that Farmers had ignored Athey's proofs of losses.)

87.) Undisputed that is what Protective Life said, DISPUTED that Protective Life was unaware that Ivan was having difficulties. Protective Life creates difficulties for policy holders by refusing to disclose coverage. Meanwhile, already by December 12, 2013 Protective Life was aware that Ivan was having difficulty hearing. Because Protective Life did not disclose coverages the way they must, i.e. biopsy, anesthesia for the biopsy, anesthesia for the surgery, hospital room and board, home recovery, etc., the insured would have trouble knowing what bills to ask for (Plaintiff's Brief in Opposition to Motion for Summary Judgment p. 25).

88.) Undisputed.

89.) Undisputed.

90.) Undisputed.

91.) Undisputed.

92.) Undisputed.

93.) DISPUTED. On May 6, 2013 billings from Prairie Lakes and other associated charges. See Bates No. 235.

94.) Undisputed.

95.) Undisputed.

96.) Undisputed.

97.) DISPUTED. Protective Life did not process a whole variety of billings totaling more than $33,000, all associated with the cancer treatment as detailed in Plaintiff's briefs. Protective Life did not properly process the Surgery Benefit ($420) as detailed above and in Plaintiff's briefs. If Protective Life would have done what it was supposed to do, like

fairly investigate Ivan's claim, fully and fairly process Ivan's claim, and fully disclose coverages, these benefits would have been paid to Ivan years earlier.

98.) Undisputed.

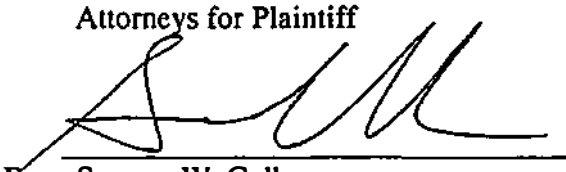
99.) Undisputed.

100.) DISPUTED. Ivan attempted at the beginning of the claim to give Protective Life what it wanted fulfilling his good faith obligation. But, Ivan never agreed to being taken advantage of and never agreed to do Protective Life's job. Ivan wanted to be paid for his loss after he had paid premiums for 22 years. Ivan did not know what coverages Protective Life admitted existed and exactly what billings to ask his providers for. Ivan did not know why Protective Life only paid $420 toward surgery when it should have paid more, nor did Ivan understand why Protective Life did not pay for everything else – anesthesia, antibiotics, pain medication, pre-operative work ups, and so forth.

101.) DISPUTED. Mr. Zochert through Attorney Culhane attempted to furnish Protective Life with anything and everything that would trigger full and fair coverage under the Zochert policy to Protective Life, including bills. DENY that Ivan Zochert did not "object" to furnishing bills. By August 26, 2013 it become more obvious that Protective Life was attempting to make the insured effectively handle their own claim by taking a totally passive approach to claims handling, and via email at Bates No. 310, Ivan Zochert and Attorney Culhane were effectively "objecting" to furnishing additional bills. In the claim handler's response email appearing on Bates No. 309, the claim handler avoids the issue and improperly relies on the "Claims Provisions" section of the policy to justify the totally passive approach to claims handling that shifted the burden to Ivan to investigate his own claim.

Dated October 18, 2017

TURBAK LAW OFFICE, P.C.
Attorneys for Plaintiff



By: Seamus W. Culhane
Nancy J. Turbak Berry
26 S. Broadway, Suite 100
Watertown, SD 57201
(605) 886-8361
seamus@turbaklaw.com
nancy@turbaklaw.com

STATE OF SOUTH DAKOTA) : SS		IN CIRCUIT COURT
COUNTY OF MOODY)		THIRD JUDICIAL CIRCUIT
IVAN ZOCHERT individually and as Administrator for the Estate of Lenore Zochert,	*	50CIV14-000061
Plaintiff,	*	
vs.	*	JUDGMENT
PROTECTIVE LIFE INSURANCE COMPANY,	*	
Defendant.	*	

A hearing was held on Monday, November 6, 2017, at 10:30 a.m. at the Moody County Courthouse, Flandreau, South Dakota, before the Honorable Patrick T. Pardy, on Plaintiff Ivan Zochert's Motion for Partial Summary Judgment and on Defendant Protective Life Insurance Company's Motion for Summary Judgment. Plaintiff appeared by and through his counsel of record, Seamus W. Culhane and Nancy T. Turbak Berry of Turbak Law Office, P.C. Defendant, Protective Life Insurance Company, appeared by and through its counsel of record, Edwin E. Evans and Ryan W.W. Redd of Evans, Haigh, & Hinton LLP and Katherine A. Weber of Maynard, Cooper & Gale, P.C.

Based upon the pleadings, papers, memoranda, and the records herein, and upon the arguments of counsel, IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

1. Defendant Protective Life Insurance Company's Motion for Summary Judgment is GRANTED;

2. Plaintiff Ivan Zochert's motion for summary judgment is DENIED;

3. Plaintiff Ivan Zochert's Complaint is dismissed in its entirety and with prejudice;

4. Costs in the sum of $_____, to be hereinafter inserted by the clerk, are awarded to Defendant Protective Life Insurance Company and against Plaintiff, Ivan Zochert;

Dated at Madison, South Dakota, this _____ day of November, 2017.

BY THE COURT:

Signed: 11/7/2017 11:23:11 AM

Attest:
Johnson, Lisa
Clerk/Deputy

Honorable Patrick T. Pardy
Circuit Court Judge

ATTEST:

LISA JOHNSON, Clerk

By_____
Deputy

(SEAL)

ph 1-800-866-8532
9-21-05

Middle Last Birthdate: 1

Empl

dicate desired plan and indemnity benefits with ✓. Rates sh

(605) 345-4293

PROTECTIVE LIFE
INSURANCE COMPANY

SR - 001011

PROTECTIVE LIFE®
INSURANCE COMPANY

PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202
A STOCK COMPANY

CANCER POLICY

IVAN E ZOCHERT

Policy Number D00054903

THIS IS A LIMITED POLICY - PLEASE READ CAREFULLY.

This policy has been written in readable language to help you with its terms. As you read through the policy, please note that the words "we", "us" and "our" refer to Protective Life Insurance Company.

We will, subject to the terms of this policy, pay the benefits provided by this policy. The policy comes into force on the Date of Issue for the Premium Period shown on the Policy Schedule. The Premium Period begins and ends at 12:01 a.m. Standard Time of the place where the Insured lives. The Insured is herein referred to as "you" and "your".

The policy is issued in consideration of the statements in the application and the payment of the premium shown on the Policy Schedule. A copy of the application is attached to and made part of the policy. The terms of this policy are contained on this and the following pages.

Please read the copy of your application attached to this policy. Errors or omissions in the application may void the policy or cause an otherwise valid claim to be denied. Advise us at once if any information on the application is wrong or incomplete.

YOU HAVE A RIGHT TO RETURN THIS CONTRACT. If you decide not to keep this policy, return it within 30 days after you get it. It may be returned to our Home Office or to the agent who sold the policy. Then, the policy will be as though it had never been issued. We will promptly refund any premium paid.

Chairman | President | Secretary

CANCER POLICY
This Policy Is Guaranteed Renewable For Life As Long As The Premiums Are Paid When Due. The Company Has The Right To Change Premium Rates. It Provides Benefits For Hospital Services And Other Expenses Caused By Cancer To The Extent Herein Provided.

INDEX

POLICY SCHEDULE

INSURED:	IVAN E ZOCHERT
POLICY NUMBER:	D00054903 —
DATE OF ISSUE:	MARCH 1, 1990
ISSUE AGE:	65
TYPE OF CANCER POLICY:	FAMILY

SCHEDULE OF BENEFITS AND PREMIUMS

FORM NO.	BENEFITS	ANNUAL PREMIUM
CA05	CANCER INSURANCE POLICY	$195.00
IC02	INTENSIVE CARE RIDER - $600 DAILY BENEFIT	120.00
	TOTAL ANNUAL PREMIUM	$315.00

TOTAL PREMIUMS* FOR ALL BENEFITS

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
$315.00	$157.50	$78.75	$26.25

PLANNED PREMIUM: $26.25 PAYABLE MONTHLY BY PRE-AUTHORIZED PAYMENT FACILITY

*YOUR PREMIUM WILL NOT CHANGE IF YOU LEAVE YOUR PRESENT EMPLOYER. HOWEVER, PREMIUMS ARE SUBJECT TO CHANGE AS PROVIDED IN THE PREMIUM PROVISIONS OF THIS POLICY.

52LW022190 26.25 0054903 M21 05

PROTECTIVE LIFE INSURANCE COMPANY

CANCER INSURANCE APPLICATION TO: Protective Life Insurance Company, P.O. Box 2606 Birmingham, Alabama 35202

PLEASE PRINT — (FIRST) (MIDDLE) (LAST)	(SEX)	DATE OF BIRTH (APPLICANT) MONTH DAY YEAR	SOCIAL SECURITY NUMBER
APPLICANT'S NAME Ivan E. Zochert	M	[redacted]	[redacted]
SPOUSE'S NAME (FIRST) (MIDDLE) (LAST)		DATE OF BIRTH (SPOUSE) MONTH DAY YEAR	PHONE NUMBER (AREA CODE)
Lenore K. Zochert		[redacted]	605-345-4293
APPLICANT'S — HOME ADDRESS (NUMBER AND STREET) (P.O. BOX)		EMPLOYER'S/ASSOCIATION'S NAME	
RR#1		Zochert Farms Inc.	
(CITY) (STATE) (ZIP CODE)		COUNTY OR PARISH	
Webster, So. Dak. 57274		Day	

CANCER POLICY DESIRED: ☐ CA-03 ☐ CA-04 ☒ CA-05 ☐

TYPE OF CANCER POLICY DESIRED: ☐ INDIVIDUAL ☒ FAMILY

DREAD DISEASE RIDER IS DESIRED: ☐ YES ☒ NO

RETURN OF PREMIUM RIDER IS DESIRED: ☐ YES ☒ NO

INTENSIVE CARE RIDER IS DESIRED: ☒ YES ☐ NO

DAILY BENEFIT DESIRED: ☒ $600 ☐ $300

PREMIUM BASIS DESIRED

☒ PAYROLL DEDUCTION ☐ MONTHLY P.A.C.
☐ ASS'N./EMPLOYEE NON-PAYROLL ☐ ANNUAL
☐ DIRECT ☐ SEMI-ANNUAL
☐ QUARTERLY

INITIAL PREMIUM $ 26.25

SEND POLICY TO: ☒ AGENT ☐ APPLICANT

APPLICANT'S STATEMENTS AND AGREEMENTS:

1. To the best of my knowledge and belief, no person to be covered under the terms of this policy now or within the last five (5 years has had cancer in any form, except _____ (NAME) _____ (TYPE OF CANCER)
   Any person(s) named as an exception will not be covered by this policy.
2. Have you (or your spouse if a family policy is desired) smoked a cigarette within the last twelve months? ☐ Yes ☒ No
3. Is this insurance intended to replace or change other cancer insurance in force? ☒ Yes ☐ No
   Name of Company: Capitol American Life Ins. Co. Policy Number: 0722694
4. I understand that: (a) the insurance I am now applying for will be issued solely upon the written answers to question and information asked for in this applica ion; (b) the Company is not bound by any statement made by myself, th applicant, or any agent unless w itten herein; (c) the Agent cannot change the provisions of the policy or waive an of its provisions either orally or in writing; (d) the policy with this application and any endorsements, riders or othe papers, if any, is the entire contract of insurance; (e) no change to the policy will be valid until approved by an Office of the Company which must be noted on or attached to the policy; (f) if the Dread Disease Rider is applied for, an person who now or within the last five (5) years has been diagnosed or t eated for any of the following diseases *Cystic Fibrosis*Diphtheria*Encephalitis*Meningitis (Epidemic Cerebrospinal)*Multiple Sclerosis*Muscula Dystrophy*Osteomyelitis*Poliomyelitis*Rabies*Rocky Mountain Spotted Fever*Scarlet Fever*Sickle Cell Anemi *Smallpox*Tetanus*Tuberculosis*Tularemia*Typhoid Fever will not be covered under the Rider for that (those) dis ease(s); (g) if the Intensive Care Rider is applied for, any person who now or within the last five (5) years has bee diagnosed or treated for any of the following conditions or diseases: * Heart Attack * Any Hea t Condition or Hear Trouble * Any Abnormality of the Heart * Acquired Immune Deficiency Syndrome (AIDS) * AIDS Related Comple (ARC) will not be covered under the Rider; and (h) the policy will become effective on "Date of Issue" ecorded o the Policy Schedule by the Home Office. It is not the date the application is signed. No benefits are payable for cance diagnosed before the policy has been effective 30 days.
   I have read, or had read to me, the completed application end ealize policy issuance is based upon statements an answers provided herein and they are complete and true to the best of my knowledge and belief.

DATE: 2-14-90 APPLICANT'S SIGNATURE: X Ivan Zochert

SIGNED AT: Webster, So. Dak.
(CITY) (STATE)

This is to certify that to the best of my knowledge and belief replacement or change of existing cancer insurance is ☒ is not ☐ involved in connection with the application. (If a replacement or change is involved, attach a copy of all required forms completed and furnished to the Applicant).

X Richard C. Bellaar AGENT'S NUMBER: 6008395 DATE: 2-14-90
(LICENSED RESIDENT AGENT)

MAKE CHECKS AND MONEY ORDERS PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY

CA026-R

PROTECTIVE LIFE INSURANCE COMPANY

SR - 001015

Family. If the Policy Schedule indicates that this policy is a Family policy, the term "an Insured" shall refer to: (1) the Insured; (2) the spouse of the Insured named in the application (or in a later supplemental application in the event of remarriage); and (3) all dependent children of the Insured (or of the spouse) unmarried and under age 21. For purposes of this policy; the term "dependent children" includes only: (1) the Insured's natural child or adopted child; and (2) the Insured's stepchild, grandchild, or other child who lives with the Insured in a regular parent-child relationship and for whom the Insured (or the Insured's spouse who lives with the Insured) has permanent legal custody. Newborn children will be covered from birth. Newly adopted children will be covered from the start of the six-month adoption bonding period. The insurance on any child covered under the terms hereof shall terminate upon such child's marriage or twenty-first birthday, whichever occurs first. Coverage will continue until such child's twenty-fifth birthday, provided such child is unmarried and a full-time student. The insurance on the spouse shall terminate upon divorce.

Coverage shall not terminate if such child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is unmarried and is chiefly dependent upon you for support and maintenance. Proof of such incapacity and dependency must be furnished to us within 31 days from the date the child's coverage would have terminated had such child not been incapacitated by reason of mental retardation or physical handicap. We may subsequently require proof of continued incapacity annually.

Cancer. Leukemia, Hodgkin's disease, malignant growths, or any other form of malignancy positively diagnosed as Cancer by a Physician other than yourself. Premalignant conditions or conditions with malignant potential are not to be construed as Cancer for purposes of this policy. Such diagnosis must be based on a microscopic examination of tissue or preparations from the hemic system (either during life or post-mortem) performed by a qualified pathologist. Clinical diagnosis of Cancer will be accepted as evidence that Cancer exists in an Insured when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and such Insured receives treatment for Cancer. The pathologist making the diagnosis shall base his judgment solely on criteria accepted by the American Board of Pathology or the Osteopathic Board of Pathology.

Hospital. An institution which meets all of the following requirements:

a. Operates pursuant to law;
b. Operates mainly for the care and treatment of sick or injured persons as inpatients for a charge;
c. Provides 24-hour nursing service under the supervision of a registered nurse (R.N.);
d. Is supervised by a staff of Physicians; and
e. Has medical, diagnostic and major surgical facilities or has access to such facilities.

For purpose of this policy, the term "Hospital" shall include ambulatory surgical centers provided they provide elective surgical care as their primary purpose and admit and discharge patients within the same working day.

The term "Hospital" does not include: (a) convalescent, rest or nursing facilities; (b) facilities for the aged, alcoholics or drug addicts; or (c) any government owned hospital or facility except for services rendered on an emergency basis where legal liability exists for charges incurred.

Physician. A duly licensed doctor of medicine or osteopath or chiropractor not related to you and practicing within the scope of such license.

Hospice. A legally operated agency or facility, or part thereof, which specializes in Hospice Programs; operates under the supervision of a Physician; and meets the standards of the National Hospice Organization or like standards.

Hospice Program. A centrally administered, coordinated program of services designed to ease the symptoms of terminally ill patients and provide support. Services include, but are not limited to, nursing, therapy and counseling. Nurses are on call 24 hours a day. Curative treatment is not provided. A "Hospice Program" encourages home care; is provided by a Hospice; and meets the standards of the National Hospice Organization or like standards.

Usual and Customary Charge. The charge for a particular item of care, services or supplies to the extent that it meets both of these tests:

a. It is not higher than the usual charge made by the person or other party who actually provides the item of care, services or supplies; and
b. It is within the range of the charges customarily made for the item of care, services or supplies by other providers (who are of similar training and experience in the case of professional services) located in the same community.

Premium Provisions

Payment of Premiums. Coverage will not be effective until the first premium is paid. Each premium after the first is due at the end of the period for which the last premium was paid.

Each premium after the first is to be paid to us at our Home Office or to an agent authorized to accept such premium. If we accept a premium, coverage will continue until the end of the period for which the premium is accepted.

Premiums may be paid by payroll deduction through your employer or at 12, 6, or 3 month intervals. We may agree to payment of premiums on a monthly basis under a pre-authorized payment plan. The premium rate is determined by the interval requested. If we agree, the interval may be changed.

Guaranteed Renewable. This policy is guaranteed renewable for life. You may renew the policy by paying each renewal premium as it falls due or during the grace period. We cannot cancel or refuse to renew the policy.

Premium Subject to Change. We reserve the right to change premium rates. A change in the rates will apply to all policies of this form issued by us and in force in the state where you live. If we change the rates, your premium will be determined by your age and premium class on the Date of issue of this policy. If we change the rates, we will write you at least 30 days before the change at the address in our records.

Grace Period. The policy has a 31 day grace period. If a premium is not paid on or before its due date, it may be paid within the following 31 days. The policy will stay in force during the grace period.

Insuring Clause

This policy provides benefits for losses due to Hospital confinement and certain other expenses resulting from treatment for Cancer of an Insured. Such Cancer must be first diagnosed 30 or more days after the Date of Issue of this policy.

Schedule of Benefits

Benefits are payable for those expenses incurred by an Insured from 10 days preceding the date of positive diagnosis of Cancer or from the first day of a period of Hospital confinement during which the positive diagnosis is made, whichever is more favorable to you. Such expenses will consist of the actual charges by the Hospital, Physician, or other providers subject to the limitations stated herein. No benefit will be paid in excess of the Usual and Customary Charge made by the provider of services or treatment.

In-Hospital Room and Board Benefit. We will pay $160 per day for each of the first 10 days of each period of Hospital confinement and $200 per day for each day thereafter. Readmission within 3 days considered same confinement.

In-Hospital Special Nursing Benefit. We will pay up to $100 per day for special nursing services (other than those regularly furnished by the Hospital) received from a full-time private duty registered nurse (R.N.) or licensed practical nurse (L.P.N.), while an Insured is Hospital confined. Such nursing care must be required and authorized by the attending Physician and be given by a person not related to you.

In-Hospital Attending Physician Benefit. We will pay up to $25 per day for all personal visits by attending Physicians, other than a surgeon, while an Insured is confined in a Hospital.

Blood and Plasma Benefits. We will pay for blood and plasma not replaced by donors. We will also pay for transfusion service, administration, processing and procurement fees and crossmatching. No payment will be made under this benefit for laboratory expenses except those described.

Ambulance Benefit. We will pay the charges made by a professional ambulance company for ground transportation of an Insured to or from a Hospital where such Insured was admitted as a patient.

Radiation Therapy and Chemotherapy Benefits. We will pay the charges made by a Hospital or a Physician for radiation therapy, chemotherapy drugs, and the professional administration thereof. No payment will be made under this benefit for laboratory tests and diagnostic x-rays related to such therapy.

New or Experimental Treatment Benefit. New or experimental treatment for Cancer is covered under the Schedule of Benefits in the same way as any other treatment for Cancer.

Transportation Benefit. We will pay the actual charges incurred for transporting an Insured who has been diagnosed as having Cancer, by commercial aircraft, bus or railroad from home to and from the nearest Hospital in the continental United States prescribed by a Physician. Such Hospital must provide special types of treatment, covered under this policy, which are not available locally. In lieu of traveling by commercial aircraft, bus or railroad, an Insured may travel by car and, if such Hospital shall be a minimum of 50 miles, one-way, from your home using the most direct route, we will pay $.25 per mile for each mile so traveled.

Home Recovery Benefit. We will pay $100 per week ($14.28 per day) while an Insured is confined at home immediately following a Hospital confinement. The maximum period this benefit will be paid is equal to the number of consecutive days of the prior Hospital confinement. Readmission to the Hospital or death will limit the benefit payable to the actual number of days the Insured was confined at home prior to such readmission or death.

Prosthesis Benefit. We will pay actual charges up to $500 for each prosthetic device which is prescribed by a Physician as a direct result of surgery performed while this policy is in force and as a direct result of Cancer first diagnosed 30 or more days after the Date of Issue. No payment will be made for the surgical implantation of any prosthetic device. Maximum lifetime benefit is 2 devices.

Surgical Expense Benefit. When a surgical operation for the treatment of Cancer is performed on an Insured, we will pay for charges incurred for such operation and anesthesia in accordance with the 1969 California Relative Value Schedule with a unit value of $50 for surgery and $42 for anesthesia. Examples of various type operations are listed in the Schedule of Operations. To determine the maximum surgical benefit multiply the S.V. by $50. To determine the maximum anesthesia benefit multiply the A.V. by $42. Two or more surgical procedures performed through the same incision will be treated as one operation, and the benefit paid will be that for the procedure providing the greater benefit. Maximum benefit is $2,500 for surgery and $630 for the anesthesia. We will be glad to furnish you the benefit amount for any operation not listed in the Schedule of Operations.

SCHEDULE OF OPERATIONS

		Maximum Amount	
Abdomen	**Code**	***S.V.**	****A.V.**
Complete resection of the stomach	(43620)	28.0	7.0
Partial resection of the stomach	(43635)	21.0	6.0
Resection of the small bowel	(44120)	17.0	6.0
Resection of the ascending or transverse colon	(44310)	14.5	4.0
Combined abdominal perineal resection or cancer of the rectum or sigmoid	(45110)	26.0	7.0
Colostomy or Iliostomy	(44150)	26.0	6.0
Resection of esophagus	(43110)	30.0	12.0
Gastrostomy done in connection with esophagus	(43620)	28.0	7.0
Splenectomy	(38100)	14.5	6.0
Complete cystectomy with ureteral transplant	(51580)	34.0	7.0
Simple excision of the bladder	(51570)	26.0	6.0
Eye			
Enucleation with complete resection	(65100)	10.0	3.0
Amputations			
Thigh	(27590)	14.5	4.0
Arm, entire hand, entire foot	(24900)	10.0	3.0
Leg	(27880)	12.0	4.0
Forearm	(25900)	9.0	3.0
Genito-Urinary Tract			
Removal of kidney	(50230)	26.0	5.0
Removal of prostate, complete procedure	(55810)	26.0	6.0
Removal of uterus, tubes and ovaries	(58150)	16.0	5.0
Heart			
Excision of intra-cardiac tumor with bypass	(33120)	50.0	15.0
Rectum			
Proctectomy	(45110, 45120)	26.0	7.0
Brain			
Exploratory craniotomy	(61100)	13.0	8.0
Complete removal of cancer of brain	(61510)	34.0	12.0
Breast			
Simple mastectomy	(19180)	8.0	3.0
Radical mastectomy	(19200)	18.0	3.0

Chest			
Exploratory thoracoplasty to establish cancer	(32900)	14.0	9.0
Complete lobectomy	(32480)	26.0	11.0
External-Genitalia - Women			
Complete excision for removal of the vulva or vagina with regional lymph nodes	(57110)	14.0	3.0
Cauterization of the cervix	(57510)	0.6	0
External-Genitalia - Men			
Cancer of penis-complete excision with regional lymph nodes	(54130)	26.0	3.0
Orchiectomy (unilateral)	(54520)	6.0	3.0
Orchiectomy (bilateral)	(54521)	8.0	3.0
Skin			
Operation for removal from:			
Lip, ear, nose	(11640)	3.0	3.0
Spinal			
Operation with removal of portion of vertebra or vertebrae:			
Cervical	(63300)	34.0	8.0
Thoracic	(63300)	34.0	7.0
Throat			
Excision of larynx	(31300)	16.0	6.0
Thyroidectomy	(60240)	16.0	5.0
Thyroid and radical complete removal of thyroid gland	(60250)	28.0	6.0

*S.V.-Surgical Value **A.V.-Anesthesia Value

Special Benefits

Extended Benefits. During any period when an Insured is confined to a Hospital for less than 76 consecutive days for the treatment of Cancer, benefits will be paid as provided under the Schedule of Benefits. If, however, an Insured shall be continuously confined to a Hospital for an uninterrupted period exceeding 75 consecutive days for the treatment of Cancer, then on and after the 76th day of such continuous Hospital confinement and until the termination of such period of continuous Hospital confinement, in lieu of all other benefits, we will pay 100% of the charges made by the Hospital for such care and treatment on and after the 76th day. We will make no deduction for prior benefits paid.

Government Hospital Confinement Benefit. In lieu of all other benefits under this policy, when an Insured is confined in a U. S. Government Hospital for the treatment of Cancer, and not legally obligated to pay for such confinement, we will pay an indemnity of $200 per day.

Hospice Benefit. We will pay up to $50 per day for services under a Hospice Program provided by a Hospice. This benefit is available when an Insured's Physician determines that Cancer treatments are no longer beneficial and that life expectancy is 6 months or less. This benefit shall be in lieu of all other benefits. Maximum lifetime benefit is $9,000.

Waiver of Premium Benefit. If, while this policy is in force, the Insured becomes disabled due to Cancer first diagnosed 30 or more days after the Date of Issue of this policy and remains so for 90 days, we will pay all premiums due after such 90 days for as long as the Insured remains so disabled. The term "disabled" means that you are (a) unable to work at any job for which you are qualified by education, training, or experience; (b) not working at any job for pay or benefits; and (c) under the care of a Physician for the treatment of Cancer.

This benefit does not apply if your spouse or a child becomes disabled. This benefit includes the premium for any riders attached to the policy.

Exceptions and Limitations

Benefits For Cancer Only. This policy pays only for loss resulting from definitive Cancer treatment, including only direct extension, metastatic spread or recurrence. Pathologic proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness or incapacity.

Treatment Outside U.S. Excepted. No benefits will be paid under this policy for, or in connection with, any treatment for Cancer which is received outside the United States or its territories.

Exchange and Conversion Privileges

Exchange Privilege. If you should die while this policy is in force, your spouse may exchange it for an individual or family policy with similar benefits. If your spouse should die while this policy is in force, and you have no other dependents, you may exchange it for an individual policy with similar benefits. Written application for the exchange must be made within 30 days from the date of death of you or your spouse. The premium for the new policy will be determined by the age of the continuing insured on the Date of Issue of this policy and the premium rates in use at the time of the exchange.

Conversion Privilege. If coverage for any member of your Family ends because they cease to meet the definition of Family contained herein, such person will be entitled to have issued to him or her an individual policy of cancer insurance. The converted policy will: be issued at the attained age of the proposed insured; be issued without evidence of insurability; be most nearly similar to this policy as is then being issued by us; and waive any waiting periods or time limits on defenses to the extent same have been met under this policy.

Written application for such policy and payment of the first premium must be made within 31 days after termination of insurance under this policy. The converted policy, if issued, will take effect on the day following termination of coverage under this policy. Any special exclusion applicable to such Family member under this policy will also apply to such person under any converted policy.

Riders Excluded. The Exchange and Conversion Privileges apply only to the basic policy. No additional benefits provided by rider may be included with a policy obtained through exercise of the Exchange or Conversion Privilege,

Claim Provisions

Notice of Claim. Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice must be given to us at our Home Office or to any authorized agent.

Claim Forms. When we receive a notice of claim we will send you forms for filing proof of loss. If the forms are not mailed or given to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of your loss within the time limit stated in the Proofs of Loss provision.

Proofs of Loss. Written proof of loss must be given to us within 90 days after the occurrence or commencement of any loss covered by the policy. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. Unless you were legally incapable, this proof must be given within 1 year from the time specified.

Time of Payment of Claims. After we receive written proof of loss, and subject to the terms of this policy, we will pay all benefits then due under this policy.

Payment of Claims. All benefits will be paid to you, unless you direct otherwise in writing. Any benefits unpaid at your death may be paid, at our option, to your surviving spouse or your estate. If the benefits are payable to your estate or if you cannot execute a valid release, we can pay benefits up to $1,000 to someone related to you by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payments made in good faith.

Physical Examinations. We can have an insured medically examined, at our expense, as often as reasonably necessary while a claim is pending.

General Provisions

Ownership. The owner of this policy is the insured. All rights and benefits under this policy belong to the insured. This includes the right to assign policy benefits. However, we will not recognize an assignment until a signed form acceptable to us is received at our Home Office. Also, we are not responsible for the validity of any assignment. All written notices will be sent to your latest address of record.

Entire Contract–Changes. The policy with the application and any attached papers is the entire contract. A change in the policy will not be effective until approved by our President, a Vice President, our Secretary, or an Assistant Secretary. This approval must be noted on or attached to the policy. No agent may change the policy or waive any of its provisions. Any rider, endorsement or application which modifies, limits or excludes coverage under this policy must be signed by you, the insured, to be valid.

Time Limit on Certain Defenses. (a) After two years from the Date of Issue no misstatements, except fraudulent misstatements, made in the application shall be used to void the policy or deny any claim for expenses incurred after the expiration of such two-year period; (b) No claim for expenses incurred after two years from the Date of Issue shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to the Date of Issue.

Reinstatement. If a premium is not paid by the end of the grace period the policy will lapse. If we, or an agent authorized to accept a premium, later accept payment without requiring an application for reinstatement, the policy is reinstated.

If an application for reinstatement is required, a conditional receipt will be given for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of its disapproval.

The reinstated policy will cover only loss that results from Cancer that is manifested more than 10 days after the reinstatement date.

In all other respects your rights and our rights remain the same, subject to any new provisions added to the reinstated policy.

Legal Actions. No one may bring legal action against us for benefits until 60 days after prior written proof of loss has been given. No one may bring legal action against us after 3 years from the date written proof of loss is required.

Misstatement of Age. If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age. For purposes of this policy, your age and your spouse's age will be the age nearest birthday on the Date of Issue. If the coverage for you, your spouse or your dependant children provided by this policy at the correct age would not have become effective or would have terminated, then our liability will be limited to a refund. Such refund must be requested by you and will equal the portion of the premiums paid for the period not covered by the policy and attributable to you or your spouse and dependant children.

Age Limits. The coverage provided by this policy on you or your spouse will not become effective if, in fact, you or your spouse were over 70 years of age on the Date of Issue. In the event any coverage would not have become effective, our liability will be limited to a refund. Such refund must be requested by you and will be equal to all premiums paid for such coverage.

Conformity With State Statutes. Any provision of the policy which, on its Date of Issue, is in conflict with the laws of the state in which you reside on that date, is amended to conform to the minimum requirements of such laws.

PROTECTIVE LIFE®
INSURANCE COMPANY

PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202

HOSPITAL INTENSIVE CARE BENEFIT RIDER

This Hospital Intensive Care Benefit Rider forms a part of, and is effective concurrently with, the policy to which it is attached. This rider is subject to all terms, definitions and limitations of the policy except as may be modified herein.

SECTION 1 - CONSIDERATION

This rider is issued in consideration of your application and the timely payment of the required premiums. We agree to provide the benefits described herein to you (and your covered Family members if this rider is attached to a Family policy) for Intensive Care Unit (ICU) confinement. The Policy Schedule in the policy indicates if you have Individual or Family coverage.

SECTION 2 - INTENSIVE CARE UNIT DEFINED

The term "Intensive Care Unit" or "ICU" shall mean only that specifically designated facility of a Hospital that provides the highest level of medical care and which is restricted to those patients who are physically and critically ill or injured. Such facilities must be separated and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special life-saving equipment for the care of the critically ill or injured, and the patients must be under constant and continuous observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (a) Intensive Care Unit; (b) Cardiac Intensive Care Unit; and (c) Infant (Neonatal) Intensive Care Unit.

Important: Carefully read Section 4 - LIMITATIONS AND EXCLUSIONS for facilities that do not meet the requirements for an Intensive Care Unit.

SECTION 3 - BENEFITS

While this rider is in force, if an Insured is confined in an ICU, we will pay you the Daily Benefit described in Section 3(a) or 3(b) below. Benefits will be paid from the first day of ICU confinement due to accidental bodily injury; and from the second day for ICU confinement due to any other cause. A day is defined as a 24-hour period. If an Insured is confined to an ICU for only a portion of a day, then a pro-rata share of the Daily Benefit will be paid. Benefits shall be limited to payment for a total of 30 days for any one period of ICU confinement. Benefits under this rider will be reduced by fifty percent (50%) with respect to ICU confinements which begin on or after an Insured's sixty-fifth (65th) birthday.

EXCEPTION: If less than 30 days separates periods of ICU confinement for the same or related causes, then the later periods of ICU confinement shall be considered a part of the initial ICU confinement.

(a) INTENSIVE CARE UNIT CONFINEMENT DAILY BENEFIT: The Daily Benefit payable for each day of ICU confinement is shown in the Policy Schedule. There is no lifetime limit.

(b) INTENSIVE CARE UNIT CONFINEMENT DUE TO SPECIFIED ACCIDENTS: The Daily Benefit described in Section 3(a) will be DOUBLED when an Insured is confined to an ICU for treatment of an accidental bodily injury sustained as the result of (1) being struck by an automobile, bus, truck, farm tractor, motorcycle, train or airplane; or (2) being involved in an accident in which an Insured was the operator of or was a passenger in such vehicle. This benefit will be paid only for the initial ICU confinement which occurs within 48 hours of the accident. Subsequent confinements for the same accidental bodily injury will be paid under Section 3(a) above.

(c) EMERGENCY HOSPITALIZATION AND SUBSEQUENT TRANSFER TO AN ICU: If a critically ill or injured Insured is receiving the highest level of care available in a Hospital that does not have an ICU and within 48 hours of admission to such Hospital, such Insured is transferred directly to another Hospital for confinement in an ICU, then the period of confinement in the previous Hospital will be considered as ICU confinement for benefit purposes.

SECTION 4 - LIMITATIONS AND EXCLUSIONS

Except as provided in Section 3(c), this rider does not provide benefits for confinement in units such as: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units or other facilities which do not meet the definition of ICU in Section 2.

This rider does not pay benefits for ICU confinement which occurs during a hospitalization that began before the Date of Issue of the policy. The Date of Issue of the policy is shown in the Policy Schedule.

This rider does not cover ICU confinement resulting from intentionally self-inflicted bodily injury or suicide attempts.

This rider does not pay benefits for any ICU confinement due to or resulting from an Insured being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss or loss occurred.

Persons who have been diagnosed as having a heart attack, heart trouble or any abnormal condition of the heart (or who have received treatment for any such condition) during the five year period immediately prior to the policy's Date of Issue will not be covered under this rider.

Persons who have been diagnosed as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC) prior to the policy's Date of Issue will not be covered under this rider.

SECTION 5 - TERMINATION

All benefits under this rider will cease on the earliest of the following: (1) the date elected by the Insured to cancel this rider or (2) the date the policy to which this rider is attached terminates.

Signed for Protective Life Insurance Company as of the Date of Issue.

Secretary

PROTECTIVE LIFE®

PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202

ENDORSEMENT

The policy to which this endorsement is attached is amended as follows:

The thirty (30) day waiting period described in the "INSURING CLAUSE" provision in the policy will be waived for covered persons.

Nothing contained in this endorsement shall be held to vary, alter, waive or extend any of the terms of the policy except as stated above.

Signed for the Company as of the Date of Issue of this policy.

PROTECTIVE LIFE INSURANCE COMPANY

Sylvia H. Bailey

Secretary

Applicant's Signature

CE-04-SD

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CANCER POLICY

This Policy Is Guaranteed Renewable For Life As Long As The Premiums Are Paid When Due. The Company Has The Right To Change Premium Rates. It Provides Benefits For Hospital Services And Other Expenses Caused By Cancer To The Extent Herein Provided.

Policy D00054903 for IVAN E ZOCHERT

Protective
Protective Life Insurance Company
Protective Life Insurance Company
Post Office Box 2606
Birmingham, Alabama 35202
205-268-1000

OCTOBER 13, 2005

62250-CIA D00
IVAN E ZOCHERT
13768 441ST AVE
WEBSTER SD 57274-5707

RE: Protective Life Insurance Company Policy Number D00054903

Dear Policyholder:

In response to your request, your CancerPay Policy has been amended as set forth in Endorsement CE-21. Enclosed is a copy of Endorsement CE-21 (a sample of which was previously sent to you) and a revised Policy Schedule reflecting the effective date of the Endorsement. Also, enclosed is a copy of your Amendment to Application. Your current premium is $ $78.12
MTH PAW

Please keep a copy of the enclosed Endorsement, Amendment to Application, revised Policy Schedule and this letter with your policy for future reference.

If you have any questions or need assistance, please call our customer service representative at 1-800-866-8592.

Sincerely,

/s/ Eva T. Robertson
Vice President and Director of Operations

Enclosure
GP218

Protective
Protective Life Insurance Company

PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202

ENDORSEMENT

The policy to which this endorsement is attached is amended as follows:

(1) By deleting the provision entitled "Radiation Therapy and Chemotherapy Benefits" in its entirety and substituting in lieu thereof the following provision:

"Radiation and Chemotherapy Benefit. We will pay the charges incurred for teleradiotherapy or chemical treatments prescribed by a physician for the treatment of Cancer subject to a maximum of $10,000 per calendar year per Insured. This includes x-ray radiation, radium and cesium implants, cobalt, hormone therapy and chemotherapy drugs. This also includes such treatments designed to prevent a reoccurrence of Cancer for a period of up to 6 consecutive months beginning with the date of the first preventive treatment. Treatments may be done on an inpatient or outpatient basis.

We will also pay up to $250 per calendar year for physical exams, laboratory tests, diagnostic tests and consultations related to such treatments.

No payment will be made under this benefit for prescribed medications for side effects or complications related to or resulting from such treatments (including, but not limited to, analgesics, colony stimulating factors or immunoglobuline). If the administration of a chemotherapy drug does not require direct administration by a medical professional in a Hospital, Physician's office or clinic, only the charge for the drug itself will be covered under this policy."

(2) By adding a new provision entitled "Special Drug Benefit" to read as follows:

"Special Drug Benefit. We will pay up to $500 per calendar year for drugs and medicines prescribed by a Physician for side effects or complications related to or resulting from radiation or chemotherapy treatments (including, but not limited to, analgesics, colony stimulating factors or immunoglobuline)."

(3) By deleting the provision entitled "Extended Benefits" in its entirety.

Nothing contained in this endorsement shall be held to vary, alter, waive or extend any of the terms of the policy except as stated above.

Signed for the Company as of the effective date. The effective date of this Endorsement is shown in the Policy Schedule.

PROTECTIVE LIFE INSURANCE COMPANY

Donald J. Long

Secretary

Protective
PROTECTIVE LIFE INSURANCE COMPANY

AMENDMENT TO APPLICATION

NAME OF INSURED IVAN E ZOCHERT POLICY NO. D00054903

The application to PROTECTIVE LIFE INSURANCE COMPANY for the policy named above is hearby amended by the undersigned to conform in every respect to any and all changes indicated below:

Amount of Insurance:$ N/A	Plan of Insurance: CA05	Premium Payable $ 78.12

Other Changes:

I want Endorsement CE-21 added to my policy. I understand that I have the option to continue my policy as it currently exists, but I have decided to add Endorsement CE-21 to my policy.

I understand that Endorsement CE-21 modifies and limits the benefits for radiation therapy and chemotherapy drugs and removes the Extended Benefits provision from my policy. These changes will reduce the benefits I might otherwise receive under my policy. I understand that once Endorsement CE-21 is added to my policy it may not be removed.

I also understand that by adding Endorsement CE-21 I will not receive a rate increase at this time. However, I understand that regardless of whether or not my policy is endorsed, the Company has the right to change premium rates in the future.

I understand that, upon receipt of this Amendment to Application, Endorsement CE-21 will be added to my policy. I also understand that the effective date of Endorsement CE-21 will be shown in the new Policy Schedule that will be sent to me.

It is agreed by the undersigned that the changes shown above shall be an amendment to and form a part of the application and the policy, and that the changes shall be binding on any person who shall have or claim any interest in the policy. A copy of this form shall be as valid as the original.

Signed at Webster (City) S.D. (State) this 7 day of Oct, 20 05.

X [signature] Witness to Signature

X [signature] Signature of the Insured (Not required for ages under 16)

X Signature of Applicant (if other than Insured)

If Corporation - full name of Corporation and signature of officer other than the Insured.

By: X [signature]

RECEIVED
OCT 12 '05
BPC

D-247-2/99

IMPORTANT NOTICE

If any change is incorrect or incomplete, correct information should be written on this form. If any change is made, the policy and this form must be returned to the Company. No insurance will take effect until such changes have been reviewed and accepted by the Company.

Protective Life 001832

PROTECTIVE LIFE®

PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202

HOSPITAL INTENSIVE CARE BENEFIT RIDER

This Hospital Intensive Care Benefit Rider forms a part of, and is effective concurrently with, the policy to which it is attached. This rider is subject to all terms, definitions and limitations of the policy except as may be modified herein.

SECTION 1 - CONSIDERATION

This rider is issued in consideration of your application and the timely payment of the required premiums. We agree to provide the benefits described herein to you (and your covered Family members if this rider is attached to a Family policy) for Intensive Care Unit (ICU) confinement. The Policy Schedule in the policy indicates if you have Individual or Family coverage.

SECTION 2 - INTENSIVE CARE UNIT DEFINED

The term "Intensive Care Unit" or "ICU" shall mean only that specifically designated facility of a Hospital that provides the highest level of medical care and which is restricted to those patients who are physically and critically ill or injured. Such facilities must be separated and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special life-saving equipment for the care of the critically ill or injured, and the patients must be under constant and continuous observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (a) Intensive Care Unit; (b) Cardiac Intensive Care Unit; and (c) Infant (Neonatal) Intensive Care Unit.

Important: Carefully read Section 4 - LIMITATIONS AND EXCLUSIONS for facilities that do not meet the requirements for an Intensive Care Unit.

SECTION 3 - BENEFITS

While this rider is in force, if an Insured is confined in an ICU, we will pay you the Daily Benefit described in Section 3(a) or 3(b) below. Benefits will be paid from the first day of ICU confinement due to accidental bodily injury; and from the second day for ICU confinement due to any other cause. A day is defined as a 24-hour period. If an Insured is confined to an ICU for only a portion of a day, then a pro-rata share of the Daily Benefit will be paid. Benefits shall be limited to payment for a total of 30 days for any one period of ICU confinement. Benefits under this rider will be reduced by fifty percent (50%) with respect to ICU confinements which begin on or after an Insured's sixty-fifth (65th) birthday.

EXCEPTION: If less than 30 days separates periods of ICU confinement for the same or related causes, then the later periods of ICU confinement shall be considered a part of the initial ICU confinement.

(a) INTENSIVE CARE UNIT CONFINEMENT DAILY BENEFIT: The Daily Benefit payable for each day of ICU confinement is shown in the Policy Schedule. There is no lifetime limit.

(b) INTENSIVE CARE UNIT CONFINEMENT DUE TO SPECIFIED ACCIDENTS: The Daily Benefit described in Section 3(a) will be DOUBLED when an Insured is confined to an ICU for treatment of an accidental bodily injury sustained as the result of (1) being struck by an automobile, bus, truck, farm tractor, motorcycle, train or airplane; or (2) being involved in an accident in which an Insured was the operator of or was a passenger in such vehicle. This benefit will be paid only for the initial ICU confinement which occurs within 48 hours of the accident. Subsequent confinements for the same accidental bodily injury will be paid under Section 3(a) above.

(c) EMERGENCY HOSPITALIZATION AND SUBSEQUENT TRANSFER TO AN ICU: If a critically ill or injured Insured is receiving the highest level of care available in a Hospital that does not have an ICU and within 48 hours of admission to such Hospital, such Insured is transferred directly to another Hospital for confinement in an ICU, then the period of confinement in the previous Hospital will be considered as ICU confinement for benefit purposes.

SECTION 4 - LIMITATIONS AND EXCLUSIONS

Except as provided in Section 3(c), this rider does not provide benefits for confinement in units such as: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units or other facilities which do not meet the definition of ICU in Section 2.

This rider does not pay benefits for ICU confinement which occurs during a hospitalization that began before the Date of Issue of the policy. The Date of Issue of the policy is shown in the Policy Schedule.

This rider does not cover ICU confinement resulting from intentionally self-inflicted bodily injury or suicide attempts.

This rider does not pay benefits for any ICU confinement due to or resulting from an Insured being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss or loss occurred.

Persons who have been diagnosed as having a heart attack, heart trouble or any abnormal condition of the heart (or who have received treatment for any such condition) during the five year period immediately prior to the policy's Date of Issue will not be covered under this rider.

Persons who have been diagnosed as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC) prior to the policy's Date of Issue will not be covered under this rider.

SECTION 5 - TERMINATION

All benefits under this rider will cease on the earliest of the following: (1) the date elected by the Insured to cancel this rider or (2) the date the policy to which this rider is attached terminates.

Signed for Protective Life Insurance Company as of the Date of Issue.

Secretary

PROTECTIVE LIFE®
INSURANCE COMPANY

PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202

ENDORSEMENT

The policy to which this endorsement is attached is amended as follows:

The thirty (30) day waiting period described in the "INSURING CLAUSE" provision in the policy will be waived for covered persons.

Nothing contained in this endorsement shall be held to vary, alter, waive or extend any of the terms of the policy except as stated above.

Signed for the Company as of the Date of Issue of this policy.

PROTECTIVE LIFE INSURANCE COMPANY

Secretary

Applicant's Signature

Employee Incentive Plan Overview

The Employee Incentive Plan (EIP) is a performance-based cash incentive plan designed for all exempt and non-exempt employees not participating in other incentive plans (such as sales incentive programs or other annual incentive plans).

The plan will reward high performing employees in the form of a cash award based on their performance for the plan year. The plan year runs from January to December each year with awards made in March the following year. These awards are based on manager recommendations and assessment of performance. The funding for the plan is driven by overall corporate performance. In years that the company performs well and meets its goals, more dollars are available for awards, up to a maximum of 150% of the target pool. In years that company performance is not as strong, fewer dollars will be available to reward. However, even if corporate performance falls below threshold, the plan will fund a minimum amount of dollars (50% of target pool) for awards.

The incentive plan highlights the importance of:

- **Individual Performance**: Employees will receive awards based on their individual overall performance, as well as other key factors such as:
    - overall contributions to the team
    - value of results delivered to the organization
    - adherence to company values
    - how unanticipated issues and challenges were handled
- **Communications**: Since individual performance is a key factor, employees and managers should engage in an ongoing conversation about their performance, how they are achieving their results and their overall development.
- **Meritocracy and Pay for Performance**: Our goal is to continue to build an environment where employees are rewarded for their results, and how they achieve those results. These results should be aligned with overall Corporate goals and result in the delivery of rewards and recognition to employees based on performance.

Employee Incentive Plan Process

Incentive Plan Process

The timeline below provides a high-level overview of the EIP process. The plan year for compensation and performance review runs January through December.

1. **Target Incentive Pool Established**
   The purpose of establishing the target pool is to identify the total amount of dollars available for potential incentive award payouts if the company achieves its annual goals. The incentive target pool is established in the first quarter of the plan year, and is based on 3% of all eligible participants' salaries as of March 1st.

2. **Performance Discussions**
   Individual performance is the key factor in determining incentive awards, so employees and managers should meet throughout the year to discuss performance and overall development, as well as corporate performance against goals.

3. **Performance Evaluated**
   Plan participants will receive their annual performance evaluation from their manager.

4. **Incentive Pool Funded & Allocated**
   The incentive pool will be funded after the plan year has ended, when Corporate results versus goals are determined. The actual funding of the pool will be based on performance results versus the established goals for the plan year. And, depending on the percent of actual goals attained, the pool will be adjusted up or down to reflect over and under performance.

Employee Incentive Plan Guidelines

Plan and Payment Guidelines

- All regular employees (including part-time and job share) not participating in any other incentive plan are eligible to participate in the plan. Contractors and temporary employees are not eligible for participation.
- Participants typically do not participate in other cash incentive plans.
- Participants must be employed by the end of the plan year in order to be considered for an award in March of the following year; however, it is not expected that participants hired after September 30th of the plan year will receive a payment.
- Participants are eligible for payment based on the incentive plan they are in as of September 30th of the plan year.
- Participants may not be eligible for an incentive payment if they have received or have been subject to disciplinary action or are on a performance improvement plan.
- Participants on a continuous Leave of Absence are eligible to participate in the plan.
- If your employment terminates before annual incentives are paid, the Company reserves the right to reallocate your incentive funding amounts to eligible participants in the incentive plan.
- Incentive payments will be disbursed per the participant's normal manner of payment (e.g. direct deposit or check).
- All incentive payments made under the plan are considered taxable compensation, and appropriate deductions will be withheld according to applicable federal, state, and local tax laws.
- Incentive payments under the plan are considered compensation under the pension and 401(k) plans, and appropriate deductions will be made if the participant has a current contribution election on file with the 401(k) plan administrator.
- There are no deductions for medical, dental, vision, long term disability, and voluntary group life insurance premiums or medical/dependent care account deferrals.

Plan Administration

The Chief Human Resources Officer and Human Resources staff are responsible for administering the Employee Incentive Plan. The Compensation and Management Succession Committee of Protective's Board of Directors ("Committee") is ultimately responsible for administration of the Employee Incentive Plan, and has authority to make all determinations under the Plan. The Committee delegates the authority to make determinations under the Plan to Protective's CEO. All decisions made by the Committee or the CEO are final and binding on all persons.

If there is a conflict between this document and the Plan Documents, the Plan Documents will govern. The CEO or the Committee may, at its discretion, at any time, amend, suspend, or terminate the Plan, except as specifically set forth in the Plan.

Protective.

Audit Information

Date Added: 01/09/2016 Author: Teri McCord

INFORMATION

Team: Health

Date Approved: 11/18/2015 Pending Analyst:

Policy #: D0013[redacted] Paying Analyst: Lia Velez

Approving Analyst:

Overall Quality: 100.00 %

NOTIFICATION INFO

Analyst to send Notification to:

Login: ProID: Mgr:

Comments to Analyst:

HEALTH

HEALTH TEAM	YES/NO				COMMENTS
Is the Payee correct?	◉ Yes	○ No	○ N/A	1	
Is the Payee's address correct?	◉ Yes	○ No	○ N/A	2	
Was PNI / PTO updated?	◉ Yes	○ No	○ N/A	3	
Is the provider Tax ID # correct?	◉ Yes	○ No	○ N/A	4	
Was the correct dollar amount paid?	◉ Yes	○ No	○ N/A	5	
Was the correct letter sent?	◉ Yes	○ No	○ N/A	6	
Was the information UDC'd to the file?	◉ Yes	○ No	○ N/A	7	
Was the "PAID TO" date correct?	◉ Yes	○ No	○ N/A	8	
Were there any endorsements?	◉ Yes	○ No	○ N/A	9	
Was the term date entered for the previous policy?	◉ Yes	○ No	○ N/A	10	
Are the dates of service correct?	◉ Yes	○ No	○ N/A	11	
Are the total charges correct?	◉ Yes	○ No	○ N/A	12	
Are the procedure codes correct?	◉ Yes	○ No	○ N/A	13	
Was the policy active on the date of service?	◉ Yes	○ No	○ N/A	14	
Has the deductible been met? / Carryover					

been verified?	◉ Yes ○ No ○ N/A	15
Was the claim paid within 5 days?	◉ Yes ○ No ○ N/A	16
Was the response to correspondence within 5 days?	◉ Yes ○ No ○ N/A	17
Were the correct codes / notes entered on EOB?	◉ Yes ○ No ○ N/A	18
If applicable, were patient notes updated?	◉ Yes ○ No ○ N/A	19
Were the services improperly split into segments?	◉ Yes ○ No ○ N/A	20
Were there keying errors?	◉ Yes ○ No ○ N/A	21
Has the co-payment been met?	○ Yes ○ No ◉ N/A	22
Has the co-insurance been met?	○ Yes ○ No ◉ N/A	23
Was re-pricing done?	○ Yes ○ No ◉ N/A	24
Did we verify max benefits for Chemo / Radiation?	◉ Yes ○ No ○ N/A	25
Did we verify the travel benefits?	◉ Yes ○ No ○ N/A	26
Did we complete all necessary worksheets?	◉ Yes ○ No ○ N/A	27
Other	◉ Yes ○ No ○ N/A	28

Total Possible Errors:	28	N/A:	3
Total Wrong:	0		
Error Ratio:	100.00 %		

Hidden Fields

Path

http://teamsites.secure.protective.com/LAD/ClaimsQuality/ClaimsAuditForms/

FileName

20160109_181448

Link

http://teamsites.secure.protective.com/LAD/ClaimsQuality/ClaimsAuditForms/20160109_181448.xml

Submitted Yes

ProtectiveLife 0185

SR - 001327

Benefits and Health Administration

P.O. Box 10807 Birmingham, AL 35202
Toll Free 1-800-866-3808

August 17, 2012

Claim Form Request

Ivan [redacted] Zochert
13758 441st Ave
Webster, SD 57274-5707

RE: Protective Life Insurance Company
Insured: Ivan E. Zochert
Patient: Ivan E. Zochert
Policy Number: D00054903

Dear Insured:

This letter acknowledges receipt of your request for claim form(s). Enclosed you will find the claim form(s) you have requested. We strive to provide the best customer service by processing this completed claim according to the policy provisions as quickly as possible.

If you have any questions concerning the above, please do not hesitate to contact us at our toll-free number of 1-800-866-3808. We are available Monday through Thursday from 8:00 AM to 5:00 PM CST and on Friday from 8:00 AM to 3:00 PM CST.

Sincerely,

Debi Henry
Benefits Department

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Benefits and Health Administration

Division of Protective Life Insurance Company
PO Box 10807 Birmingham, AL 35202 Toll Free 1-800-866-3808

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION FOR EVALUATION OF CLAIM

1 Authorization and Purpose I, Ivan Zochert, the owner of Policy # D000 54903 authorize Protective Life Insurance Company and its reinsurers to obtain and use information about or relating to the insured that is relevant to evaluating a claim for benefits of a Protective policy insuring the life of the insured. With this authorization, Protective may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical diseases and illness. With this authorization Protective may also obtain information about mental diseases and illness including psychiatric disorders.

2 Persons and Organizations Authorized to Release and Disclose Information I authorize the following person(s) and organization(s) to release and disclose the information described in paragraph 1 to Protective or its agents acting on its behalf: (i) doctor(s); (ii) medical practitioners; (iii) pharmacists; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (MIB); (viii) employers of the insured; and (ix) commercial consumer reporting agencies (CRA). All of these persons and organizations other than MIB may release the information described above to a CRA (such as Equifax Medical Services) acting for Protective. MIB may not release the information described in paragraph 1 to a CRA. I authorize Protective to release and disclose any information obtained through this authorization to its reinsurers, its affiliated companies, the insured's insurance agent or agents servicing the insured's Protective policy or policies and persons or organizations providing services, including legal and investigative services, to Protective relating to claims administration.

3 Expiration of this Authorization This authorization shall be valid from the date signed for the duration of a claim for the benefits of a Protective insurance policy. This authorization shall expire on the earlier of the date the claim for which this authorization is given is either paid or denied or twenty-four months from the date this authorization is signed.

4 Revocation of this Authorization I understand that I have the right to revoke this authorization by writing to Claims Administration P.O. Box 3129 Brentwood TN 37024-3129. I also understand that revocation of this authorization will not affect any action taken in reliance on this authorization before Protective receives written notice of the revocation nor will the revocation be effective to the extent other law provides Protective with the right to contest a claim under the policy or the policy itself.

Signature and Date of Authorization

I have had full opportunity to read and consider the contents of this authorization. I understand that I may refuse to sign this authorization and that Protective does not condition payment of a claim for benefits on whether or not I sign this authorization. I further understand that pursuant to the policy, Protective is eligible to require written proof of loss in order to process a claim under the policy. I also understand that by signing this form I am granting to Protective the authority to obtain, use and disclose information as described for the purposes stated in this form. I further understand that if the persons or organization I authorize to obtain or use the information through this authorization are not subject to federal health information privacy laws, they may disclose the information, and it may no longer be protected by the federal health information privacy laws. 09 17 12 12 17

Signature Ivan Zochert, Policy Owner

Signature Lenore Zochert, Insured (if different from owner)

Date 8/30/12

ORIGINAL SIGNATURE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Protective Life Insurance Company
P. O. Box 10807
Birmingham, AL 35202
1-800-868-3808

Failure to complete this form in its entirety may result in a delay in processing this claim.
Please include your policy number on all documents.

Policy Number D-00054903 Insured's Name Ivan Zochert Patient Name Lenore Zochert

☒ Cancer Policy ☐ Hospital Intensive Care Policy ☐ Dread Disease

CANCER CLAIMS:

- **A PATHOLOGY REPORT diagnosing cancer MUST accompany your first claim.** The hospital or doctor will furnish this report to you at your request. If the diagnosis of cancer was made clinically instead of pathologically, please submit the clinical evidence that established the diagnosis of cancer.
- Submit all bills related to this cancer claim. All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Provider's Federal Tax Identification Number.
- Please have your doctor complete section B: Physician's Statement.

DREAD DISEASE:

- Submit all bills related to this Dread Disease. All bills should be itemized and should include the diagnosis, services rendered, and actual charges for the service, provider's name valid address, phone number and Tax ID #.
- Please have your doctor complete section B: Physician's Statement.

HOSPITAL INTENSIVE CARE CLAIMS:

- Send a copy of your hospital bill that lists the number of days confined in the Intensive Care Unit.
- This bill should include the diagnosis, services rendered, and actual charges for the service, Provider's Name Address, Phone Number and Provider's Federal Tax Identification Number.
- If your confinement is due to an accident, please have your doctor complete section B: Physician's Statement.
- If you policy has been issued within the last 24 months, please have your doctor complete section B: Physician's Statement.

DECEASED

- Please include a copy of the death certificate if the Insured/patient is deceased.

SECTION A: PATIENT INFORMATION

Last Name Zochert First Name Lenore Middle Initial K

Address 13758 441st Ave ( ) New Address please check box

City Webster State SD Zip 57274

Social Security Number (optional) ___/___/___ Date of Birth 3/17/31 Sex: M ☐ F ☒

Phone Number (605) 345-4293 RELATIONSHIP: ☒ Self ☐ Spouse ☐ Dependent

Dependent Full Time Student ☐ Y ☐ N, Is Dependent Married? ☒ Y ☒ N

09

☒ Eligible for Medicare Benefits: Effective Date if Applicable: _____ 17

☐ Eligible for Federal or State Medicaid Benefits: Effective Date if Applicable: _____ 12

X Ivan Zochert husband 8/30/12 12

INSURED / PATIENT SIGNATURE Relationship if other than Insured Date 17

ORIGINAL SIGNATURE

PHYSICIAN STATEMENT

POLICY NUMBER D00054903 PATIENT NAME Lenore Zochert

Failure to complete this form in its entirety may result in a delay in processing this claim.
Please include your policy number on all documents.

SECTION B: PHYSICIAN'S STATEMENT (To be completed by your treating physician)

1. Has patient been diagnosed with Cancer : Y ☑ N ☐
2. Date of Initial diagnosis: 7 / 11 / 2012
3. Patient first consulted with you for this condition on: 5 / 31 / 2012
4. Has patient ever had same or similar symptoms : Y ☐ N ☒
5. Did any other Physician previously treat the patient: Y ☐ N ☐
   If Yes, Physician's Name _____

   Referring Physician's Address _____

   Referring Physician's Phone Number _____

- **Hospitalization Information:**

1. Admission Date: 8 / 14 / 2012 Discharge Date 8 / 16 / 2012 Diagnosis / ICD Code 174.9
   Hospital Name: Prairie Lakes Healthcare
   Hospital Address: 401 9th Ave NW City Watertown State SD
2. Admission Date: ___/___/___ Discharge Date ___/___/___ Diagnosis / ICD Code _____
   Hospital Name: _____
   Hospital Address: _____ City _____ State _____

- **Surgery Information:**

Date: 8 / 14 / 2012 CPT Code: 19301 Description: Lapsrid closure Partial Lumpectomy Charge See attached

Date: ___/___/___ CPT Code: _____ Description: _____ Charge _____

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- **Physician Information:**

Physician's Name Alan Christensen (PLEASE PRINT) 12

Physician's Address 901 4th St NW 17

City Watertown State SD Zip 57201

Physician's TAX ID # 46-0447693 Phone Number 605-886-8471 Fax Number 605-882-8626

Physician's Signature A Christensen Date 9-6-12

ORIGINAL SIGNATURE

SR - 001324
ProtectiveLife 0182

Professional Hospital Account Summary (Account 18218296)
Professional Billing Balances

Tot Chg	Tot Db Adj	Ins Pmt	Ins Adj	Self Pmt	Self Adj	Balance	Ins Bal	Self Bal
3383.00	0.00	0.00	0.00	0.00	0.00	3383.00	3383.00	0.00

Hospital Account Information

Patient:	ZOCHERT,LENORE KATHRYN (E881684)	Encounter form #:	11799813
Service date:	8/14/12	Payor:	MEDICARE
Location:	WATERTOWN SURGERY	Provider:	Christensen, Alan R, MD
Place of service:	PRAIRIE LAKES HOSPITAL OUTPT (OH)	Referring provider:	
Department:	WATERTOWN SURGERY SC	Billing provider:	Christensen, Alan R, MD
Admission/Discharge:	Adm 8/14/12, Dis 8/14/12		
Diagnosis:	1) 174.9 - Malignant neoplasm of breast (female), unspecified site		

Activity History (Hospital Account 18218296)
Show Detail
Posted: 8/27/12

Charges

	Tx #	Svc Date	Procedure	#	Diagnosis	C	Charge	Insurance	Due	
C	791	8/14/12	19301 (CPT®) MAS PAR LUMP LT	1	1	Y	2371.00	2371.00	2371.00	sur
C	792	8/14/12	12035 (CPT®) LAYER CLOSUR 51	1	1	Y	1012.00	1012.00	1012.00	sur

Posted: 8/28/12

Claims

	Payor	Invoice	Form
C	MEDICARE	18032810	Elec SHPB EMDEON 837

Action History (Hospital Account 18218296)

Action Date	Action	Pmt Payor	Adj Code	Tx#	Amount	User

No Action History for this visit

Claim History (Hospital Account 18218296)

Filed	Resubmit	Payor	Plan	Ins	Amount	Payment Date	Pay/Adj Amt
8/28/12		MEDICARE	MEDICARE PART A & B	Y	3,383.00		No Payment On File

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Benefits and Health Administration
Division of Protective Life Insurance Company
PO Box 10807 Birmingham, Al 35202 Toll Free 1-800-866-3808

December 18, 2012

Ivan Zochert
13758 441st Ave.
Webster. SD 57274-5707

RE: Company: Protective Life Insurance Company
Insured: Ivan Zochert
Patient: Lenore Zochert
Policy: D00054903

Dear Mr. Zochert:

This letter is in regards to our phone conversation on December 13, 2012 and your inquiry on claim# LV1C02324-00. Per you policy, the surgical expense benefit is payable in accordance with California Relative Value Schedule with a unit value of $50 for surgical procedures.

At this time the surgery charges were paid according to your policy, with the procedure codes indicated on the surgery bill from Watertown Surgery for services on August 14, 2012.

If you have any questions concerning the above, please do not hesitate to contact us at 1-800-866-3808. We are available Monday through Thursday from 8:00 AM to 5:00 PM CST and on Friday from 8:00 AM to 3:00 PM CST.

Sincerely,

Lia Velez
Benefits Department

EXPLANATION OF BENEFITS

CLAIM OFFICE ADDRESS
PROTECTIVE LIFE INSURANCE CO
P.O. BOX 10807
BIRMINGHAM, AL 35202
1-800-866-3808

CLAIM NUMBER LV1C02098-00

INSURED IVAN E ZOCHERT
PATIENT LENORE K ZOCHERT
RELATIONSHIP SPOUSE

EXAMINER TN S01

POLICY NUMBER 000054903
PLAN I.D. CA CEOSPD
PROTECTIVE LIFE CANCER POLICY
DATE PROCESSED 08/21/2012

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

PROVIDER AND TYPE OF SERVICE	DATE OF SERVICE FROM THRU	AMOUNT CHARGED	AMOUNT EXCLUDED	REMARK CODE	APPLIED TO DEDUCTIBLE	PATIENT COPAY	BENEFIT
WATERTOWN NON-COVERED SERVICE	08/14/12 08/14/12	3,383.00	3,383.00	50			0.00
	TOTALS	3,383.00	3,383.00				0.00

PAYMENT ISSUED

DRAFT/CHECK	BENEFIT	COB AMOUNT	ADJUSTMENT	PAYMENT	PAYEE

EXPLANATION OF REMARK CODE

PLEASE SUBMIT PATHOLOGY REPORT FOR 1ST DIAGNOSIS OF BREAST CANCER
50 PLEASE SUBMIT PATHOLOGY REPORT FOR CANCER VERIFICATION.

Retain for your records. A duplicate of this form cannot be provided.

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IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

SR - 001001

ProtectiveLife 0201

EXPLANATION OF BENEFITS

NJ

CLAIM OFFICE ADDRESS
PROTECTIVE LIFE INSURANCE CO
P.O. BOX 10807
BIRMINGHAM, AL 35202
1-800-866-3808

CLAIM NUMBER LV1C02324-00

INSURED IVAN E ZOCHERT
PATIENT LENORE K ZOCHERT
RELATIONSHIP SPOUSE

EXAMINER TN S01

POLICY NUMBER D00054903
PLAN I.D. CA CE05PD
PROTECTIVE LIFE CANCER POLICY
DATE PROCESSED 11/13/2012

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

PROVIDER AND TYPE OF SERVICE	DATE OF SERVICE FROM	THRU	AMOUNT CHARGED	AMOUNT EXCLUDED	REMARK CODE	APPLIED TO DEDUCTIBLE	PATIENT COPAY	BENEFIT
WATERTOWN SURGICAL BENEFIT	08/14/12	08/14/12	2,371.00	2,071.00	P1			300.00
WATERTOWN SURGICAL BENEFIT	08/14/12	08/14/12	1,012.00	892.00	P1			120.00
TOTALS			3,383.00	2,963.00				420.00

PAYMENT ISSUED

DRAFT/CHECK	BENEFIT	COB AMOUNT	ADJUSTMENT	PAYMENT	PAYEE
10000170	420.00	.00	.00	420.00	IVAN E ZOCHERT

EXPLANATION OF REMARK CODE

P1 CHARGES EXCLUDED EXCEED THE AMOUNT WHICH CAN BE CONSIDERED AS A COVERED CHARGE.

DETACH ALONG DOTTED LINE BELOW AND CASH IMMEDIATELY

Retain for your records. A duplicate of this form cannot be provided.

PROTECTIVE LIFE INSURANCE COMPANY

64-975
612

CHECK NO. 10000170

DATE ISSUED 11-13-2012

PLAN I.D. CA 00CE05PD
CLAIM NUMBER LV1[illegible]
INSURED/PATIENT IVAN E ZOCHERT / LENORE K

VOID VOID VOID

VOID AFTER 90 DAYS

PAY: FOUR HUNDRED TWENTY DOLLARS AND NO CENTS

AMOUNT $********420.00**

TO: IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

VOID VOID VOID

TWO SIGNATURES REQUIRED WHEN AMOUNT IS OVER $25,000

WELLS FARGO N.A.

AUTHORIZED SIGNATURE

SR - 001126

⑈10000170⑈ ⑆061209756⑆ [redacted]

PROTECTIVE LIFE INSURANCE CO
P.O. BOX 10807
BIRMINGHAM, AL 35202
1-800-866-3808

DH4C10665-00

IVAN E ZOCHERT
LENORE K ZOCHERT
SPOUSE

TN S13

D00054903
CA CE05PD
PROTECTIVE LIFE CANCER POLICY
05/13/2013

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

PRAIRIE LAK ROOM - SEMI-PRIVATE	08/14/12	08/18/12	2,265.00	1,945.00 P3		320.00
PRAIRIE LAK NON-COVERED SERVICE	08/14/12	08/18/12	4,035.00	4,035.00	38	0.00
HOME RECOVE HOME RECOVERY BENEFITS	08/17/12	08/18/12	28.58		MO	28.58
PRAIRIE ANESTHESIA BENEFIT	08/14/12	08/14/12	553.00	427.00 P1		126.00
PRAIRIE NON-COVERED SERVICE	08/14/12	08/14/12	280.00	280.00	63	0.00
	TOTALS		7,141.58	6,687.00		474.58

10004311	474.58	.00	.00	474.58	IVAN E ZOCHERT

P3 CHARGES RECEIVED EXCEED THE AMOUNT WHICH CAN BE CONSIDERED AS A COVERED CHARGE.
38 THE BALANCE OF SUBMITTED CHARGES ARE NOT COVERED BY THIS POLICY.
MO ADJUDICATION AND ELIGIBILITY OVERRIDE
P1 CHARGES EXCLUDED EXCEED THE AMOUNT WHICH CAN BE CONSIDERED AS A COVERED CHARGE.
63 POLICY DOES NOT PROVIDE BENEFITS FOR DIAGNOSTIC X-RAY OR LABORATORY CHARGES. PLEASE REFER TO YOUR POLICY FOR PROVISIONS.

PROTECTIVE LIFE INSURANCE COMPANY

64-975
612

CHECK NO. 10004311

05-13-2013

CA 00CE05PD
DH4C10665 00
IVAN E ZOCHERT / LENORE K

FOUR HUNDRED SEVENTY-FOUR DOLLARS FIFTY-SIX CENTS

$********474.56**

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

WELLS FARGO N.A.
X

SR - 001127

⑈10004311⑈ ⑆061209756⑆ [redacted]

PROTECTIVE LIFE INSURANCE CO
P.O. BOX 10807
BIRMINGHAM, AL 35202
1-800-868-3808

LV1C05950-00

IVAN E ZOCHERT
LENORE K ZOCHERT
SPOUSE

TN S01

D00054803
CA CE05PD
PROTECTIVE LIFE CANCER POLICY
08/29/2014

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

PROF BILLIN						
NON-COVERED SERVICE	01/17/12	08/28/12	2,102.00	2,102.00	82	0.00
PROF BILLIN						
NON-COVERED SERVICE	07/10/12	11/27/12	2,551.00	2,551.00	69	0.00
PROF BILLIN						
SURGICAL BENEFIT	07/10/12	07/10/12	549.00	519.00	P1 ,MO	30.00
PROF BILLIN						
NON-COVERED SERVICE	07/17/12	11/20/12	525.00	525.00	81	0.00
PROF BILLIN						
NON-COVERED SERVICE	08/14/12	08/14/12	3,383.00	3,383.00	76	0.00
	TOTALS		9,110.00	9,080.00		30.00

10013216	30.00	.00	.00	30.00	IVAN E ZOCHERT

PREVIOUSLY CONSIDERED CL# LV1C0232400
82 THESE CHARGES ARE PRIOR TO THE PATHOLOGY REPORT WE HAVE ON FILE. PLEASE SUBMIT A PATHOLOGY REPORT FOR THESE CHARGES.
69 OFFICE VISITS, LAB WORK, XRAYS AND/OR NON-CHEMOTHERAPY DRUGS ARE NOT COVERED. PLEASE REFER TO YOUR POLICY FOR PROVISIONS.
P1 CHARGES EXCLUDED EXCEED THE AMOUNT WHICH CAN BE CONSIDERED AS A COVERED CHARGE.
MO ADJUDICATION AND ELIGIBILITY OVERRIDE
81 THIS TYPE OF EXPENSE IS NOT COVERED BY YOUR POLICY. PLEASE REFER TO POLICY PROVISIONS

PROTECTIVE LIFE INSURANCE COMPANY

64-975
612

CHECK NO. 10013216

08-29-2014

CA 00CE05PD
LV1C05950 00
IVAN E ZOCHERT / LENORE K

THIRTY DOLLARS AND NO CENTS

$*********30.00**

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

WELLS FARGO N.A.
X

SR - 001128

⑈10013216⑈ ⑆061209756⑆ [redacted]

PROTECTIVE LIFE INSURANCE CO
P.O. BOX 10807
BIRMINGHAM, AL 35202
1-800-866-3808

LV1C05950-01

IVAN E ZOCHERT
LENORE K ZOCHERT
SPOUSE

TN S01

D00054903
CA CE05PD
PROTECTIVE LIFE CANCER POLICY
08/29/2014

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

PRAIRIE LAK							
NON-COVERED SERVICE	07/05/12	07/05/12	351.00	351.00	63		0.00
SANFORD HEA							
NON-COVERED SERVICE	07/18/12	07/18/12	1,024.00	1,024.00	69		0.00
PRAIRIE LAK							
NON-COVERED SERVICE	07/24/12	07/24/12	3,501.00	3,501.00	70		0.00
PRAIRIE LAK							
HOSPITAL-INTENSIVE CARE	08/31/12	09/02/12	5,112.00	4,512.00	MD		600.00
PRAIRIE LAK							
ROOM - SEMI-PRIVATE	08/31/12	09/07/12	4,704.00	3,584.00	P3		1,120.00
PRAIRIE LAK							
NON-COVERED SERVICE	08/31/12	09/07/12	2,280.00	2,280.00	38		0.00
	TOTALS		16,952.00	15,232.00			1,720.00

10013217	1,720.00	.00	.00	1,720.00	IVAN E ZOCHERT

ICU PAYS FROM 2ND DAY, REDUCES 50% AFTER AGE 65
63 POLICY DOES NOT PROVIDE BENEFITS FOR DIAGNOSTIC X-RAY OR LABORATORY CHARGES. PLEASE REFER TO YOUR POLICY FOR PROVISIONS.
69 OFFICE VISITS, LAB WORK, XRAYS AND/OR NON-CHEMOTHERAPY DRUGS ARE NOT COVERED. PLEASE REFER TO YOUR POLICY FOR PROVISIONS.
70 DIAGNOSIS DOES NOT APPEAR TO BE CANCER RELATED. PLEASE REFER TO YOUR POLICY FOR PROVISIONS.
MD ADJUDICATION AND ELIGIBILITY OVERRIDE
P3 CHARGES RECEIVED EXCEED THE AMOUNT WHICH CAN BE CONSIDERED AS A COVERED CHARGE.

PROTECTIVE LIFE INSURANCE COMPANY

64-975
612

CHECK NO. 10013217

08-29-2014

CA 00CE05PD
LV1C05950 01
IVAN E ZOCHERT / LENORE K

ONE THOUSAND SEVEN HUNDRED TWENTY DOLLARS AND NO CENTS

$******1,720.00**

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

WELLS FARGO N.A.
X

SR - 001129

⑈10013217⑈ ⑆061209756⑆ [redacted]

PROTECTIVE LIFE INSURANCE CO
P.O. BOX 10807
BIRMINGHAM, AL 35202
1-800-866-3808

LV1C05950-02

IVAN E ZOCHERT
LENORE K ZOCHERT
SPOUSE

TN S01

D00054803
CA CE05PD
PROTECTIVE LIFE CANCER POLICY
09/02/2014

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

HOME RECOVE				
HOME RECOVERY BENEFITS	09/08/12 09/14/12	100.00		100.00
TOTALS		100.00		100.00

10013232	100.00	.00	.00	100.00	IVAN E ZOCHERT

PROTECTIVE LIFE INSURANCE COMPANY

64-975
612

CHECK NO. 10013232

09-02-2014

CA 00CE05PD
LV1C05950 02
IVAN E ZOCHERT / LENORE K

ONE HUNDRED DOLLARS AND NO CENTS

$********100.00**

IVAN E ZOCHERT
13758 441ST AVE
WEBSTER, SD 57274-5707

WELLS FARGO N.A.
X

⑈10013232⑈ ⑆061209756⑆ 2079980003596⑈

SR - 001311
ProtectiveLife 0035

Comments Information

Comments:

spoke with Mr. Zochert he had difficulty hearing asked that I respond in a letter to the explanation of benefits he received, he does not understand how the claim was paid. verified aos, he is also sending in additional bills
12/13/2012 10:49:14 AM Comments By: Lia Velez

---

called and spoke to Mr. Zochert , he was not at home asked that I call back tomorrow around 8 am
12/12/2012 2:28:42 PM Comments By: Lia Velez

---

please call back to discuss recent claim. gentleman is elderly and wasn't able to discuss much said he had a question about the P1 code on the letter he was sent. could not go over the letter because not in AX. please call to discuss
12/12/2012 12:49:30 PM Comments By: Justin Deas

Tracking Information

Created By:	Justin Deas
Created On:	12/12/2012 12:49:29 PM
Closed By:	Lia Velez
Date Received:	12/12/2012
Date Into Group:	12/12/2012
Date Completed:	12/13/2012
EFT:	No
Sent to Reinsurance:	No
Reviewed by Reinsurance:	No

CI: CA GROUP: 00CE05PD NOTES MAINTENANCE TOTAL PAGES:001
FUNC: REC ID: PA KEY: D00054903WLENORE TYPE: PAGE: 00
B/L: XFER: OPTIONS:
NOTE TEXT: MEMBER: IVAN E ZOCHERT
RCVD CLAIM 091712 FOR DX:174.....NEED PATH, PROCESSED AS NCS 50.....LV 092112

RCVD PATH ABLE TO REPROCESS CLAIMS RCVD 091712.....LV 111312
PATH 081412-LT BREAST - INVASIVE DUCTAL CARCINOMA DX:174.....LV 111312
8/14/12 PARTIAL MASTECTOMY LT BREAST..DH 5/13/13
SPOKE W/VICKIE AT PRAIRIE LAKES HOSP. WHO VERIFIED INSURED WAS CONFINED FROM 8-14 @ 11:35 AM AND RELEASED 8-16 @ 13:10 PM I AM PAYING FOR 2 DAYS CONFINEMENT .....DH 5/13/13

WINDOW ID: WINDOW:
RECORD SUCCESSFULLY CHANGED

EXHIBIT tabbies 82
SR - 001579

Date: 5/13/2013 Time: 2:04:42 PM

SANFORD HEALTH

REFER TO 500 53805

Sanford Clinic Watertown
901 4th Street NW
Watertown, SD 57201-1558

PRSRT AUTO
FIRST-CLASS

US POSTAGE $00.35⁰
OCT 24 2012
ZIP 57201
0901 1052422

Protective Life Insurance Co
PO Box 10807
Birmingham AL 35202

HAUQS5B 35202

SR - 001003

Protectivel ife 0204

PRAIRIE LAKES HEALTHCARE SYSTEM, INC
DEPARTMENT OF SURGICAL PATHOLOGY
401 9TH AVE NW
WATERTOWN, SD 57201
605-882-7750

PATHOLOGY REPORT

Patient Name: ZOCHERT LENORE K
DOB: [redacted]
ORDER PHY: CHRISTENSEN ALAN
ADMIT DATE: 08/14/12
RECEIVED DATE: 08/14/12 11:40

AGE: 81 SEX: F
STAY TYPE: O/P

ACCT NUMBER: 484558
MR NUMBER: 064251
ADMIT PHY: CHRISTENSEN ALAN
DISCH DATE:
ORDER NUM: 37807

Unsigned Transcriptions represent a preliminary report and do not represent a medical or legal document

ACCESSION NUMBER: S12-1208

RECEIVED
AUG 15 2012

FINAL DIAGNOSIS:

LEFT BREAST (LUMPECTOMY) - Invasive ductal carcinoma, nuclear grade 3, overall grade 2 of 3 with apocrine features and extracellular mucinous component.
- **Tumor measures 2.3cm (single slide measurement).**
- **No angiolymphatic invasion identified.**
- **Inked surgical margins negative for malignancy.**
- **Minimal radial margin at least 1 cm from inked posterior (deep) margin.**
- **Adjacent fibrocystic changes.**
- **AJCC pathologic stage - pT2 pNX.**

CH

CLINICAL DIAGNOSIS & HISTORY: Left breast mass.

TISSUE SOURCE: Left breast tissue (lumpectomy) (formalin added @ 0948)

GROSS DESCRIPTION: A fragment of breast tissue designated left measures 17.2 x 15.5 x 3.5 cm. Located on the anterior surface of the specimen is a 15.3 x 8.7 cm ellipse of generally unremarkable tan skin without nipple. A mass is vaguely palpable in the midportion of the specimen. A surgical suture indicates the superior margin of the specimen. The specimen is oriented and marked using the following color code: superior margin blue ink, deep margin black ink, inferior margin green ink. Serial sections display areas of dense, white, fibrous tissue intermixed with yellow adipose. Located in the midportion of the specimen is a previous biopsy site and residual mass measuring approximately 2.4 x 2.2 x 1.7 cm. The tumor appears to approach within 1 cm of the inked deep (posterior) resection margin. No additional tumor masses are identified. Representative sections are used following the key code: cassettes A - H sections of tumor, cassettes I, J and K closest posterior (deep) inked margin to tumor, cassette L random sections breast parenchyma.

Located in the same container is an additional irregular ellipse of tan skin and underlying subcutaneous fat designated lateral ellipse measuring 2.8 x 2.5 x 0.7 cm. The skin and fat are both unremarkable.

MICROSCOPIC DESCRIPTION: Sections of breast tissue display invasive ductal carcinoma. Tumor consists predominantly of solid nests of tumor cells with generous eosinophilic cytoplasm. No tubule formation is present. Moderate nuclear pleomorphism is present with generally prominent eosinophilic nucleoli. Mitotic activity is low with less than 5 mitotic figures per 10 high powered field found in the most active areas. Minimal peritumoral lymphocytic proliferation is evident. No angiolymphatic invasion is appreciated. Tumor displays a minor extracellular mucinous component. Sections of random breast tissue show benign fibrocystic changes. Inked surgical resection margins are negative for malignancy.

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STATE OF SOUTH DAKOTA | IN CIRCUIT COURT

COUNTY OF MOODY | THIRD JUDICIAL CIRCUIT

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert,
Plaintiff,

vs.

Protective Life Insurance Company,
Defendant.

50CIV14000061

SECOND DECLARATION OF ELLIOTT S. FLOOD

Elliott S. Flood, being first duly sworn, on oath states the following:

Declaration of Elliott S. Flood

1. **Scope of engagement.** I have been engaged to provide my expert opinions on insurance industry customs and practices as they may apply the handling of the Zochert claim, which may be useful in assessing the reasonableness of the insurer's conduct. I use the terms "customs and practices," and "industry standards" to refer to the ordinary, customary standards of business practices that are generally accepted by insurers as necessary for the proper handling of claims. If I state an opinion on whether an insurer followed industry customs, practices or standards, I am analyzing whether or not the insurer's practices deviated from the norms of what the industry teaches as necessary for the proper handling of claims.

2. **Purpose of this declaration.** This is a limited declaration intended to describe my expert opinions to the extent they have been developed based on existing documentation. If further documents are produced, I may supplement my opinions in a future report.

3. **Experience and fees.** I have 30 years of experience with insurance industry standards, customs and practices. Early in my career, I worked as a defense attorney for major insurers, as well as insureds. In 1997 I left law practice to work for an insurance company client, which lasted 14 years. At first, I served as vice president of the special investigations department, where part of my job was to give expert testimony about industry customs and practices on behalf of the insurer. After that until I retired from the industry, I held the position of senior vice president of internal audit, examining my company's business practices for compliance with industry standards. Finally, I retired from the insurance industry in 2011, and since that time I have been a consultant and expert witness on insurance standards, customs, and practices. My time spent on this matter is being billed at $350 per hour. See Appendix A for my qualifications and C.V., and Appendix B for my testimonial history.

4. **Materials relied upon.** The documents that I have reviewed and relied upon are described in Appendix C.

5. **Appendices.** The attached Appendices are an essential part of my testimony, and are incorporated herein by reference.

6. **General claim handling practices.** Appendix D contains excerpts from adjuster education and insurance industry textbooks. These and similar materials are used by insurance companies and regulators to ensure that adjusters are adequately trained in the principles of proper claim handling.

7. **The Zochert policy contains a broad grant of coverage.** In my review of the cancer insurance policy issued to the Zocherts, I noted that it promises to pay expenses incurred for cancer treatment, stating that "Such expenses will consist of actual charges by the Hospital, Physician, or other providers subject to the limitations stated herein." This is a typical statement of what is customarily referred to in the industry as a broad grant of coverage. The phrase "broad grant of coverage" is a term frequently used by the industry in teaching claims handlers about insurance policy coverage. Essentially, as used in the literature, a "broad grant of coverage" is used to refer to a general promise to pay, subject to listed exclusions or limits. Claims handlers are taught that when a policy makes a broad grant, all losses falling under that grant must be paid, unless the insurer has clearly shown that a specific exclusion spelled out in the policy applies. I would expect an adequately trained claim handler to pay all claims falling under the broad grant, subject only to the stated limits. If a limitation is not clearly stated in the policy, it should not be applied. Likewise, I would expect an insurer which automates bill payment to ensure the computer system is programmed to properly pay in accordance with the insurance policy, and not to program limits and exceptions not appearing in the policy.

8. **Exclusions and limits are customarily interpreted by insurers to favor the insured.** If there are any doubts about the policy exclusions caused by poor wording of the policy, they are customarily resolved in favor of covering claims. Appendix E, which contains samples from the insurance business literature for adjusters, demonstrates that deciding ambiguous policy language in favor of the insured is one of the customs and practices taught to adjusters about how to properly handle claims. An insurer adjusting claims in good faith will train its adjusters to apply this approach, and not allow them to make self-serving interpretations against the insured's interests. Neither will an insurer program its bill payment systems to apply exclusions or limitations in a self-serving manner that takes advantage of ambiguities in the policy. An example of such a bad faith practice would be to apply exclusions and limits that are not clearly spelled out in the policy. The company must not allow its staff or computer systems to apply internal policies and procedures that are not clearly listed in the policy. Applying ambiguous terms in the policy in the insurer's favor lead to the denial of several claims that fell within the broad grant of coverage.

9. **Claim properly filed, per instructions.** After his wife's cancer surgery, Mr. Zochert filed the claim form sent to him by Protective. Following Protective's instructions, Mr. Zochert attached a Physician Statement signed by the surgeon, a medical release, and a bill for breast cancer surgical expense for $3,383. The physician statement stated the date of first cancer diagnosis was July 11, 2012, and that Mrs. Zochert was admitted for her surgery on

August 14, 2012. The bill also reflected that she had her cancer surgery on August 14, 2012. These document were all received by Protective on September 17, 2012, as is shown by the date stamp on their records. A copy of the envelope that Mr. Zochert mailed is also in Protective's file.

10. **Mr. Zochert forced to adjust own claim, to his prejudice and Protective's advantage.** After Protective received the claim, it determined that a pathology report diagnosing cancer was not included in the packet of documents. Rather than using its medical authorization to obtain that record from the surgeon, Protective denied the claim with an EOB that stated only "Non-covered service" and "please submit pathology report." The statement "non-covered service" is false. Everything submitted to Protective at that date indicated a covered service. Any reasonable insurer would know that a surgeon would likely not perform a mastectomy for cancer unless the patient had a diagnosis of cancer, which means he has a copy of the pathology report. In fact, the surgeon indicated in the physician's statement that the initial diagnosis was July 11, a month before the surgery. And, the initial pathology report indicating cancer was indeed in July.

11. When Mr. Zochert had the hospital send Protective the second pathology report, which was performed on the day of the surgery, Protective should have known that this was the wrong report. This is the effect of shifting the burden of adjusting claims to the insured, who is not trained or knowledgeable about insurance claims. Protective later took advantage of this, alleging that the date of diagnosis was August 14 and denying payment for services prior to 10 days before August 14. Any reasonable claim handler would know the first diagnosis was not on the same date as the surgery, especially given the initial claim forms correctly indicated the date of diagnosis was in July. Even under Protective Life's narrow interpretation of the grant of coverage, if the claim handler would have investigated properly, they would have found bills for services that were covered under the policy for in-hospital room and board, anesthesia, intensive care, and doctor's visits. Only after being questioned by an attorney who read the policy and identified coverage did Protective Life pay for these things, nearly two years after they were due. This is contrary to the policy language. As soon as Mr. Zochert provided notice of a claim, the pathologist's proof of cancer, and a signed medical release authorization, Protective Life had a reasonable opportunity to investigate his claim. Under the time for payment of claims provision, Protective knew or should have known that Mr. Zochert was owed "all benefits then due under this policy." However, he was not paid "all benefits then due under this policy."

12. Initially, Mr. Zochert was only paid the benefits that he happened to stumble on bills for and that is where it was left. Mr. Zochert hired an attorney to read his policy and obtain his medical records, bills, and apply the coverage provisions to the loss. Had he not hired an attorney, Protective Life would have kept the money that was rightfully owed on this claim, creating a windfall for Protective Life. Protective Life had been paid for this investigative service for about 22 years. Then, when cancer struck his wife, Protective Life effectively made him hire an attorney to do their job.

13. **Pattern of passive claim handling continued**. Any reasonable insurer would know that the "surgical expense" bill of $3,383 would not be the only bill associated with the cancer – it was just the first of several. In addition to the surgeon's bill, there will inevitably be other bills, such as charges for the hospital, biopsies, etc. As will be discussed below, throughout the course of the claim, Protective continued to take a totally passive approach, shifting the entire burden to Mr. Zochert to obtain and submit the billing and supportive medical records.

14. **Inadequate Explanation of Denial.** Of the amount billed for the surgery, $3,383, Protective paid $420 and denied the rest. The explanation of the denial stated only: "Charges excluded exceed the amount which can be considered a covered charge." This explanation does not comply with industry standards requiring an explanation of what policy exclusion is being applied. The insured is at a disadvantage, because there is no way for the insured to read the policy provision that the insurer is relying on to deny his claim and know what the basis for denial is. In fact, it is customary for insurers to cite the provisions of the policy so that the insured knows what part of the policy excludes benefits. The inadequacy of the explanation is aggravated because Protective knew (per their internal notes) that Mr. Zochert "is elderly and wasn't able to discuss much," "had difficulty hearing," and "he does not understand how the claim was paid." Protective wrote a letter to Mr. Zochert on December 18, 2012. The letter stated "the surgical expense is payable in accordance with California Relative Value Schedule with a unit value of $50 for surgical procedures." This explanation is still inadequate, and any reasonable insurer would know that it was inadequate. The codes used in the bill were 19301 and 12035, which were not listed in anywhere in the policy. Therefore there was no express limitation for surgical benefits other than the maximum surgical benefit of $2,500, which should have been paid rather than only $420.

15. **Another inadequate explanation of denial.** As a result of Protective's conduct of the claim, Mr. Zochert sought the help of a lawyer, who wrote to Protective to ask for an adequate explanation. After consulting with a manager, Protective wrote back that it paid under code 19301 but did not need the codes spelled out in the policy, and the codes given "are for reference only and meant as examples." This is still a non-responsive answer.

16. **Additional bills denied without adequate explanation.** As mentioned above, there would be additional bills. Three additional bills, plus supporting medical records, were submitted to Protective on May 9, 2013. Protective denied the vast majority of these charges.

    - $6,300 from the hospital (Prairie Lakes) for the room charges, pharmacy and pathology. Protective paid only $320 of this amount for room charges, and denied all the other services. (Protective 0411).

    - $260 from Dr. Edward Wegner for pathology related physician services. Protective paid nothing (Protective 0413).

- $553 from Dr. Keith Wanner for anesthesia related physician services. Protective paid only 126.00, but only after prodding from the insured. (Protective 0412).

When asked to explain these denials, Protective sent an email on August 26, 2013 that stated: "we have processed the room and board benefits" and "We have not processed any Attending Physician Benefits because we have yet to receive any itemized bills." This explanation is inadequate and misleading. First, I found itemized bills in the file which were date stamped May 9, 2013. Second, it totally does not even attempt to explain why only the room charges were paid, while denying all other charges on the hospital bill. Finally, it does not explain the reduction in the physician bills.

17. **Misleading statements about claim handling practices.** When protective was again asked to explain how it determined the claims and whether it had requested itemized billings from physicians, it responded that it had not requested billings, as "it is the insured's responsibility" and that "benefits eligibility is based on itemized bills submitted for review by the insured or providers." Throughout this claim file, I saw Protective make similar statements. Another example is "The policy does not contemplate that Protective Life will communicate directly with the health care provider."[1] This is not only contrary to industry practices, but the file notes show that Protective actually called the hospital and spoke with them to verify that Mrs. Zochert was there for 2 days. This puts some context around Protective's contention that it does not need to investigate claims, implying that the burden is on the insured to contact providers. Of note, contacting providers is the sole purpose for the medical authorization obtained by Protective in the beginning.

18. **Unreasonable refusal to provide California Relative Value Schedule.** When the insured pressed again for an adequate explanation, Protective that it "cannot provide you with any page for the California Relative Value Schedule, when our system was first set up, out IT department programmed these into our system to calculate benefits." Protective had already said the codes for the surgical bill were not in the policy, but now it refuses to provide anything. This violates industry customs and practices for explaining reasons for denial. Further, the policy itself even says that Protective will "glad" to furnish this on codes not given in the policy examples. It is not an excuse that the computer was programmed by another department. Refusing to provide the reason for denial is universally considered an unfair claim practice and is truly shocking to see.

19. **Protective again refuses to pay the surgical bill in full, continues to ignore other bills.** After its initial refusal, and upon being pressed by the insured, Protective ultimately provided the California RVS. In April 2014, after finally being provided access to the California RVS, the insureds lawyer wrote "Procedure Code 19301 appears to be a procedure with a unit value determined by report" which would mean that it would be determined by the physician report rather than a stated relative value. Protective had asserted back in November 2013 that 19301 had replaced another code that they used in the computer. If stated correctly, that would not make sense, since the code on the bill, 19301

1 William McCarty letter of August 13, 2014 to insured's lawyer.

was still valid. Further, it does not matter, since, as discussed above, the policy has no reference to the billed code. It would be apparent to any reasonable claim handler that ambiguities abound, and since the surgical maximum of $2,500 is clearly exceeded, that $2,500 should have been paid. During this time frame, Protective continued to ignore the other bills.

20. **Additional bills and records provided to Protective.** On July 21, 2014, the insured's lawyer sent a letter to protective stating that he would be filing suit and that he wanted to speak with Protective's legal counsel. Attached to the letter was a spreadsheet listing the bills and amounts paid, which included bills that had previously been submitted to protective and other outstanding bills. Protective responded by asking for the initial pathology report and the additional bills. As discussed above, Protective should have known about the initial pathology report. It was disingenuous for Protective to state, as it did in its July 29 email, that "in this case, we did not know until you referenced some bills that there was a biopsy performed prior to the date of the pathology report we had previously been sent." Note that the pathology report was the one ON THE SAME DAY as the surgery. See above discussion about the absurdity of this position. On August 4, 2014, the insured provided the initial pathology report and the additional bills. On August 13, Protective's again contended that that the burden is on the insured to contact providers and provided relevant medical records, contrary to industry practices. See above discussion.

21. **Protective denies the bulk of the additional bills, again without adequate explanation.** On August 29, 2014, Protective issued payment of $1,750 on billing of over $16,000, mostly without adequate explanation. (The January 2012 date of service was denied for being more than 10 days prior to diagnosis, which is an adequate explanation, with most of the other items being of the class "refer to your policy").

22. **Denial of claim without adequate investigation.** Insurers must investigate claims. A claim must not be denied for "lack of documentation" when the reason for the lack of documentation is the insurer's failure to investigate. This is a basic industry standard. In order to adequately investigate, insures must seek out and make reasonable efforts to obtain documents concerning a loss. A primary job function of claim handlers is to help the policy holder identify coverage and what triggers coverage. My review of the file indicates that Protective has failed to carry out these basic industry standards. For example: "we don't investigate a claim" Turner at p 15 l 8; "We don't go out and look for bills. We expect insured to send in their bills. Velez p. 18 l. 10; Protective never contacts healthcare providers to get the bills that would tell them what codes to pay with p. 20 l. 1-4. Despite knowing there are benefits that cancer stricken policy holders qualify for, particularly after a diagnosis of cancer has been made along with a hospitalization, claim handlers do not help policy holders identify other coverages within their policies. See Valez Depo at pp. 50-52. At some point in time Protective Life told claim handlers that if there were bills and charges that were illegible, they should deny the whole claim, make a phone call and send a letter. Then, the claim manager struck out "make a phone call and send a letter" which effectively relieved the claim handlers of doing exactly the kind of investigation that

insurers are supposed to do. See Bates p. 2955. This document comes from what Protective Life calls the cancer insurance claim handlers "Bible."

23. **Inadequate Training and Material Access.** Claim handlers are supposed to be trained to properly handle insurance claims. That is the business of Protective life and what is required under industry standards and norms, as well as under every state's laws, regulations. Protective Life has adopted a wide range of corporate policies, including social media, lactation policy, and what printer claims handlers are allowed to use - but no clear training manual or system to assist claim handlers process cancer insurance claims properly. See for example, Velez p. 64 l. 21-24; p.65 l 4-11.

24. **Insurer automated claim handling systems.** Computer automation of claim handling process is a common industry practice, but insurers must ensure data is correctly inputted to their systems, and that systems are correctly programmed to properly calculate payment of claims. Apparently, Protective's bill payment system did not utilize the correct procedure codes the physician used to describe the surgery and instead the claim handler/software utilized procedure codes that were not identified in the policy – codes different that utilized by the physician. This lead to the underpayments, because the correct procedure code had a qualifier, "BR" or "By Report," which meant that the value of the procedure could vary case-by-case. Neither the claim handler nor the system accounted for anything included in the physician's report, and instead, used a different procedure code than what the physician used for billing.

25. **Misapplication of policy qualification period.** Protective misapplied its policy qualification period, which was from "10 days preceding diagnosis" to "date of diagnosis," resulting in improper denial of diagnostics that policy holders must undergo to diagnose cancer. See Valez pp. 70 – 71.

26. **Improper audit process.** All reasonable insurers audit their claim payment to ensure that they promised benefits are delivered accurately and on time. Protective's auditing only consisted of those bills that were submitted to the insurer instead of everything that was owed under the policy. The audit process should look at the policy, the loss, and make sure the loss was fully paid. Instead, the insurer only looks at what was paid and makes sure the payment was adequate for what was in the file. Meanwhile, the audits do not look at denied claims, the auditors only look at paid claims. Basically, the audit process guarantees that only those bills that the insured obtains, identifies coverage, and submits will (sometimes) get paid. By not auditing whether a claim is properly investigated, or whether a claim handler corresponds with a medical provider, Protective Life creates a situation where the claim handlers are not judged on some of the most important tasks in getting a loss correctly paid.

27. **Medical authorizations and proofs of loss.** The reason insurers obtain medical authorizations is to enable them to obtain confidential records from physicians to substantiate claims. Proofs of loss forms are customarily obtained as well, to substantiate claims. Protective requires a medical authorization and proof of loss when a claim is filed,

but then does not use the authorizations to conduct a medical investigation. This confuses policy holders - the policy holders think they are going to get their claim processed. Protective Life then does nothing with the releases and the insured is left with cancer, bills, and few if any benefits under their cancer insurance policy.

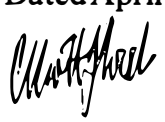
28. **Pay for performance incentives.** Protective incentivized its claim handlers to conduct passive investigations, to avoid any active investigation and only pay what provided to their file — not to look for other bills for covered services.

29. **Protective's corporate performance goals.** Tracking "corporate performance," while connecting that performance and audit results to claim handler and claims manager bonuses creates corporate culture where claim handlers investigate in a passive manner, to the detriment of claimants and to the profit of the company - not actively investigate claims, not help identify coverage for insureds, not tell policy holders exactly what documentation to get that is necessary to pay their claims. These incentive have lead to the underpayment of hundreds of insurance claims. Managers are rated based on their employees performance and given bonuses under the EIP, Employee Incentive Plan. The funding of that plan is based on corporate performance. Ultimately, if claim handlers were actively investigating claims, they would be finding many more bills to pay. That would cost the company money and ultimately reduce the amount of money that employees are paid because the EIP program would not be as fully funded. This corporate culture is passed on from top down through daily huddles that give undue focus to inadequate audit process and during other times like annual reviews.

30. Even after deficiencies are brought to the claim manager's attention through letters, emails, and eventually a lawsuit, the claim manager who oversees all the claim handlers and all the claims, does not know whether the Zochert claim was handled properly.

31. **Conclusion.** The primary job of the claim handler is to assist the insured obtain benefits, not to obstruct their recovery. The reader is invited to read Appendix D, and compare the high standards of professionalism that is taught to claim handlers with the conduct of Protective in this claim. You will find they come up short. Here, I noted multiple instances of behaviors that are contrary to industry standards – the claim handling was full of obstruction and neglect, as discussed above.

Dated April 17, 2017.



Elliott S. Flood
Elliott S. Flood Company
8300 Adirondack Trail
Austin, TX 78759
512.215.0596

STATE OF SOUTH DAKOTA
COUNTY OF MOODY

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert, Plaintiff,	No. 50CIV14000061
vs.	
Protective Life Insurance Company, Defendant.	

Videotaped Deposition of:

DEBRA L. TURNER

Taken on behalf of the Plaintiff

November 9, 2016

CLEETON DAVIS COURT REPORTERS, LLC
402 BNA Drive, Suite 108
Nashville, Tennessee 37217
(615) 726-2737
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answer.

THE WITNESS: I -- I don't know. I mean, I don't know if they are like any other business.

BY MR. CULHANE:

Q. Well, there's a lot of, kind of, special rules that help protect policyholders in the insurance business, isn't there?

A. Yes, where we have to have -- you know, process a claim within a certain amount of time.

Q. Some other ones too?

A. Yeah.

Q. For example, one of the most basic rules is that an insurance company must treat the policyholder's interests with equal regard as it does its own interests?

A. Right. We pay all the claims the same.

Q. I mean, an insurance company can't put its own interests ahead of the policyholder's interests, can they?

A. No, I never would.

Q. And that's a violation, that would be a violation of insurance standards that protect policyholders?

MS. WEBER: Object to form. You can answer.

THE WITNESS: Yes.
BY MR. CULHANE:
Q. In addition to that, insurance companies are supposed to assist policyholders with claims, aren't they?
A. Yes.
Q. I mean, part of what policyholders buy when they get an insurance policy is not only coverage, but also service?
A. Correct.
Q. And, in addition to that, when the premiums are paid, those premiums actually prepay the insurance company to investigate claims?
MS. WEBER: Object to form.
BY MR. CULHANE:
Q. Don't they?
A. Yes.
Q. That's part of the service, providing a full and fair investigation when the claims are made?
A. To process the claim according to the policy, yes.
Q. Well, and part of processing includes investigation, though, right?
MS. WEBER: Object to form.
THE WITNESS: It involves reviewing the

THE WITNESS: Yes.
BY MR. CULHANE:
Q. And when an insurance company is conducting an investigation, that means they must look for reasons to support paying claims, not just reasons for denying claims?
A. I'm not real sure where you are going with investigation, because we don't investigate a claim. We review the bill that we receive from the insured against the policy to determine the payable amount.
So I'm not really sure what you mean by "investigation." If you can explain that, that would help.
Q. Well, the insurance company has to -- they are being prepaid by the policyholder every month when every policyholder pays premiums to provide service, right?
A. Correct.
Q. And that service includes providing investigation when a claim is made?
MS. WEBER: Object to the form.
Are you now talking about cancer or are you talking about life, or are you talking about all insurance --
THE WITNESS: Right.

A. Yes.
Q. Claim departments are not supposed to be used as insurance company profit centers, are they?
A. No.
Q. And all claims decisions should be made without regard to the effect on company profitability?
A. Correct.
Q. Ultimately the policy, the insurance policy contains the entire agreement or promise between the insurance company and the policyholder?
A. Yes.
MS. WEBER: Object to form.
BY MR. CULHANE:
Q. And in the insurance industry most states require that insurance companies implement reasonable standards to promptly complete claim investigations and settlement of claims arising under its policies?
MS. WEBER: Same objection. You can answer.
THE WITNESS: Yes.
BY MR. CULHANE:
Q. And insureds or policyholders shouldn't have to hire a lawyer to get their insurance claims paid, should they?
A. No, they shouldn't.

A. I mean, it's customer service. You --
Q. Well, unlike other customer service, with the promise of an insurance policy, there actually comes with it the duty of good faith, isn't there?
MS. WEBER: Object to form. Object to the extent you are calling for a legal conclusion from this nonlawyer witness.
You can answer.
THE WITNESS: Ask me again. I'm sorry.
BY MR. CULHANE:
Q. The policyholder is buying a friend; they are buying good faith when they by an insurance policy, aren't they?
MS. WEBER: Object to form.
THE WITNESS: They are buying an insurance policy, and they are buying a company that would stand behind that insurance policy.
BY MR. CULHANE:
Q. It's not an adversarial process, just pay the claims, what's owed, no more, no less?
A. Correct. That's what they are paying for.
Q. Okay. Well, no, I just want to lay some groundwork to make sure we are on the same page.
A. Okay. Yeah.
Q. I'll take that back from you. Thank you.

Q. Protective Life tracks their average claims made, don't they?
A. Yes, I believe so, looking at that.
Q. Well, when claim handlers are evaluated, they are evaluated in terms of their accuracy to the averages, right?
MS. WEBER: Object to the form. You can answer.
THE WITNESS: They are audited on their accuracy of payment of the claim.
BY MR. CULHANE:
Q. In terms of whether -- and we went through that kind of exhaustively. But in terms of whether the bill in the file gets paid or not paid, right?
A. Correctly, right.
Q. And that's the extent of what they are audited on?
A. Yes.
Q. They are not audited on whether they investigated the claim?
A. No. They are audited on how they paid the claim, if they paid it correctly.
Q. And they are not audited on whether or not they called the doctor's office or the hospital?
A. No.

Q. Just take a look at those pages for me.
A. Okay.
Q. The yellow stuff is I -- is what I've added.
But what --
A. On 2014, 2015.
Q. Is this the same software that would have been used at the time that the Zochert claim happened?
A. I'm not sure.
Q. Well, either way --
A. I --
Q. Oh, sorry. Go ahead.
A. I'm not sure.
Q. The audit results themselves, the audit, the questions like: Is the payee correct, is the payee's address correct, was PNI/PTO updated, is the provider tax ID correct, was the correct dollar amount paid, was the correct letter sent, all of those questions that show up on 3201, 3205 and 3206, those are all questions that you asked as an auditor before, right?
A. Yes.
Q. But is there any other questions or is there anything else to these audits besides these questions?
A. No. That's the audit.
Q. And you never audit your claim handlers on whether they tell a policyholder that there might be

additional benefits under their policy?
A. No.
MS. WEBER: Object to form.
BY MR. CULHANE:
Q. Have you ever given testimony before?
MS. WEBER: You can answer.
THE WITNESS: Have I ever done -- ever done depositions before?
BY MR. CULHANE:
Q. Yeah.
A. Yes.
Q. Or trial?
A. Depositions, yes.
Q. Regarding your cancer policies?
A. No.
Q. Well, were they regarding life claims?
A. Yes.
Q. Was there anything else they were about?
A. No.
Q. And so at Protective Life I showed you the employee incentive plan at page 3175. I also want to show you some other plan -- or some other policies at Protective Life. There's a lot of them, aren't there?
THE WITNESS: I don't know.
MS. WEBER: Object to the form.

BY MR. CULHANE:

Q. It's not defined anywhere, is it? "Treatment" is an undefined term in that policy, isn't it?

A. I don't know.

Q. You are on the claim committee that makes determinations of whether people with cancer deserve benefits or not under their policy that some of them may have paid for for over 20 years, you are in charge of the entire claim department that handles all the cancer claims at Protective Life, and you don't know whether "treatment" is defined in the policy?

A. No, I don't know.

Q. And this is all on top of the fact that the CE 21 endorsement specifically includes -- if there was any question, it specifically includes, "We will also pay up to $250 per calendar year for physical exams, laboratory tests, diagnostic tests, and consultations related to such treatments"; isn't that right?

A. Yes, if we receive the bills. And also on that endorsement it has about the radiation and chemo treatment.

Q. Well, that's extra too, isn't it?

A. It's not extra. It's changing the original policy.

Q. Well, when that changed the original policy,

STATE OF SOUTH DAKOTA
COUNTY OF MOODY

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert,	)	
Plaintiff,	)	No. 50CIV14000061
vs.	)	
Protective Life Insurance Company,	)	
Defendant.	)	

Videotaped Deposition of:

LIA M. VALEZ

Taken on behalf of the Plaintiff

November 9, 2016

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Nashville, Tennessee 37217
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MS. WEBER: You have to answer out loud.
THE WITNESS: Yes.
BY MR. CULHANE:
Q. So even though you had that right in front of you, you still opted to go with an August 14 date?
A. We went with the date the pathology was submitted, the date that states the positive diagnosis.
Q. You never told Ivan that he might qualify for other benefits like anesthesia, did you?
A. No, not to my knowledge. Not that I can remember.
Q. You never told him that he might qualify for in-hospital room and board benefits, did you?
A. Not that I can remember, no.
Q. You never told him that he might qualify for attending physician benefits, did you?
A. I can't remember any of that, no.
Q. You don't normally tell people they might qualify for other benefits, do you?
A. We do, because when -- what we would have done on these, we would have said and the -- I think the explanation of benefit code is 17 when we need itemized bills for it, so it would have been -- those are codes -- we do let them know on their explanation of benefit, you know.

Q. Well, let me show you a copy of the EOB form, page 31, where you actually made payment, and show me where on there where you made payment for the 19301, the part where they surgically removed the lump, the lumpectomy, and the closure, which is, I think, 12034; is that right?

A. The closure, according to the amount charged, was 12035.

Q. Okay. That was sewing the area up where the lump was removed from Lenore's breast, right?

A. Right.

Q. And then there was the 19301?

A. Yes.

Q. That was the lumpectomy where they actually -- the doctor surgically removed the lump, right?

A. Yes.

Q. And then right in front of you on page 31 is the EOB for when you made payment for those two services?

A. Correct.

Q. Where on there or anywhere does it say you might qualify for anesthesia, you might qualify for hospital benefits, you might qualify for attending physician benefits, you might qualify for intensive care if you had to go to ICU?

A. Well, it doesn't. I mean, for one, there's only so many lines and characters we can write a note on, and we don't put all of the information on their schedule of benefits limitations on their policy on an explanation of benefit. This is regarding the claim that was submitted.

Q. Well, I thought you just said the code. You said the code would show up on there that said we need more information regarding these other things. But there's no code on there, is there?

A. Because we were able to pay from the bill.

Q. Well, and I'm talking about all of the other things that, as a claim handler that does this for a living, that you -- you knew the policy pretty well, right?

A. Yes.

Q. And you knew that there was all sorts of benefits on there that you never helped Ivan get?

MS. WEBER: Object to the form.

THE WITNESS: I do not make it a practice and call -- and call and go over his policy schedule with him. No, I did not.

BY MR. CULHANE:

Q. And you never wrote a letter or anything like that either?

MS. WEBER: Object to form.

THE WITNESS: No, because we have to go off of what the word "treatment" means. Having a biopsy isn't treatment.

BY MR. CULHANE:

Q. Okay.

A. It's surgery.

Q. Okay.

A. So it's not a form of treatment, because it's not -- a biopsy is for the purposes of diagnosis only, not necessarily to treat or remove their cancer.

Q. Okay.

A. That's a separate surgery.

Q. So you don't think the word "treatment" includes things like a biopsy or mammogram, things that are used before chemotherapy might start?

A. Those are for -- for me personally the way I would view it, and the way the policy dictates from my understanding, is that those are for laboratory purposes.

Q. Okay.

A. Because we are not -- they are not treating the cancer. A form of treatment would be chemotherapy or radiation.

Q. Is surgery treatment?

STATE OF SOUTH DAKOTA
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Plaintiff,	)	No. 50CIV14000061
vs.	)	
Protective Life Insurance Company,	)	
Defendant.	)	

Videotaped Deposition of:

DEBI K. HENRY

Taken on behalf of the Plaintiff

November 10, 2016

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402 BNA Drive, Suite 108
Nashville, Tennessee 37217
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you were trained about or that you held that we haven't discussed?

A. Not that I know of.

Q. Insureds and policyholders shouldn't have to hire a lawyer to get benefits under their policy, should they?

A. Absolutely not.

Q. The purpose of insurance and a claim handler is to help them get the benefits they have coming without ever instituting legal action, isn't it?

A. Claim examiners will pay the policy provisions according to each individual policy.

Q. And while you were handling claims, you were under the impression that you had to have medical bills instead of just a written proof of loss, weren't you?

A. No, sir.

Q. So you never were -- you didn't think you needed the bills to pay the claim?

A. If we received a pathology report diagnosing cancer and any and all itemized bills that came through submitted as a claim with the diagnosis and procedure codes, we could process without medical bills.

Q. But you weren't allowed to process the claim just based on the written proof of loss without the bills, were you?

Benefits and Health Administration
Division of Protective Life Insurance Company
PO Box 10807 Birmingham, AL 35202 Toll Free 1-800-866-3808

March 22, 2013

Seamus Culhane
1301 4th Street NE
Watertown, SD 57201-1206

RE: Company: Protective Life Insurance Company
Insured: Ivan Zochert
Policy: D00054903

Dear Mr. Culhane:

This letter acknowledges receipt of your inquiry in our office on March 15, 2013, regarding claim number LV1C02324-00.

The Surgical benefit was paid at $300.00 due to the procedure code the physician used, CPT 19301. The codes that are in the sample policy are for reference only and meant as examples.

In regards to the In-Hospital Room and Board benefit and the Attending Physician benefit, Mr. Zochert has not submitted these bills for processing. In order to review for these benefits, we will need a hospital bill (UB04) and bills from the treating physicians while confined due to the treatment of cancer.

I have included a sample copy of the policy for your reference as well as a copy of the bill that was submitted for processing.

If you have any questions concerning the above, please do not hesitate to contact us at 1-800-866-3808. We are available Monday through Thursday from 8:00 AM to 5:00 PM CST and on Friday from 8:00 AM to 3:00 PM CST.

Sincerely,

Lia Velez
Benefits Department

Henry, Debi

From: Henry, Debi
Sent: Monday, August 26, 2013 2:26 PM
To: 'Seamus Culhane'
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

Mr. Culhane:

Protective Life has not requested billing from the physician, it is the insured's responsibility to submit any/all itemized bills pertaining to cancer treatment.

Benefits eligibility are based on itemized bills submitted for review by the insured or providers.

We based benefits according to policy provisions. (see previous attachment)

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Monday, August 26, 2013 1:56 PM
To: Henry, Debi
Cc: Seamus Culhane
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

Ms. Henry,

Have you requested an itemized billing from the physician? If so, when?

What else have you done to determine what other benefits Ivan would be eligible for?

How did you determine the amount of money that the Zocherts were eligible for under the policy?

Best Regards,

Seamus Culhane

From: debi.henry@protective.com [mailto:debi.henry@protective.com]
Sent: Monday, August 26, 2013 12:11 PM
To: Seamus Culhane
Subject: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

From: debi.henry@protective.com

Subject: ApplicationXtender - AppXtender - POLICY - HEALTH

Click the "View Message" link to view your secure email message. The message will be available for 30 days. To access this message after 30 days or to save this message, select the "Secure Envelope" attachment at the bottom of this message. For issues, questions, or additional information, please contact Protective Life's Secure Email Support at 1-877-507-7732.

View Message

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

No. 28467

IVAN ZOCHERT,

Plaintiff/Appellant,

vs.

PROTECTIVE LIFE INSURANCE COMPANY,

Defendant/Appellee.

Appeal from the Circuit Court
Third Judicial Circuit
Moody County, South Dakota

The Honorable Patrick T. Pardy, Presiding Judge

BRIEF OF APPELLEE

Seamus W. Culhane
Nancy J. Turbak Berry
TURBAK LAW OFFICE, P.C.
26 South Broadway, Suite 100
Watertown, SD 57201
Telephone: (605) 886-8361

Attorneys for Plaintiff/Appellant

Edwin E. Evans
Ryan W. W. Redd
EVANS HAIGH & HINTON LLP
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599

Attorneys for Defendant/Appellee

Notice of Appeal filed December 5, 2017

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PRELIMINARY STATEMENT

Citations to the Certified Record are "R." followed by the applicable page number(s) in the Clerk's Index. References to Appellant's Brief are "Appellant's Brief" followed by the applicable page number(s). References to Appellant's Appendix are "App." followed by the applicable page number(s). Ivan Zochert is referred to as "Plaintiff." Protective Life Insurance Company is referred to as "Protective." References to Protective's Appendix are "ProApp." followed by the applicable page number(s).

JURISDICTIONAL STATEMENT

Plaintiff appeals from the order, dated November 7, 2017, granting summary judgment in favor of Protective in the Third Judicial Circuit, Moody County. R.1659. Notice of Entry of Order and Judgment was served via Odyssey File & Serve and email on November 8, 2017. R.1661. Plaintiff filed a Notice of Appeal on December 5, 2017. R.1675. This Court has jurisdiction pursuant to SDCL § 15-26A-3(1).

REQUEST FOR ORAL ARGUMENT

Protective respectfully requests oral argument.

STATEMENT OF THE ISSUES

1. **Whether the circuit court erred in granting summary judgment in favor of Protective and against Plaintiff.**

The circuit court ruled the Protective Life cancer insurance policy was unambiguous; the undisputed facts showed that Protective, as a matter of law, did not breach its contract with Plaintiff; and that Protective did not breach its implied duty of good faith and fair dealing. ProApp. 3-4. As a result, the circuit court held the record did not support a claim for bad faith. ProApp. 4. The circuit court entered an order granting Protective's motion for summary judgment on November 7, 2017. R.1659-60.

- *Bertelsen v. Allstate Ins. Co.*, 2011 S.D. 13, 796 N.W.2d 685
- *Hein v. Acuity*, 2007 S.D. 40, 731 N.W.2d 231
- *Nygaard v. Sioux Valley Hosps. & Health Sys.*, 2007 S.D. 34, 731 N.W.2d 184
- *United Ins. Co. of Am. v. Cope*, 630 So.2d 407 (Ala. 1993)

STATEMENT OF THE CASE

On August 25, 2014, Plaintiff filed a complaint against Protective alleging claims for (1) Breach of Contract, (2) Statutory Entitlement to Attorney's Fees, and (3) Tortious Breach of Duty of Good Faith and Fair Dealing. App. 1-8.

On October 6, 2017, the parties filed cross-motions for summary judgment. R.835-36, 1164-65. On November 6, 2017, a hearing was held before the Honorable Patrick T. Pardy. At the conclusion of the hearing, the circuit court granted Protective's motion for summary judgment and denied Plaintiff's motion for summary judgment, finding the Protective cancer policy was unambiguous, Protective made timely payments upon receipt of medical bills, and it paid the amounts due in accordance with the terms of the Policy. R.1659-60; ProApp. 2-4. Plaintiff is not appealing the circuit court's interpretation of the contract or that Protective paid the full amounts due under the contract. ProApp. 6-9. Instead, Plaintiff is appealing only the dismissal of his claim for breach of the duty of good faith and fair dealing arising out of the insurance contract and for bad faith failure to investigate Plaintiff's claim.

STATEMENT OF FACTS

Protective issued to Ivan and Lenore Zochert a supplemental cancer insurance policy ("the Policy"). App. 72-96. The Policy is a limited policy. App. 73. The first

page is titled "**CANCER POLICY**." *Id.* Below the title, the Policy states: "**THIS IS A LIMITED POLICY – PLEASE READ CAREFULLY**." *Id.* It provides coverage for benefits that derive from "cancer treatment." App. 48, 82. The Policy states, "Pathologic proof" of definitive cancer treatment must be submitted to Protective. *Id.* It only covers losses specifically listed in the Schedule of Benefits. App. 73, 79; ProApp. 3. It also contains procedures necessary to file a claim. App. 82, 48-49. Under the Policy, the insured is responsible for filing a claim and providing the information necessary for Protective to determine if the claim is for "cancer treatment." App. 82.

The insured is responsible for giving Protective Notice of Claim. *Id.* Once Protective receives Notice of Claim, the Policy states, "[Protective] will send [insured] forms for filing proof of loss." App. 49, 82. Next, the Policy states: "Written proof of loss must be given to [Protective] within 90 days after the occurrence or commencement of any loss covered by the policy." *Id.* Once coverage is determined, the Policy states payments of covered claims will be made to the insured. App. 49, 83.

Ms. Zochert's Medical Treatments

On July 5, 2012, Dr. Christensen performed a needle core biopsy on a lump identified in Ms. Zochert's left breast. App. 49. Laboratory tests were conducted on the tissue, and on July 11, 2012, Dr. Wegner, a pathologist, diagnosed Ms. Zochert with invasive ductal carcinoma. ProApp. 58, App. 65. On July 18, 2012, Dr. Christensen took x-rays and performed additional laboratory tests. R.1460. On August 14, 2012, Ms. Zochert was admitted to Prairie Lakes Hospital, and Dr. Christensen performed a partial mastectomy and layered closure on her left breast. R.992, 1339; App. 107. Ms. Zochert was discharged on August 16, 2012. R.1339. On August 31, 2012, as a result of

complications associated with her August 14, 2012 procedure, Ms. Zochert was readmitted to Prairie Lakes Hospital for additional treatment. R.995. She was hospitalized from August 31 through September 7, 2012, including three days in the intensive care unit—August 31 through September 2, 2012. R.1464; App. 113. On September 7, 2012, Ms. Zochert was discharged from the hospital. *Id.*

The Claim Process

A chronology of undisputed material facts follows:

- August 17, 2012: Plaintiff requested claim forms from Protective for filing a claim under the Policy. App. 50. On that same day, Protective mailed Plaintiff the claim forms. *Id.*; App. 103. The claim forms included a Patient Information form, Physician Statement form, and Medical Release form. ProApp. 16-21. In accordance with the Policy requirement that "Pathologic proof" of definitive cancer treatment be provided by the insured, the Patient Information form instructions stated, "**A PATHOLOGY REPORT diagnosing cancer MUST accompany your first claim.**" ProApp. 17; App. 82. The Patient Information form informed Plaintiff to "[s]ubmit all bills related to this cancer claim," and that "[a]ll bills should be itemized . . . ." *Id.*

- September 14, 2012: Plaintiff returned the forms to Protective. App. 102-07. He included Dr. Christensen's Physician Statement, stating Ms. Zochert was first diagnosed with cancer on July 11, 2012. App. 106. Plaintiff also included a Professional Hospital Account Summary ("PHAS"), which summarized Ms. Zochert's bills for her August 14, 2012 procedure. App. 107. The PHAS contained the billing summary for two items: (1) partial left mastectomy and (2) layered closure. *Id.* It stated that Ms. Zochert's admission *and* discharge date was August 14, 2012. *Id.* Plaintiff submitted no

other bills; he did not submit bills relating to Ms. Zochert's biopsy performed on July 5, 2012, pathology testing on July 11, 2012, hospitalization from August 14 through 16, 2012, or rehospitalization from August 31 through September 7, 2012. *See* App. 102-07. Plaintiff did not include a pathology report, as required by the Policy. See *id.*; App. 82.

- September 21, 2012: Protective responded to Plaintiff with an Explanation of Benefits ("EOB"), informing Plaintiff that he needed to send a pathology report verifying the cancer diagnosis. App. 52, 109.

- October 29, 2012: Protective received the pathology report. App. 52; ProApp. 60-62. The pathology report, dated August 14, 2012, did not reflect an earlier cancer diagnosis from July 2012. *See* ProApp. 60-62.

- November 13, 2012: After processing Plaintiff's claim, based on the Policy's terms and conditions and the PHAS provided by Plaintiff, Protective mailed Plaintiff a benefit check for the partial mastectomy and layered closure. App. 110; ProApp. 3-4. The check reflected the correct amount of benefits under the Policy for the items listed in the PHAS. App. 110; ProApp. 3-4. The mailing included an EOB. At this time, Protective had not been provided with any other bills associated with Ms. Zochert's August 14, 2012 procedure, nor had it been advised that Ms. Zochert was readmitted on August 31, 2012. App. 52.

- December 12, 2012: Plaintiff called Protective to inquire about how benefits were determined under the Policy. App. 53, 115.

- December 13, 2012: Protective called Plaintiff to answer his questions. *Id.* Plaintiff informed Protective that he would be sending additional bills. *Id.*

- December 18, 2012: Protective followed up on its December 12 and 13, 2012, phone calls by sending Plaintiff a letter, explaining how the benefits were determined. App. 108. After this communication, Plaintiff did not personally contact Protective with further questions or inquire about additional coverage. App. 55. He submitted no additional bills. *Id.*

- March 13, 2013: Seamus Culhane, Plaintiff's attorney, wrote to Protective asking how benefits were determined and why "In-Hospital Room and Board Benefit" or "In-Hospital Attending Physician Benefit" were not paid. ProApp. 22.

- March 22, 2013: Protective responded to Attorney Culhane's letter, stating the surgical benefit was paid according to the procedure code the physician used in the PHAS. App. 144. Further, Protective informed Attorney Culhane that Plaintiff had not submitted bills for In-Hospital Room and Board Benefit or In-Hospital Attending Physician Benefit. *Id.* Protective stated, "in order to review for these benefits, we will need a hospital bill . . . and bills from the treating physicians while confined due to the treatment of cancer." *Id.*

- May 6, 2013: Attorney Culhane sent Protective a letter transmitting copies of additional bills for services received by Ms. Zochert, commencing on August 14, 2012 ("May 2013 Submission"). ProApp. 23; R.1338-97. The May 2013 Submission included billing records for a two-night hospital stay beginning on August 14, 2012, pathology lab charges, and pharmacy charges. *Id.*; R.1338-39. These bills had not been previously submitted by Plaintiff or Attorney Culhane. *See* App. 107.

- May 13, 2013: Protective reimbursed Plaintiff for Ms. Zochert's two-night hospital stay, commencing on August 14, 2012; for Ms. Zochert's two days of home

recovery, commencing August 17, 2012; and for anesthesia administered to Ms. Zochert on August 14, 2012. App. 111.

- August 14, 2013: Three months later, Attorney Culhane sent a letter to Protective, stating he has not heard from Protective since March 22, 2013, and inquiring about a response to his May 2013 Submission. R.1398.

- August 26, 2013: Protective responded to Attorney Culhane's August 14, 2013 letter via email, providing Attorney Culhane with another copy of its March 22, 2013 letter, which had already answered the questions in Attorney Culhane's March 13, 2013 letter. ProApp. 24. Protective further stated:

> [s]ince this [March 22, 2013] letter we have processed the room and board benefit on May 13, 2013 when the itemized bills were presented on May 9, 2013. We have not processed any Attending Physician Benefits because we have yet to receive any itemized bills for August 12, 2012, through August 16, 2012 from the physician…
>
> If you have any further questions, please do not hesitate to contact us at 800-866-3808.

Id. Again, Protective advised Attorney Culhane they will process "any/all" itemized bills pertaining to cancer treatment once those bills are submitted. *Id.*

- August 26, 2013: Attorney Culhane responded to Protective's email by asking if Protective had requested any itemized bills. ProApp. 26. Attorney Culhane did not submit any additional bills as requested but asked, "what else have you done to determine what other benefits Ivan would be eligible for? How did you determine the amount of money that the Zocherts were eligible for under the policy?" *Id.*

- August 26, 2013: Protective replied to Attorney Culhane's email stating, "Protective Life has not requested billing from the physician, it is the insured's responsibility to submit any/all itemized bills pertaining to cancer treatment." *Id.*

Protective repeated: "Benefits eligibility are based on itemized bills submitted for review by the insured or providers. We based benefits according to the policy provisions." ProApp. 26. Protective attached the relevant policy provisions in its response. *Id.*

- August 26, 2013: Attorney Culhane responded, via email. Once again, he submitted no bills but asked, "where in the policy did it state that the insured has to submit the bills?" *Id.* Attorney Culhane also asked whether "the policy holder [has] to figure out what coverage might apply or does Protective Life do that for the policy holder?" *Id.* He also inquired about "what formula and code" Protective used to calculate the benefits. *Id.*

- August 27, 2013: Protective answered Attorney Culhane's questions, providing the Claims Provision from the Policy, requiring the insured provide written notice of claim to Protective; explaining the Policy was "an independent cancer policy . . .;" and providing the clause from page 8 of the Policy, under Surgical Expense Benefit, "we will pay for charges incurred for such operation and anesthesia in accordance with the California Relative Value Schedule." ProApp. 25.

- August 27, 2013, through November 30, 2013: There was an ongoing exchange of emails between Attorney Culhane and Protective. Attorney Culhane claimed he could not figure out how the benefits were calculated. ProApp. 25-51. Attorney Culhane submitted no additional bills. Protective responded promptly to each inquiry. *See id.*

- July 21, 2014: Over seven months later, Attorney Culhane sent another letter to Protective, which included a copy of a spreadsheet, purporting to contain all of

Ms. Zochert's medical procedures, costs, benefit limits, benefits paid, and benefits owed under the Policy ("July 21, 2014 Submission"). ProApp. 52; *see* R.1436-49.

- July 25, 2014: In response to the July 21, 2014 Submission, Protective replied to Attorney Culhane, via an email, stating the only pathology report it ever received for Ms. Zochert was for a diagnosis made on August 14, 2012; yet, his spreadsheet listed charges for services performed prior to that date; that Protective had not received any medical bills except those associated with the services provided on August 14, 2012. Protective's response, again, requested he provide "all itemized bills to include the diagnosis, procedure codes and charges" for the dates of service noted in his spreadsheet. ProApp. 53.

- July 25, 2014: Attorney Culhane responded, "*We will happily provide [Protective] with itemized billings.*" ProApp. 55 (emphasis added).

- August 4, 2014: Attorney Culhane sent Protective a pathology report for Ms. Zochert, dated July 5, 2012, as well as copies of records and bills from Watertown Family Medicine, Prairie Lakes Healthcare System, and Sanford Health Services (collectively referred to as the "August 4, 2014 Submission"). R.1453-66. The August 4, 2014 Submission was the first time these bills (almost two years after Protective requested Plaintiff to submit all itemized bills relating to cancer treatment and over 16 months since his attorney was requested to do so) were provided to Protective. App. 60. Prior to the August 4, 2014 Submission, Plaintiff and Attorney Culhane had not provided Protective the pathology report dated July 5, 2012. App. 60-61.

- August 29, 2014: These bills were promptly processed according to the terms of the Policy. The correct benefits were paid. App. 61, 112-13.

- September 2, 2014: Protective issued Plaintiff an additional check for $100 to cover Ms. Zochert's home benefits for September 8 through September 14, 2012. App. 61, 114.

Plaintiff was a farmer, who has dealt with insurance for most of his life. App. 61; ProApp. 11. He has made insurance claims in the past, which required him to submit bills and other information before the insurer would process the claim and pay any covered benefits. App. 62; ProApp. 11-12. When asked whether he thought it was reasonable for Protective to ask for copies of Ms. Zochert's medical bills before issuing him a check, Plaintiff stated he did not have any problem complying with those requests. ProApp. 13, 15. At no point did Plaintiff or Attorney Culhane claim they could not satisfy their obligations under the Policy. ProApp. 15, 54-55. In addition, Plaintiff or Attorney Culhane never indicated they were having problems obtaining copies of the bills. ProApp. 55.

In summary, it is undisputed Protective promptly paid all medical, hospital, and other covered expenses according to the Policy upon receipt of the itemized bills from Plaintiff. ProApp. 3-4; Appellant's Brief at 2 n.1. That is not at issue. Plaintiff's claims are premised on the allegation Protective breached the implied contractual duty of good faith and fair dealing by requiring Plaintiff to submit itemized bills. *See generally* Appellant's Brief.

The Policy requires the insured submit "Pathologic proof" of cancer and proof of loss. App. 82. The Patient Information form tells Plaintiff to submit a "**PATHOLOGY REPORT diagnosing cancer"** and "all bills related to [the] cancer claim." ProApp. 17. Plaintiff did not object to this requirement or inform Protective he needed its assistance.

ProApp. 55. Instead, Plaintiff told Protective in December 2012 that he would be submitting additional bills. App. 115. The next contact was from Attorney Culhane, on March 13, 2013. App. 55. From March 2013 through July 2014, Protective repeatedly informed Attorney Culhane that it was the insured's obligation under the Policy to submit itemized bills relating to the cancer treatment so benefits under the Policy could be properly calculated and paid. App. 144; ProApp. 21, 26, 53-56. It took Attorney Culhane approximately 17 months to comply with the Policy's requirements to submit all the itemized bills. When he did so, benefits were promptly paid in the correct amounts according to the terms of the Policy. ProApp. 2-4.

STANDARD OF REVIEW

The standard of review in summary judgment cases is to determine "whether genuine issues of material fact exist and whether the law was correctly applied. *Schulte v. Progressive N. Ins. Co.*, 2005 S.D. 75, ¶ 5, 699 N.W.2d 437, 438. The Court will affirm, "[i]f any legal basis exists to support the trial court's ruling." *Id.* "Unsupported conclusions and speculative statements do not raise a genuine issue of fact." *Dakota Indus., Inc. v. Cabela's.com, Inc.*, 2009 S.D. 39, ¶ 20, 766 N.W.2d 510, 516. When the material facts are undisputed, the Court's review "is limited to determine whether the trial court correctly applied the law." *Schulte*, 2005 S.D. 75, ¶ 5.

ARGUMENT

I. INTRODUCTION

Count One of Plaintiff's Complaint alleged Protective "failed to make full payment under the policy" and sought additional benefits allegedly owed. App. 5. On appeal, Plaintiff abandons this argument. Appellant's Brief at 2 n.1; *see* ProApp. 6-8. At the summary judgment hearing, Plaintiff contended the Policy was ambiguous; that

Protective improperly interpreted the Policy; and, as a result, that Protective did not distribute the full amounts owed under the Policy. *See* ProApp. 1-5; R.1691-1726, 837-62. The circuit court held the Policy was unambiguous. ProApp. 2. It held "[t]he benefits were clearly articulated in the policy. The Plaintiff should have had knowledge of the same." ProApp. 4. Further, the court held Protective correctly interpreted the Policy, and "Protective Life paid the benefits that the Plaintiff was entitled to in accordance with the language of the policy . . . ." *Id.* The court also held Protective's payments were timely made because "once the pathology report was received [benefits were promptly paid], and additional payments [were promptly made] once itemized bills were received." *Id.* at 3-4.

On appeal, Plaintiff has abandoned any issues regarding the circuit court's interpretation of the Policy. Appellant's Brief at 2 n.1. He does not challenge the circuit court's findings: (1) the Policy is unambiguous; (2) benefits were clearly articulated in the Policy; (3) Protective paid the correct amounts owed under the Policy; and (4) payments were timely made once Protective received the pathology report and itemized billings. ProApp. 6-8; *see generally* Appellant's Brief. There is no claim before this Court that Protective did not make full payment under the Policy. *Id.*

Count Two of the Complaint alleged Protective's "failure to pay insurance benefits . . . was unreasonable and vexatious" and seeks to recover attorney's fees pursuant to SDCL § 58-12-3. App. 5. By its express terms, SDCL § 58-12-3 only applies if an insurance company refuses to pay the *full* amount of the insured's loss. Plaintiff has not appealed the circuit court's finding that "Protective Life paid the benefits

that the Plaintiff was entitled to in accordance with the language of the policy." ProApp. 4, 6-8; *see* Appellant's Brief.

Thus, only Count Three, alleging Tortious Breach of Duty of Good Faith and Fair Dealing, remains. App. 6-7. The only issues on appeal are whether Protective (1) breached its implied contractual duty of good faith and fair dealing and (2) committed the tort of bad faith by requiring Plaintiff to submit itemized bills as a part of his proof of loss. *See* ProApp. 6-8; Appellant's Brief.

II. THE CIRCUIT COURT CORRECTLY HELD THAT PROTECTIVE DID NOT BREACH THE IMPLIED CONTRACTUAL DUTY OF GOOD FAITH AND FAIR DEALING.

On appeal, Plaintiff alleges Protective breached its "implied *contractual* duty of good faith." Appellant's Brief at 13 (emphasis added). In his Complaint, however, Plaintiff claimed a tortious (not contractual) breach of the duty of good faith and fair dealing. App. 6-7. Plaintiff's attempt to assert a new claim comes too late. *Liebig v. Kirchoff*, 2014 S.D. 53, ¶ 35, 851 N.W.2d 743, 752 ("We have consistently held that this Court may not review theories argued for the first time on appeal." (internal citations and quotations omitted)). Regardless, his efforts fail on the merits as well.

There are certain well-established tenets of good faith in the context of insurance. It is undisputed every insurance contract includes the duty of good faith and fair dealing. *Kunkel v. United Sec. Ins. Co.*, 168 N.W.2d 723, 726 (S.D. 1969). The basic premise of good faith requires the insurer handle the claim in a reasonable manner. *Paulfrey v. Blue Chip Stamps*, 150 Cal.App.3d 187, 199 (Cal. Ct. App. 1983). The insurer must conduct a reasonable investigation in a timely manner before denying coverage. *Dakota, Minn. & E.R.R. Corp. v. Acuity*, 2009 S.D. 69, ¶ 19, 771 N.W.2d 623, 629. Good faith precludes an insurer from exploiting the insured's ignorance of his rights. Allen D. Windt, 1

Insurance Claims and Disputes § 2:2 (6th ed.). It prevents an insurer from concealing its duty to defend. *Biegler v. Am. Family Mut. Ins. Co.*, 2001 S.D. 13, ¶¶ 33-34, 621 N.W.2d 592, 602. It prevents an insurer from requiring the insured select applicable coverage. *Eide v. S. Sur. Co.*, 226 N.W. 555, 556 (S.D. 1929). It prevents the insurer from misrepresenting available coverage. *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 N.W.2d 752, 763 (S.D. 1994). This conduct violates the duty of good faith because it injures the right of the insured in receiving an expected benefit of the agreement. *Helmbolt v. LeMars Mut. Ins. Co., Inc.*, 404 N.W.2d 55, 57 (S.D. 1987).

This Court has stated, however, "the duty of good faith and fair dealing is not a limitless duty or obligation." *Nygaard v. Sioux Valley Hosps. & Health Sys.*, 2007 S.D. 34, ¶ 22, 731 N.W.2d 184, 193 (internal quotations and citations omitted). "The implied obligation must arise from the language or it must be indispensable to effect the intentions of the parties." *Id.* The duty of good faith "prohibits *either* contracting party from preventing or injuring the other's rights to receive the agreed benefits of the contract." *Id.* ¶ 20 (emphasis added) (internal citations and quotations omitted). "If the express language of a contract addresses an issue," however, "then there is no need to construe intent or supply implied terms under the implied covenant [of good faith]." *Id.* ¶ 22 (citations and quotations omitted).

A. The Duties Owed are Characterized by the Nature of the Claim

Plaintiff fails to distinguish between cases alleging a breach of good faith and fair dealing and those cases alleging insurance bad faith. The implied covenant of good faith is violated when a party, by its lack of good faith, prevents the other party from receiving the expected benefits of the contract. *Garrett v. BankWest, Inc.*, 459 N.W.2d 833, 841 (S.D. 1990). A lack of good faith may be identified by such conduct as evasion of spirit

of the contract, abuse of power to determine compliance, and interference with or failure to cooperate with the other party's performance. *Id.* at 845 (citation omitted).

This Court differentiates between first-party and third-party claims. *See Bertelsen v. Allstate Ins. Co*., 2011 S.D. 13, ¶¶ 47-48, 796 N.W.2d 685, 700-01 (recognizing the adversarial posture of a first-party scenario, and that insurers have different and more rights in a first-party scenario than a third-party scenario). In the first-party scenario, "an insurance company contracts to pay benefits directly to an insured[;]" whereas, in a third-party scenario, "an insurance company contracts to indemnify an insured against liability to third parties." *Id.* ¶ 46. In the first-party scenario, the insured and insurer are adversaries, while in the third-party scenario they are not. *Id.* ¶ 47 (recognizing, in first-party scenario, insured and insurer's interests conflict); *Hein v. Acuity*, 2007 S.D. 40, ¶ 10, 731 N.W.2d 231, 235. As a result, the rights afforded to the insurer in a first-party scenario are broader than those in a third-party scenario. *See id.* (distinguishing the difference between first and third-party claims); *Craft v. Economy Fire & Cas. Co.*, 572 F.2d 565, 569 (7th Cir. 1978); *Love v. Fire Ins. Exch.*, 221 Cal.App. 3d 1136, 1148-49 (Cal. Ct. App. 1990) (first-party insurer cannot be fiduciary); *Beck v. Farmers Ins. Exchange*, 701 P.2d 795, 799-800 (Utah 1985) (recognizing insured is wholly dependent on insurer to protect insured's interests in a third-party situation; whereas, in the first-party situation, no such reliance is present because the parties are adversaries). In the first-party scenario, an insurer commits bad faith when it "consciously engages in wrongdoing during its processing or paying of policy benefits to its insured." *Bertelsen*, 2011 S.D. 13, ¶ 46 (internal citations and quotations omitted). In the third-party scenario, an insurer commits bad faith when it "breaches its duty to give equal consideration to the

interests of its insured when making a decision to settle a case brought against its insured by a third-party." *Id.* (internal citations and quotations omitted).

This is a first-party scenario; Protective's duties must be viewed in this context. *Id.*; App. 83. Plaintiff alleges Protective breached its duties by delaying payment of benefits. Review of the applicable duties imposed on an insurer in a first-party scenario demonstrates Protective did not breach its duty of good faith in handling Plaintiff's claim.

B. Protective Fulfilled its Duty to Investigate.

The duty to investigate requires insurers investigate the validity of a claim. *Dakota, Minn. & E.R.R.*, 2009 S.D. 69, ¶ 19. Thus, Protective had a duty to conduct a reasonable investigation before denying Plaintiff's claim. *Id.* The Policy required Plaintiff submit proof of loss. App. 82. The Policy bases benefits on the actual charges Plaintiff incurred. App. 79. Thus, the plain meaning of "proof of loss," under the Policy required Plaintiff submit proof of the actual amounts he was charged for Ms. Zochert's cancer related treatment. *See Western Nat'l Mut. Ins. Co. v. Decker*, 2010 S.D. 93, ¶¶ 11-12, 791 N.W.2d 799, 802-03 (meaning of an undefined term in an unambiguous policy is determined by referencing the policy as a whole). Plaintiff misapplies the duty to investigate and misconstrues the facts when he claims Protective did not investigate and placed the entire burden of the investigation on him. Protective never contested the validity of Plaintiff's claim; rather, it required Plaintiff submit proof of loss, as required by the Policy. Therefore, Protective Life did not breach its duty to investigate.

The duty to investigate the validity of a claim encompasses two aspects: (1) whether the occurrence (loss) was a covered event; and (2) whether the losses claimed were covered by the policy. *Dakota, Minn. & E.R.R.*, 2009 S.D. 69, ¶ 19; *Auto-Owners Ins. Co. v. Hansen Housing, Inc.*, 2000 S.D. 13, ¶ 31, 604 N.W.2d 504, 513. The purpose

of proof of loss is to provide the insurer with the ability to investigate the validity of the claim. *Auto-Owners*, 2000 S.D. 13, ¶ 31 (quoting *City of Ft. Pierre v. United Fire Casualty Co.*, 463 N.W.2d 845, 851-52 (S.D. 1990) (Sabers, J., dissenting); *Siravo v. Great America Ins. Co.*, 410 A.2d 116, 118 (R.I. 1980) (requiring insureds to provide proof of loss so insurers have the ability to investigate to determine whether the claimed loss is covered by the policy); 13 COUCH ON INSURANCE § 186:4.

In the present case, Protective satisfied its duty to investigate the validity of Plaintiff's claim. To determine whether the occurrence (loss) was a covered event, Protective had to determine whether Ms. Zochert was diagnosed with cancer. App. 82. It did so by referring to the pathology reports, which Plaintiff was required to submit under the terms of the Policy. *See* App. 82, 109, 144; ProApp. 26, 53.

Protective next determined whether the losses Plaintiff claimed to suffer as a result of Ms. Zochert's cancer diagnosis were covered by the Policy. Protective investigated Plaintiff's claimed losses, i.e. the proof of loss—the bills for Ms. Zochert's treatment. App. 79. Initially, the only losses Plaintiff claimed to have incurred were for a partial mastectomy and layered closure. App. 51, 107. Protective investigated the charges in the PHAS to determine whether they were incurred as a result of cancer treatment. It determined they were. Next, it determined whether the losses were covered by the Policy. It determined they were. Then, Protective determined the amount covered and promptly paid the correct amount to Plaintiff. ProApp. 3-4; App. 110. Protective followed this same process every time Plaintiff's attorney submitted proof of additional losses. *Id.*

It must be remembered Protective correctly denied some of the bills submitted by Plaintiff because they were not covered by the Policy. *See* App. 109-13. Payment of some claims and denial of others is evidence of Protective's investigation. Plaintiff does not object on appeal to Protective's determination of the validity of the bills submitted, nor does he assert Protective improperly calculated the benefits payable under the Policy.

An analogous case, *United Ins. Co. of Am. v. Cope*, 630 So.2d 407 (Ala. 1993), provides an example of an insurer's duty to investigate. In *Cope*, the Alabama Supreme Court addressed a similar situation. *See id.* at 408-12. The Court held an insurer does not have a duty to investigate to determine whether there was a valid claim for benefits unless the insured submits a claim for those benefits. *Id.* at 412. The insurer only has a duty to investigate the items contained in the documents submitted by the insured to determine if those items are covered by the Policy. *Id.* Until the insured submits proof of loss, as required by the policy, the insurer has no duty to investigate the unmade claims. *Id.*

Plaintiff argues the duty to investigate required Protective, once Plaintiff provided Protective with notice of some losses, to determine any additional losses Plaintiff may have suffered but did not claim. Plaintiff provides no authorities to support his argument. Likewise, Plaintiff's argument fails to address the fact the Policy placed the duty of providing proof of loss on Plaintiff.

Plaintiff is improperly attempting to use an implied duty to limit his explicit obligations under the policy while simultaneously expanding Protective's. App. 82; *see Nygaard*, 2007 S.D. 34, ¶ 22 (recognizing the duty of good faith does not supersede the express language of a contract); 13 COUCH ON INSURANCE § 186:4; *Am. Family Mut. Ins.*

Co. v. Elliot, 523 N.W.2d 100, 102 (S.D. 1994) (courts cannot diminish or enlarge the terms of an unambiguous insurance policy); *Hunter v. Fireman's Fund Ins. Co.*, 448 F.2d 805, 810-11 (10th Cir. 1971); SDCL § 58-12-1.

Plaintiff confuses two requirements under the Policy—notice of loss and proof of loss. *See Hunter*, 448 F.2d at 810-11 (notice of claim and proof of loss are "distinct and the fact that notice may have been given does not dispense with the requirement of furnishing formal proof of loss."); 13 COUCH ON INSURANCE § 186:19 (obligations to provide notice of loss and proof of loss are distinct obligations); 16 WILLISTON ON CONTRACTS § 49:89 (4th ed. 1990) (proof of loss requirement is "distinct" from notice of loss requirement).

Providing notice of a claim merely prevents the insurer from denying a claim for timeliness. *See Auto-Owners*, 2000 S.D. 13, ¶ 31. Providing proof of loss may satisfy the notice requirement, however, satisfying the notice requirement does not transfer the insured's obligation to provide proof of losses not yet claimed. *Id.*; *Hunter*, 448 F.2d at 810-11; *Cope*, 630 So.2d at 412. Further, Protective never denied any benefits due to timeliness. ProApp. 24.

Once the insured provides proof of a potentially covered loss, the insurer must investigate to determine the validity of the loss claimed. *Dakota, Minn. & E.R.R.*, 2009 S.D. 69, ¶ 19; *Auto-Owners*, 2000 S.D. 13, ¶ 31. Because the Policy covers incurred losses, the duty to investigate the validity of the loss cannot begin until the loss is claimed. App. 78; *Jameson v. Utah Home Fire Ins. Co.*, 559 P.2d 958, 960-61 (Utah 1977). The duty to investigate the validity of a claimed loss does not require the insurer investigate unclaimed losses to see if any exist. That obligation rests on the insured.

App. 82; 13 COUCH ON INSURANCE § 186:1 ("All insurers must rely on the insured or other interested party to supply sufficient and accurate proof of the amount of loss."); SDCL § 58-12-1 (recognizing insurance contract can require insured to submit proof of loss). If an insured does not claim a loss, the insurer has nothing to investigate. *See Paulfrey*, 150 Cal.App.3d at 199-200. Once the insured claims it suffered a loss, the insurer has to investigate the validity of the loss to determine whether it was covered by the policy; determine benefits owed under the policy; and pay benefits accordingly.[1] *Cope*, 630 So.2d at 412 (rejecting argument identical to Plaintiff's).

The Policy required Plaintiff submit proof of loss. App. 82; *Nygaard*, 2007 S.D. 34, ¶ 22. Requiring an insured submit proof of loss is not onerous, unreasonable, or unusual. *Morris v. Econ. Fire and Cas. Co.*, 848 N.E.2d 663, 667 (Ind. 2006) (holding, it was reasonable for insurer to request insured submit documents related to the losses they claim); *Cope*, 630 So.2d at 412, *see* SDCL § 58-12-1 (recognizing, insurer is not responsible for obtaining proof of loss from insured). "An insurer may request an insured's medical records and bills relating to a claim and may conduct any other necessary investigation." *Bertelsen*, 2011 S.D. 13, ¶ 20. The undisputed facts show Protective merely required Plaintiff to comply with his duties as plainly set forth in the Policy.

Protective repeatedly told Plaintiff of his obligation under the Policy to submit proof of loss. *See* App. 82, 144; ProApp. 17, 24-26, 53-55. As noted in *Bertelsen*, an insurer may request an insured's medical records and bills and "may conduct any other

[1] Requiring the insurer to investigate to determine if there are other losses that are not claimed would require the insurer to perform duties not required under the insurance contract and to put the insured's interest above its own. *See infra* Part II.D.

necessary investigation." 2011 S.D. 13, ¶ 20. Protective did not breach its duty of good faith by requesting Plaintiff to furnish copies of the pathology report and itemized bills because Plaintiff agreed to submit proof of loss when he purchased the Policy.

Plaintiff claims Protective breached the duty to investigate his claim because it required him submit proof of loss, which he claims equates with Protective requiring him to determine what "treatment expenses and other losses were covered" or "identify what documents were available to prove losses." Appellant's Brief at 16-17; ProApp. 17. Plaintiff cites no authorities to support his proposition that insurance companies cannot request insureds submit proof of loss. That is simply not the law in South Dakota or any other jurisdiction. *See e.g. Bertelsen*, 2011 S.D. 13, ¶ 20; *Morris*, 848 N.E.2d at 667.

Protective simply required Plaintiff and his attorney comply with the terms of the Policy by requiring Plaintiff submit proof of loss in order for Protective to determine the extent of benefits owed under the Policy. *See* App. 55-57, 59-60; ProApp. 17, 24-26, 53-55. This request did not require Plaintiff to figure out if the expenses were covered. It did not require him to figure out any specific documents he needed to provide. Protective told him exactly what documents were needed—"pathology report diagnosing cancer" and "itemized bills." ProApp. 17. Following the unambiguous terms in the Policy, Protective only required him to put forth some effort—as Plaintiff agreed to do when he bought the Policy—to submit proof of the extent of his losses in order for the Protective to pay benefits. App. 82; 13 COUCH ON INSURANCE § 186:1; SDCL § 58-12-1; *see Helmbolt*, 404 N.W.2d at 57 (stating implied covenant of good faith applies to both parties of an insurance contract). Upon receipt of the bills, Protective processed them, determined the benefits due, and paid those benefits. Because the Policy places the duty

to provide proof of loss on Plaintiff, "there is no need to construe" Protective's conduct under the implied covenant. *Nygaard*, 2007 S.D. 34, ¶ 22. Such conduct cannot breach the duty of good faith.

C. Protective Fulfilled Its Duty to Disclose.

Plaintiff maintains Protective had a duty to disclose applicable coverages. Appellant's Brief at 18-21. Plaintiff cites no authority in support of his claim. This Court has never held an insurer has a duty to inform a first-party insured of the benefits clearly articulated in an insurance policy. This Court has only found a violation of the duty of good faith when the insurer failed to inform the insured of legal duties imposed on it under the duty to defend, misrepresented coverage available under the policy, or forced the insured to elect the coverage that applied. *Biegler*, 2001 S.D. 13, ¶ 33; *Isaac*, 522 N.W.2d at 763; *Eide*, 226 N.W. at 556; *see* SDCL § 58-12-34 (stating, it is improper to knowingly misrepresent the policy but imposes no affirmative duty to disclose). None of those situations are present here.

Protective's conduct is distinguishable from the *Biegler*, *Isaac*, and *Eide*. Unlike the insurer in *Biegler* that "did everything it could to put off, and thereby deceive, the insured even though it knew it had an obligation to defend the insured," *Biegler*, 2001 S.D. 13, ¶ 58, Protective did not deceive Plaintiff. ProApp. 4. Protective repeatedly instructed Plaintiff and his lawyer to submit proof of loss in order for Protective to pay the benefits owed under the Policy. *See* App. 144; ProApp. 17, 24-26, 53-55. Unlike *Isaac*, there is no allegation that Protective misrepresented coverage available under the Policy. Finally, Protective, unlike the insurer in *Eide*, never required Plaintiff to "elect upon which of the clauses in the policy" applied to his claim. It is undisputed that Plaintiff received all benefits due under the Policy. ProApp. 4; Appellant's Brief at 2 n.1.

Biegler, *Isaac*, and *Eide* are inapposite and have no bearing on the reasonableness of Protective's conduct. *See Plucker v. United Fire & Cas. Co.*, 4:12-CV-04075-KES, 2016 WL 5415655, at *2-3 (D.S.D. Sept. 28, 2016) (distinguishing *Biegler* and *Isaac* from *Plucker* in which the insurer merely requested the insured's medical bills, did not attempt to deny payments clearly owed, and processed the insured's claim once it received her medical bills).

Plaintiff, however, contends Protective breached its duty to disclose by doing "essentially nothing to identify coverages under which her claim could yield benefits or otherwise inquire into possible bases supporting the claim." Appellant's Brief at 19. The undisputed facts show, once Plaintiff submitted his claim, Protective identified coverage for the items included in Plaintiff's claim, determined the benefits owed, and paid the benefits. ProApp. 3-4. Further, Protective explained what items were covered, which were not, and how the amount paid was determined. App. 109-14. Protective never improperly denied benefits for items included in Plaintiff's claims, so there can be no argument that Protective did not inquire into possible bases supporting the claim.

Plaintiff's argument appears to be based on the contention that Protective had a duty to anticipate losses or inform the insured of potential additional claims. This Court has never held that an insurer has a duty to inquire about potential claims or claims that have not been made. Such a duty would make the insurer a fiduciary, which cannot exist in the first-party setting. *See infra* Part III.B. Because of the adversarial posture of a first-party claim, insurers are allowed to advance their own interests, so long as they do not wrongfully deny the insured the benefits due under the insurance contract. *See Love*, 221 Cal.App.3d at 1148-49. In this case, Plaintiff got all benefits he bargained for.

Plaintiff's contention appears to be premised on his misinterpretation of the duty set forth in *Egan v. Mut. of Omaha Ins. Co.*: "To protect [the insured's] interests it is essential that an insurer fully inquire into possible bases that might support the insured's claim." 24 Cal.3d 809, 819 (Cal. 1979). This duty, however, has never been construed as Plaintiff presents it. This duty requires insurers inquire into possible bases that might *support* the validity of insured's claim—once that claim is made, not determine losses incurred but not claimed by the insured. The latter remains the obligation of the insured. *See Cope*, 630 So.2d at 412

In *Wilson v. 21st Century Ins. Co.*, 42 Cal.4th 713, 721 (Cal. 2007), the Supreme Court of California demonstrated how to apply the rule set forth in *Egan*. In *Wilson*, the insured sued her insurer, alleging the insurer breached its duty of good faith based on the insurer's investigation of her claim. *Id.* The insured submitted a claim for Under Insured Motorist coverage. *Id.* Included in her claim were medical expenses for neck pain. *Id.* The insured's doctor submitted his report, stating the insured's pain was probably caused by an automobile accident. *Id.* The insurer's doctor, however, asserted the pain was "unlikely" due to the accident. *Id.* The insurer then denied the claim without further investigating the cause of the insured's neck pain. *Id.* The Supreme Court of California, applying the standard set forth in *Egan*, stated the duty to inquire into possible bases that might support the validity of the insured's claim prevented the insurer from ignoring the insured's doctor's report and required the insurer to further investigate to determine the cause of the insured's pain. *Id.* at 721-23.

In the present case, this duty required Protective to investigate to determine whether the Plaintiff's claimed losses—Ms. Zochert's medical and hospital expenses—

were for cancer treatment. If there were conflicting indications about whether or not they were for cancer treatment, the insurer could not summarily deny the claims but would be required to investigate to determine what the bills were for. Protective satisfied this duty. It processed all of Plaintiff's claims by reviewing the Current Procedural Terminology codes to determine whether the items billed were related to cancer, and if so, whether they were covered by the Policy. *See* ProApp. 28-51, 67-68. When it was unclear whether an item was caused by cancer or the extent of coverage was uncertain, Protective did not just deny Plaintiff's claim, it contacted the hospital to obtain the information necessary to process Plaintiff's claim. *See* App. 116. Further, Protective never improperly denied benefits for bills included in Plaintiff's proof of loss, so there can be no argument that Protective did not inquire into possible bases supporting the claim. ProApp. 4.

D. Protective Fulfilled Its Duty, if Any, to Give Equal Consideration.

Plaintiff claims Protective had a duty to give his interest equal weight to the company's interest. Appellant's Brief at 20-21. It is undisputed that once Plaintiff submitted itemized bills to complete his proof of loss, Protective promptly paid Plaintiff all amounts due under the Policy. Plaintiff attempts to construe Protective's conduct as not giving enough consideration to Plaintiff. Plaintiff's characterization of this duty is not supported by the law or the facts.

This Court has never applied the "equal consideration" rule in a first-party scenario. *See Hein*, 2007 S.D. 40, ¶¶ 9-10 (addressing equal consideration in third-party scenario; however, when discussing first-party scenarios, the Court does not reference equal consideration). In *Bertelsen*, this Court recognized a distinction between first-party and third-party bad faith claims:

> First-party bad faith occurs "when an insurance company conspicuously engages in wrongdoing during its processing or paying of policy benefits to its insured" . . . and third-party bad faith occurs "when an insurer breaches its duty to give equal consideration to the interests of its insured when making a decision to settle a case" brought against its insured by a third-party.

2011 S.D. 13, ¶ 46 (quoting *Hein*, 2007 S.D. 40, ¶¶ 9-10). Protective's duty must be reviewed in this context.

In a first-party scenario, the insurer need not disregard its rights in order to promote the interests of the insured. *Id.* ¶ 47 (first-party insurer can invoke attorney-client privilege to preclude insured from obtaining privileged communications concerning insured's claim); *see Love*, 221 Cal.App. 3d at 1148-49. A first-party insurer is permitted to exercise its own rights as contained in the insurance contract. That is what Protective did in this case. The Policy required "[w]ritten proof of loss" be given by the insured. App. 82. Once Protective received the itemized bills, it processed them and paid benefits due under the Policy. ProApp. 3-4.

Assuming Protective was required to give "equal consideration" to Plaintiff's interest, Protective did so. Upon receipt of proof of loss, Protective investigated the validity of Plaintiff's claim and promptly paid all benefits owed under the Policy. *Id.* This alone shows Protective gave equal consideration to Plaintiff's interests in having the claims paid and did not exploit his ignorance or take advantage of him. Protective repeatedly informed Plaintiff and his attorney of the obligation under the Policy to submit proof of loss—any bills related to Ms. Zochert's cancer—and to contact Protective if he had any questions. When he submitted additional proofs of loss, Protective paid benefits owed. Plaintiff got the benefit of his bargain. When he inquired about the Policy, Protective promptly and truthfully answered his questions.

It is apparent Plaintiff's claim is based on a combination of misperception of the facts and misinterpretation of the applicable duties insurance companies owe first-party insureds. Review of the undisputed facts and application of the appropriate duties demonstrates Protective satisfied all the duties imposed by law. It also proves Protective did not breach its implied duty of good faith. The circuit court did not err when it granted Protective's motion for summary judgment. This Court should affirm.

III. PLAINTIFF'S CLAIM FOR BAD FAITH FAILS AS A MATTER OF LAW.

As noted, Count three of the Complaint alleges a tortious breach of the implied duty of good faith and fair dealing, i.e., bad faith breach of the Policy. In contrast to Plaintiff's claim for breach of the implied duty of good faith, insurance bad faith claims require a component of intentional or reckless conduct. *Bertelsen*, 2011 S.D. 13, ¶ 46 (quoting *Hein*, 2007 S.D. 40, ¶ 9). To establish a bad faith claim against an insurer, "[t]here must be an absence of a reasonable basis for denial of policy benefits and knowledge or reckless disregard [of the lack] of reasonable basis for denial . . . ." *Champion v. United States Fidelity & Guar. Co.*, 399 N.W.2d 320, 324 (S.D. 1987) (citations omitted). An insurance company may, however, challenge claims that are fairly debatable and will be found liable only where the claim has been intentionally denied (or failed to process or pay) a claim without a reasonable basis. *Id.*

Protective paid all benefits due under the Policy and did so promptly upon Plaintiff or his attorney providing itemized bills as a part of Plaintiff's proof of loss.

ProApp. 3-4.[2] Protective had a reasonable basis for its conduct and did not knowingly or recklessly handle the claim without a reasonable basis for its actions.

A. Protective had a Reasonable Basis for Delaying Policy Benefits

The reasonable basis was waiting for Plaintiff or his attorney to provide proof of loss as required by the Policy. *See Gordinier v. Continental Assur. Co.*, 7 N.W.2d 298 (S.D. 1942) (stating, due notice and proof of loss is an acceptable condition precedent to recovery). Once it received proof of loss, Protective promptly distributed payment according to the terms of the Policy.

It is well settled "the proper interpretation of a contract must give effect to the intention of the contracting parties." *Singpiel v. Morris*, 1998 S.D. 86, ¶ 10, 582 N.W.2d 715, 718; *Binder v. General Am. Life Ins. Co.*, 282 N.W.2d 521, 523 (S.D. 1938) ("Contracts of insurance, like other contracts, must be construed according to the terms which the parties have used, to be taken and understood, in the absence of ambiguity, in their plain, ordinary, and popular sense." (internal quotations and citations omitted). If a contract expressly addresses certain conduct, there is no need to review such conduct under the implied duty of good faith. *Nygaard*, 2007 S.D. 34, ¶ 22.

First-party bad faith occurs when the insurer frivolously refuses to comply with a duty under an insurance contract. *Hein*, 2007 S.D. 40, ¶ 10. The court "need only look to

[2] Plaintiff refers to his expert's report in support of his bad faith claim. Appellant's Brief at 27-28. Plaintiff's expert cannot change the law. The circuit court found the Policy was unambiguous. This Court need only refer to the Policy and legal duties imposed to determine whether the circuit court properly found that Protective satisfied its obligations. *Binder*, 282 N.W.2d at 523; *Nygaard*, 2007 S.D. 34, ¶ 22; *Zens v. Harriso*n, 538 N.W.2d 794, 795-96 (S.D. 1995) (an expert's legal conclusions are not admissible). Furthermore, Plaintiff's expert based his opinion of Protective's conduct on his interpretation of the Policy, which the circuit court rejected. *Compare* App. 120 (expert claims Policy is broad and ambiguous), *with* ProApp. 2-4 (circuit court held the Policy was unambiguous and provided limited coverage).

the language of that the parties used in the contract to determine their intention." *Singpiel,* 1998 S.D. 86, ¶ 10. "If that intention is clearly manifested by the language of the [agreement], it is the duty of [the c]ourt to declare and enforce it." *Ziegler Furniture and Funeral Home, Inc. v. Cicmanec*, 2006 S.D. 6, ¶ 16, 709 N.W.2d 350, 355.

The Policy is unambiguous. ProApp. 2 This Court need only look at the Policy to determine whether Protective's reliance on the terms of the Policy was a reasonable basis for its conduct. *Nygaard*, 2007 S.D. 34, ¶ 22; *Am. Family Mut. Ins. Co. v. Hansen*, 2016 CO 46, ¶ 4, 375 P.3d 115, 122 (insurer's "reliance on the unambiguous insurance contract was reasonable."). The Policy clearly states that Plaintiff had a duty to supply Protective with proof of loss. Thus, as a matter of law, it was reasonable for Protective to rely on the Policy's unambiguous requirements.

Moreover, Plaintiff agreed he had to submit the information in order for Protective to process the claim, and such a requirement was reasonable. ProApp. 13, 15. Plaintiff's own admission that Protective's conduct was reasonable is sufficient to establish that Protective did not act in bad faith. *Connelly v. Sherwood*, 268 N.W.2d 140, 141 (S.D. 1978) ("it is settled law . . . that a party to a law suit cannot claim the benefit of a version of relevant facts more favorable to his own contentions than he has given in his own testimony.").

After submitting his initial claim, Plaintiff hired Attorney Culhane to handle the submission of his claim to Protective. ProApp. 14. Had Plaintiff informed Protective that he could not comply with the Policy's requirements, or was having difficulty doing so, Protective would have assisted. ProApp. 55. Absent any such request, however,

Protective was under no obligation under the Policy to prepare Plaintiff's proof of loss. *See* App. 82; *Cope*, 630 So.2d at 412.

Protective acted reasonably by requiring Plaintiff submit proof of loss—as the Policy required. Protective did not commit bad faith.

B. Plaintiff's Examples of "Tortious Conduct" by Protective Do Not Indicate Protective Acted in Bad Faith.

Plaintiff argues Protective either knew it did not have a reasonable basis or acted recklessly by providing "examples" of conduct that showed the "tortious nature" of Protective's conduct. His examples include "how the [Protective] handles Lenore's biopsy and otherwise fudge facts to try to shrink coverage," "[Protective]'s general nondisclosure of coverages, and how [Protective] incentivizes its claims handlers." Appellant's Brief at 27.

Plaintiff's reference to the "handling of Lenore's biopsy" ignores what actually happened. *See* Appellant's Brief at 28. Plaintiff refers to the deposition of Lia Valez, a claims specialist at Protective, to try and spin the facts to show that Protective does not pay for biopsies. Appellant's Brief at 28-30. Whether a biopsy is defined as "treatment" or a "diagnostic [procedure]" is not a material fact in this case. It is immaterial because it has nothing to do with the processing of Plaintiff's claim. In truth, when Plaintiff submitted his proof of loss for Ms. Zochert's biopsy in his August 4, 2014 Submission, Protective paid what was owed under the Policy. R.1458; App. 112; ProApp. 3-4.

The claim handler's note is also not material to how Plaintiff's claim was processed. Appellant's Brief at 30. The initial pathology report stated that Ms. Zochert was diagnosed with cancer on August 14, 2012. App. 118. The Policy covers expenses incurred within 10 days of cancer diagnosis. App. 79. Accordingly, the Policy covered

expenses incurred as early as August 4, 2012. All bills included in Plaintiff's first two submissions were associated with Ms. Zochert's August 14, 2012 procedure. *See* App. 107; R.1338-97. Those benefits were promptly paid upon receipt of the proof of loss. ProApp. 3-4; App. 110-11. Plaintiff's attorney supplied a spreadsheet almost two years later on July 21, 2014, including, for the first time, a list of expenses incurred from July 11 through July 19, 2012 (25 days before diagnosis). App. 60-61; R.1436-41. The fact the note says "(cannot process bills prior to date of diagnosis)," although technically a mistake according to the terms of the Policy, was *not* how Protective processed Plaintiff's claim and did not cause any loss to Plaintiff. The only conduct that is relevant is what Protective did when it received Plaintiff's spreadsheet—promptly notify Attorney Culhane that he needed to submit a pathology report for the first diagnosis of cancer and itemized bills for the items included in the spreadsheet in order for Protective to process his claim. ProApp. 53. As Ms. Valez stated in her deposition, "We said we needed the pathology report and the bills. We can't pay off of a spreadsheet." ProApp. 72-73.

Plaintiff also claims "Insurer knows Lenore's cancer was diagnosed as of July 11, 2012; the Physician's Statement expressly stated that." Appellant's Brief at 30. Once again, Plaintiff ignores the express terms of the Policy. App. 73. The Policy requires the insured be diagnosed with cancer in order to be covered, "such diagnosis must be based on microscopic examination of tissue . . . *performed by a qualified pathologist.*" App. 77 (emphasis added). It states, "This policy pays only for loss resulting from definitive Cancer treatment . . . . Pathologic proof thereof must be submitted." App. 82. The Physician Statement was not completed by a pathologist and does not contain pathologic proof of diagnosis. The first pathology report states she was diagnosed on August 14,

2012. App. 118. Relying on the only document that provided pathologic proof, as required by the Policy, Protective only knew Ms. Zochert was diagnosed on August 14, 2012.

Furthermore, the medical bills contained in Plaintiff's initial claim were for medical services after the August 14, 2012 pathology report. There was no indication that Ms. Zochert's cancer was formally diagnosed prior to August 14, 2012, because Plaintiff never submitted any bills for expenses other than those incurred during her August 14, 2012 hospitalization. *See* R.1179, 1453-66; App. 60. The first time Plaintiff indicated Ms. Zochert incurred expenses, beyond those incurred during her August 14, 2012 hospitalization, was when Attorney Culhane submitted his spreadsheet in July 2014. App. 60-61; R.1436-49. In response, Protective asked Attorney Culhane to submit a pathology report for the first diagnosis of Ms. Zochert's cancer and all itemized bills referenced in his spreadsheet. ProApp. 53. Plaintiff did so. Protective then paid all amounts owed under the Policy. App. 112-14; ProApp. 3-4; Appellant's Brief at 2 n.1.

Plaintiff claims Protective employed "efforts to avoid applicable coverage." Appellant's Brief at 31. Plaintiff misconstrues the comments of Protective's claim manager to try to contend that Protective does not investigate claims. *See* ProApp. 65-66. Protective does investigate claims. The claim manager simply uses a different term—process claims. *Id.* Plaintiff claims Protective "*requires*" insureds to sign a medical release, giving the insured a false impression. Appellant's Brief at 31. There is no evidence to support this assertion. The insured is advised to return the Patient Information form, Physicians Statement, a pathology report diagnosing cancer, all bills related to cancer treatment, and to contact Protective if he has any questions. App. 82;

ProApp. 16-18. Protective uses the release if there are discrepancies in the bills that need clarification and to obtain information if the insured advises Protective that he is having trouble obtaining it. ProApp. 71; R.895 (Henry Depo at 8:13-21); App. 116 (Protective clarified a discrepancy in the bill by contacting the provider). The release is not a proof of loss. The Policy does not say Protective was responsible for acquiring proof of loss for Plaintiff. App. 82. The Policy clearly places that duty on Plaintiff. *Id.* Plaintiff's claim, that having him sign a medical release has "harmful effects," is contrary to the terms of the Policy and is without any support in the record.

Plaintiff claims Protective does not "divulge that additional coverage apply, nor does it tell policy holders what is necessary to trigger benefits under those coverages." Appellant's Brief at 31-32. That is not the law in South Dakota or elsewhere.

Protective paid all benefits owed to Plaintiff every time he submitted proof of loss. The Policy was unambiguous. ProApp. 2-3. Plaintiff is charged with knowing the benefits in the Policy. ProApp. 4; *Elliot*, 523 N.W.2d at 102 (rejecting reasonable expectations argument, holding unambiguous language of the policy applies). Plaintiff was experienced with dealing with insurance and hired an attorney to handle the submission of his claim. ProApp. 11-15. When Plaintiff and his counsel contacted Protective with questions, Protective promptly and accurately responded to every inquiry, repeatedly informing Plaintiff to submit any additional bills and it would process them accordingly. *See* App. 144; ProApp. 24, 53-55; Part II, *supra*; SDCL § 58-12-34 (the only affirmative obligation is to provide insured with accurate information upon their inquiries). Rather than comply the Policy's requirements, it took Attorney Culhane nearly 18 months to provide Protective with Ms. Zochert's itemized bills.

Plaintiff claims Protective's incentive programs promote bad faith claim handling. Appellant's Brief at 32. Absent from the record is any evidence the incentive program had any impact on claim handling in this or any other case. Plaintiff claims the incentive program alone is indicative of bad faith, because such a program turns insureds into adversaries, which, as Plaintiff claims, is improper because Protective was a fiduciary to Plaintiff. Appellant's Brief at 33-35. Again, Plaintiff's position is without merit.

In the first-party scenario, insureds and their insurers *are* adversaries. *Bertelsen*, 2011 S.D. 13, ¶ 46; *Hein*, 2007 S.D. 40, ¶ 10. Accordingly, Protective cannot be a fiduciary. *See id.* ¶ 47. If Protective was a fiduciary, it would have to act for the benefit of Plaintiff on all matters within the scope of their relationship. *Dykstra v. Page Holding Co.*, 2009 S.D. 38, ¶ 27, 766 N.W.2d 491, 497. That is not the requirement in a first-party scenario. In the first-party scenario, an insurer cannot be a fiduciary because it would never be able to investigate the validity of a claim. *See Bertelsen*, 2011 S.D. 13, ¶¶ 47-48 (first-party insurer entitled to invoke attorney-client privilege against insured; third-party insurer is not). Finally, Plaintiff provides no authority to support his contention that merely having an incentive program indicates bad faith. *See Cohan v. Provident Life and Accident Ins. Co.*, 140 F.Supp.3d 1063, 1075 (D.Nev. 2015) (incentive program is not relevant, absent a showing the program had any bearing on the handling of insured's claim). Therefore, the fact Protective had an incentive program based on company performance has no bearing on bad faith.

Plaintiff argues he should not have "to hire an attorney to provide services necessary to get a claim paid." Appellant's Brief at 17. Plaintiff did not need to hire an attorney; he only needed to furnish itemized bills. Once he hired an attorney, however,

Protective requested the attorney submit itemized bills, as required by the Policy. It took Plaintiff's attorney approximately 18 months to do so.

Plaintiff hypothesizes that elderly patients may not be able to submit proof of loss, as the Policy requires. Appellant's Brief at 17. In this case, Plaintiff lived on a farmstead with his son, who helped care for him. R.940. Plaintiff had personnel at the nursing home assist him with his claim. R.945. He even had an attorney. ProApp. 14. At no time did he or his lawyer advise Protective they could not comply with the proof of loss requirements. ProApp. 55. They simply did not send the bills. Just as the first-party scenario does not create a fiduciary relationship, it also does not make Protective the insured's guardian or power of attorney.

CONCLUSION

Protective required Plaintiff comply with his duties as expressly set forth in the Policy. Once Plaintiff submitted proof of loss, Protective promptly paid benefits then owed. As a matter of law, Protective did not breach the implied duty of good faith, nor did it commit bad faith. The circuit court should be AFFIRMED.

Dated at Sioux Falls, South Dakota, this 29th day of April, 2018.

EVANS HAIGH & HINTON LLP

/s/ Edwin E. Evans

Edwin E. Evans
Ryan W. W. Redd
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599
Facsimile: (605) 275-9602
eevans@ehhlawyers.com
rredd@ehhlawyers.com

Attorneys for Appellee

CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that this Brief of Appellee complies with the type volume limitations set forth in SDCL § 15-26A-66(b)(2). Based on the information provided by Microsoft Word 2016, this Brief contains 9,973 words, excluding the table of contents, table of authorities, jurisdictional statement, statement of legal issues, any addendum materials, and any certificates of counsel. This Brief is typeset in Times New Roman (12 point) and was prepared using Microsoft Word 2016.

Dated at Sioux Falls, South Dakota, this 29th day of April, 2018.

EVANS HAIGH & HINTON LLP

/s/ Edwin E. Evans

Edwin E. Evans
Ryan W. W. Redd
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599
Facsimile: (605) 275-9602
eevans@ehhlawyers.com
rredd@ehhlawyers.com

Attorneys for Appellee

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

No. 28467

IVAN ZOCHERT,

Plaintiff/Appellant,

vs.

PROTECTIVE LIFE INSURANCE COMPANY,

Defendant/Appellee.

Appeal from the Circuit Court
Third Judicial Circuit
Moody County, South Dakota

The Honorable Patrick T. Pardy, Presiding Judge

APPELLEE'S APPENDIX

Seamus W. Culhane
Nancy J. Turbak Berry
TURBAK LAW OFFICE, P.C.
26 South Broadway, Suite 100
Watertown, SD 57201
Telephone: (605) 886-8361

Attorneys for Plaintiff/Appellant

Edwin E. Evans
Ryan W. W. Redd
EVANS HAIGH & HINTON LLP
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
Telephone: (605) 275-9599

Attorneys for Defendant/Appellee

Notice of Appeal filed December 5, 2017

PROTECTIVE LIFE'S APPENDIX

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STATE OF SOUTH DAKOTA) IN CIRCUIT COURT
:SS
COUNTY OF MOODY) THIRD JUDICIAL CIRCUIT

****

IVAN ZOCHERT, individually
and as Adminstrator for the
Estate of Lenore Zochert, MOTION
Plaintiff, HEARING

vs.

50CIV14-000061

PROTECTIVE LIFE
INSURANCE COMPANY,
Defendant.

****

PROCEEDINGS: Taken on November 6, 2017, in the Moody County Courthouse, in Flandreau, South Dakota, at the hour of 2:00 o'clock P.M.

BEFORE: The Honorable PATRICK T. PARDY, Circuit Court Judge

APPEARANCES: MS. NANCY TURBACK BERRY
AND
MR. SEAMUS W. CULHANE
Turback Law Office, P.C.
26 S. Broadway, Ste. 100
Watertown, SD 57201
For the Plaintiff

MS. KATHARINE A. WEBER
Attorney at Law
1901 Sixth Avenue North
2400 Regions Harbert Plaza
Birmingham, AL 35203
For the Defendant

MR. EDWIN E. EVANS
Evans, Haigh & Hinton
Attorney at Law
101 N. Main Ave., Ste. 213
Sioux Falls, SD 57104
For the Defendant

here if these are all limitations. Well, that's looking at it upside down. The reason we need them benefits consisting of the expenses is because that's what each one of these things are, benefits. And some of these benefits contain limitations. $160 a day for the first 10 days of hospital confinement. So, benefits are the expenses consisting of these benefits, subject to the limitations. No ambiguity, clear, unambiguous, and Summary Judgment should be granted since there's no ambiguity.

As far as his argument that you still can have bad faith, you have the chronology. The longest Protective Life ever took to issue a benefit after they received the bill was 21 days. And most were within seven. They always explained the process to him, they explained the benefits, and they explained the limitation of benefits. They were cooperative in every form. The only thing they consistently did, or one of the -- they were consistent throughout, and the one thing they did is please send us the bills that unfortunately were not forthcoming.

THE COURT: Thank you. Well, first I will find or I'll rule, and when the Court reviews the plain language of the cancer policy, that it is unambiguous. And I have reviewed all of those

exhibits that you had laid out before me today, specifically the first page of the policy clearly states, "Benefits for hospital services and other expenses caused by cancer to the extent herein provided." Page 6, "This policy provides benefits for loss due to hospital confinement and certain other expenses resulting from treatment for cancer of an insured."

And page 7, the Schedule of Benefits, "Such -- such expenses will consist of the actual charges by the hospital, physician, or other provided -- providers, subject to the limitations stated herein." Those paragraphs include limiting language. And the language used throughout the policy makes it clear the policy is subject to those limitations. And the policy clearly states that it will provide for the benefits for loss incurred due to the hospital confinement, and the Schedule Of Benefits explains how those benefits due to the hospital confinement will be calculated.

I do find that Protective Life did not breach its Contract with the Plaintiff. It appears from a review of the record that the insurer made timely payments once the pathology report was received, and additional payments once itemized bills were

received.

The Plaintiff's argument for failure to pay other benefits allegedly owed, I -- really I addressed it with my first statement in regards to interpretation of the Contract, but those are outside of what is required by the policy.

I do find that the Plaintiff's claim on covenant of good faith and fair dealing fails as well. The benefits were clearly articulated in the policy. The Plaintiff should have had knowledge of the same. Specifically, the benefit for home recovery are listed on page 7 of the policy, and that information was not held from the Plaintiff. Protective Life paid the benefits that the Plaintiff was entitled in accordance with the language of the policy, and had not breached the language of the policy, and had not acted deceitful.

In regards to the independent tort for breach of duty of good faith and fair dealing, this Court finds that South Dakota's not recognized that action. And if it did, the record does not support such a claim. And for those same reasons the request for attorney's fees is dismissed as well.

The Plaintiff's Motion for Summary Judgment is denied, and the Defendant's is granted. I don't

believe there's anything else I have to deal with today for the parties. The -- I know you all worked very hard on it, we read everything, I will give this back to you, you will need it for your record.

MR. CULHANE: Thank you, Judge.

THE COURT: Mr. Evans, anything further today?

MR. EVANS: No, Your Honor. We'll prepare the Order and mail it to you after counsel has an opportunity to review it.

THE COURT: Alright. Mr. Culhane, anything else?

MR. CULHANE: Nothing, sir.

THE COURT: Alright. Thank you.

(End of the proceedings).

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

Ivan Zochert, individually and as Administrator for the Estate of Lenore Zochert, Appelant, vs. Protective Life Insurance Company, Appellee.	APPELLANT'S DOCKETING STATEMENT #_____

SECTION A. TRIAL COURT

1. The circuit court from which the appeal is taken: Third Judicial Circuit
2. The county in which the action is venued at the time of appeal: Moody County
3. The name of the trial judge who entered the decision appealed: Honorable Patrick T. Pardy

PARTIES AND ATTORNEYS

4. Identify each party presently of record and the name, address, and phone number of the attorney for each party.

Attorneys for Appellant:
Seamus W. Culhane
Nancy J. Turbak Berry
Turbak Law Office, P.C.
26 S. Broadway—Suite 100
Watertown, SD 57201
seamus@turbaklaw.com
nancy@turbaklaw.com
(605) 886-8361

Attorneys for Appellee:
Edwin E. Evans
Ryan W. W. Redd
Evans Haigh & Hinton, LLP
101 North Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101-2790
eevans@ehhlawyers.com
rredd@ehhlawyers.com
(605) 275-9599

Katharine A. Weber
Maynard, Cooper & Gale, P.C.
1901 Sixth Avenue North, Ste. 2400
Birmingham, AL 35203
kweber@maynardcooper.com
(205) 254-1070

SECTION B. TIMELINESS OF APPEAL

1. The date the judgment or *ORDER* appealed from was signed and filed by the trial court:
   a. Judgment was signed and filed by the trial court November 7, 2017.

2. The date *NOTICE OF ENTRY OF JUDGMENT* or order was served on each party:
   a. *NOTICE OF ENTRY OF JUDGMENT* was served by Odyssey File and Serve system on November 8, 2017.

3. State whether either of the following motions was made:
   a. Motion for judgment n.o.v., SDCL 15-6-50(b): No
   b. Motion for new trial, SDCL 15-6-59: No

NATURE AND DISPOSITION OF CLAIMS

4. State the nature of each party's separate claims, counterclaims or cross-claims and the trial court's disposition of each claim:

- Plaintiff filed a breach of contract claim against Defendant for failure to pay insurance contract benefits due to Plaintiff after Plaintiff's late wife, who was also an insured, was diagnosed with breast cancer and filed a claim for cancer related benefits on an in-force cancer insurance contract purchased 22 years earlier. After the diagnosis of breast cancer, following anesthesia & biopsy, surgery & anesthesia, multiple doctor and nurse visits, a hospitalization, and an intensive care stay, Defendant made only partial payment of the amounts owed under the surgical benefit in the policy.

  Defendant did not notify Plaintiff of other potential benefits under the policy. Defendant did not make any investigation into things that would lead to the payment of Plaintiffs benefits for the things that were clearly owed under the insurance policy, including the surgical biopsy, anesthesia that accompanied the biopsy and the eventual surgery to remove the cancer, in hospital room and board, in hospital attending physician and nursing benefits, nor home recovery benefits. These benefits were all available under the policy, many of which were clearly owed from the very beginning of the claim.

  Plaintiff hired counsel, who made investigation that Defendant should have made, identified potential coverages and after approximately 24 months, was able to obtain for Plaintiff most of the benefits that had been arbitrarily and unfairly withheld from Plaintiff. Because of the Defendant's complete and total failure to investigate Plaintiff's claim, Defendant's failure to fairly process Plaintiff's claim, Defendant's failure to disclose applicable coverages and Defendant's failure to treat Plaintiff's interests with equal consideration to its own interests, Plaintiff also filed suit for the breach of the implied duty of good faith and fair dealing i.e. "insurance bad faith" implicit in the cancer insurance contract at issue.

- Defendant alleges that because it made payment of benefits it owed once Plaintiff's counsel obtained medical records, identified potential coverage(s), and specifically requested payment of particular benefits within 30 days of receiving various submissions, it did not breach the contract nor act in bad faith for failure to fairly investigate, process and pay a claim that it received as much as two years prior. Defendant also alleges that Plaintiff acted in bad faith.

- The trial court ruled that Defendant did not breach the insurance contract. The trial court also ruled that there is no cause of action for the implied breach of good faith and fair dealing in insurance contracts in South Dakota. The trial court further ruled that if there

is a bad faith cause of action in South Dakota, there are no genuine issues of material facts to be tried to a jury regarding said cause of action. Thus, the trial court denied Plaintiff's *MOTION FOR SUMMARY JUDGMENT*, granted Defendant's *MOTION FOR SUMMARY JUDGMENT*, dismissed Plaintiff's *COMPLAINT* with prejudice, and awarded Defendant costs in the sum of $1,446.40.

5. Appeals of right may be taken only from final, appealable orders. See SDCL 15-26A-3 and 4.

   a. Did the trial court enter a final judgment or order that resolves all of each party's individual claims, counterclaims, or cross-claims? Yes.

   b. If the trial court did not enter a final judgment or order as to each party's individual claims, counterclaims, or cross-claims, did the trial court make a determination and direct entry of judgment pursuant to SDCL 15-6-54(b)? N/A

6. State each issue intended to be presented for review.

   Whether the trial court erred in finding Defendant did not breach the insurance contract?

   Whether the trial court erred in finding that there is no cause of action in South Dakota arising from the breach of the implied duty of good faith and fair dealing in an insurance contract?

   Whether the trial court erred in effectively finding that Defendant had no duty to investigate an insured's claim despite having received notice of claim, a medical release authorization, and a proof of loss?

   Whether an insured must specifically identify and elect upon which insurance coverages their claim is based to be entitled to payment?

   Whether eventual payment of insurance contract benefits following a lengthy delay, added expense of legal counsel's involvement and an eventual lawsuit alleviates an insurer's good faith duty to fairly process and pay an insured's benefits such that summary judgment is appropriate in the insurer's favor because it eventually paid benefits?

Dated December 5, 2017

TURBAK LAW OFFICE, P.C.
Attorneys for Appellant

By: Seamus W. Culhane
Nancy J. Turbak Berry
26 South Broadway, Suite 100
Watertown, SD 57201
605-886-8361
seamus@turbaklaw.com
nancy@turbaklaw.com

In The Matter Of:

Ivan Zochert v.

Protective Life Insurance Company

Ivan Zochert

November 17, 2016

Video Deposition

Pat Beck, Court Reporter

Original File 111716Zochert.txt

Min-U-Script® with Word Index

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A Well, the funeral home furnished them.
Q Gave you the death certificate?
A Yeah.
Q And then did you submit it to the insurance company or did somebody on your behalf?
A I think I sent it to them, yes.
Q And that was a requirement that they said they needed that; right?
A Yes.
Q And so you did that?
A Yes.
Q Exhibit 1, the Protective Life Insurance policy that you bought back in 1990, did you know that was a cancer policy when you bought it?
A Yes.
Q You knew it wasn't a life insurance policy?
A Oh, yeah. Yeah.
Q And you knew it wasn't a health insurance policy?
A Yeah.
Q But it was a policy for -- to pay for some benefits for cancer treatment; correct?
A Yeah. It was supposed to cover -- supposed to cover any costs with cancer.
Q Why did you and your wife decide to buy a

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cancer insurance policy?
A In my years of farming, I always tried to insure everything that I couldn't control myself; wind, hail, and so forth. Cancer, I -- you can't control that. When it comes, it comes.
Q During your life, before you turned 65 and went on Medicare, did you have health insurance?
A Oh, yes.
Q And that would provide benefits for you if you were ill; correct?
A Yeah.
Q Including if you had cancer; right?
A I suppose. I -- I don't --
Q But this was going to be an additional benefit that was related to cancer only?
A Yeah.
Q You understood it wasn't for health insurance, in general?
A Yeah. Right.
Q Did you go on Medicare when you turned 65?
A I had bypass surgery, heart surgery when I was 58, and they put me on Medicare. Back then it was just automatic, you went. They didn't even ask you. Just put you on.
Q And so because of your heart surgery you were

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considered you had this disability because of the heart surgery, so you just went on Medicare; correct?
A Yeah.
Q Have you ever had any Medicare supplemental coverage, a Medicare supplement policy?
A Well, we do -- yeah, I do. It's -- I'm trying to think of the name of the company. Yeah, I do. We had Blue Cross for a lot of years, and then we switched now --
Q Yeah.
A -- to Medica.
Q But, I mean, Medicare only pays a portion of your medical bills if you -- if you get sick; right?
A Yeah. I guess so.
Q And then you have a supplemental policy that you pay for and pay a premium for to get additional benefits that Medicare doesn't cover?
A Yeah. Yeah.
Q Okay. So if you went on Medicare after your heart surgery, when you bought this cancer policy you would have already been on Medicare; correct?
A I suppose, but that was before that.
Q Well, if you were 58 --
A Fifty-eight, yeah. It was before that, yeah.

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Q Yeah. Because this you would have gotten in 1990. So in 1990 you would have been 66 years old or so, about?
A Yeah, yeah.
Q Except for this Protective Life policy and the life insurance for your wife that we talked about earlier, have you ever had to submit other claims to insurance companies?
A Well, we had things happen. My wife had both hips replaced and one knee. I'm sure the insurance paid for it. I know they did.
Q Yeah. I mean, have you ever -- you mentioned wind, and hail, and risks like that. Have you ever submitted claims for any wind damage, or storm damage, or hail damage?
A Oh, yes. Yeah.
Q And you had to submit certain things to the insurance company for that?
A Well, they'd just come out and take pictures of things.
Q But, like, if you had bills to repair, reshingle a roof or repair things, did you have to submit those to the insurance company?
A Oh, sure.
Q So you would submit the bills you wanted paid

EXHIBIT
tabbies
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to the insurance company; correct?
A Yeah. Yeah. They come out and inspect it, and then I get a contractor to come in and see what it would cost and that's what we'd settle on.
Q And you'd submit the contractor's estimate, or whatever --
A Yeah.
Q -- to the insurance company?
A Yeah.
Q And that was a part of the process in order to get paid?
A Yes.
Q The life insurance policy that you had on your wife, did that -- was that through the same person that sold you this Exhibit 1, this Richard Belsaas?
A Belsaas. It could have been, yeah.
Q Okay. I mean, do you think you had, you had other business dealings with him other than this and your kids as well?
A Yeah. He probably did sell that to us.
Q Okay. Now, one of the documents that your lawyer, Mr. Culhane, gave us is what I'm going to show you. It says, "Cancer Pay Plus." And this is Exhibit 12. Have you ever seen that before that you know of?

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A Dick Belsaas.
Q That's what I wondered. It has the insurance agent's stamp on it here on the first page. Did he give that to you, do you know?
A I don't know. If it was part of the policy, well, he probably did. I -- I don't know.
Q Okay. Well, that was my question, whether you understood this was a part of the policy or not, but you just don't know?
A I suppose it is, but I don't know for sure.
Q Yeah. Well, the reason I ask that is when I look -- go back to Exhibit 1, in your application here, it talks about different policies that are available, cancer policy. And you can get a CA-05, a CA- -- or I guess a CA-03, a CA-04, and a CA-05. Do you see that?
A Yeah.
Q And apparently you picked the CA-05.
A So?
Q Well, and this -- and this Exhibit 12 shows a CA-08 which would be a different policy. And so I'm wondering if this was given to you by him but it was something that was different than this policy that you bought. Do you know?
A Don't know.

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Q All right. Did he go over different -- do you recall if he went over different types of policies with you and that had different benefits?
A I don't remember.
Q Long time ago?
A Yeah.
Q And that's fine. If you don't remember, that's fine. I'm just trying to get your best recollection of what you do remember. Okay, sir? Thank you.
I also note in Exhibit 1 that it says that the policy you are getting from him, under No. 3 here, it says, "Is this insurance intended to replace or change other cancer insurance in force?" And you have the name of Capitol American Life Insurance Company and a policy number written down there. Do you see that? Take a minute and look at that?
A (Witness complies with request.)
Q And I guess my question is: Were you replacing a cancer policy that you had before this?
A I don't know.
Q Okay. Don't remember?
A (Witness indicates.)
Q Did you have any other cancer insurance policies other than Exhibit 1, the one that we have

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here in front of us?
A Not that I know of.
Q Okay. Now, when you bought Exhibit 1, do you know, did your agent, Mr. Belsaas, bring it out to you and give it to you, do you recall?
A Did he what?
Q Bring it out and deliver it to you, the policy?
A I don't remember.
Q Okay. And the reason I ask is I think sometimes they just mail you a policy and sometimes an agent will bring it out and give it to you. And do you recall which happened in this case?
A Well, we're in Watertown so many times, and I don't know. I may have stopped and picked it up. I don't know.
Q Sounds right -- sounds fair. And I guess my question is: Did he ever go over this with you, the policy and what the benefits were?
A Well, as far as I remember it was supposed to pay for everything cancer.
Q Okay. But did he ever go over and talk to you about that, talk about it?
A Well, I suppose he did. I've known Dick for a few years.
Q Is he still alive?

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Q Okay.
A And I got along good with everybody.
Q When you sent in Exhibit 3 to Protective Life with that doctor's statement, and then this form that you signed, and the hospital bill; did you have any objection to furnishing that information to Protective Life?
A No. I don't think I did.
Q Okay. I mean, they'd requested it and so that's what you sent them; correct?
A Yeah, yeah.
Q I mean, you didn't object or say, Why do you need this, or, I'm not going to send it to you, or anything like that?
A No, no, no, no, no.
Q Okay. Did you have any problem with furnishing it to them? I mean, did you have any concerns or problems about furnishing this to them?
A No, no.
Q Next I'll show you -- and this is maybe one of the things that you and Mr. Culhane looked at. This looks like a check that they sent you -- or an explanation of benefits, I should say, not a check. An explanation of benefits that they sent you that it says the date processed was September 21, 2012.

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Do you recall getting that in the mail from them?
A No.
Q You don't recall that?
A Well, they're just asking for reports, aren't they?
Q I think that what they said is that they wanted a pathology report --
A Yeah.
Q -- with the diagnosis of cancer. Do you recall getting that?
A Well, I don't know if I got it. I think the doctors would have furnished that.
Q Okay. But I think that this came to you, and then did you make arrangements to send the pathology report to them, do you recall?
A I don't remember if I sent it or what.
MR. CULHANE: What Bates number? You're looking at 201 on the front page of Exhibit 4?
MR. EVANS: Yes.
MR. CULHANE: But I see there's multiple pages there.
MR. EVANS: There's the next page which is -- oh, the reason there's multiple pages is because you're supposed to get one.

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MR. CULHANE: Thank you.
Q (By Mr. Evans) And then I'll show you Exhibit 5, and it looks to me that Dr. Christensen's clinic, the Sanford Clinic here in Watertown, sent that pathology report to them. Is that what happened? Is that what your understanding is?
A Well, I suppose. They'd be the ones that would send it.
Q So when they asked you for a copy of it, you had the doctor's office send it?
A I suppose.
Q And, again, did you have any objection to sending that pathology report?
A No.
MR. CULHANE: Those are pages 203 -- 202 and 203?
MR. EVANS: Yes.
MR. CULHANE: Okay.
Q (By Mr. Evans) I mean, they said they needed that to show that your wife's surgery was related to cancer and so you made arrangements to get them that information?
A Yeah.
Q All right. And that was okay with you?
A Well, yes. You got to give them the

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information.
Q I understand. I mean, that seemed like a reasonable request to you for them to ask for that pathology report and then send it in?
A Oh, yes. Yes.
Q I'm next showing you Exhibit 6, which is Protective Life 31 with a page attached that's not Bates stamped.
MR. CULHANE: Can we use the Bates stamped one if I have one?
MR. EVANS: Pardon?
MR. CULHANE: Can we use --
MR. EVANS: No. It's just the second page that doesn't have a Bates stamp. First page does.
MR. CULHANE: Okay. All right.
Q (By Mr. Evans) So Exhibit 6, do you recall receiving that check then from Protective Life?
A For 420?
Q Yes.
A Yeah, I got that when I --
Q And did you cash the check?
A After a while, yeah. Yeah.
Q And then what happened next after you got Exhibit 6 and cashed the check?
A (Witness indicates.)

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Q Do you recall calling them and asking them why the check wasn't bigger than that?
A I don't think I called them. If I did I don't remember it.
Q Fair enough. And, again, we're talking about a phone call several years ago?
A Yeah.
Q So I don't blame you for not remembering. But I want to show you Exhibit 7, which is Protective Life 0216. And this -- the reason I say you might have called on this because the first sentence says, This letter is in regards to our phone call on December 13, and your inquiry, which suggests to me, at least, that you might have called them and asked a question about your --
A Looks like it, by that.
Q And then they sent you this letter to explain; correct?
A I suppose, yes.
Q Do you recall getting the letter as we sit here now or not?
A No, I don't, but I must have.
Q Fair enough. Do you recall what you did after getting a copy of Exhibit 7, this letter?
A Well, sometime in there I went and talked to an

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attorney.
Q Okay. And I think you're right because the next thing that I have in order here as far as the paper trail, so to speak, Exhibit 8 looks like a letter from Mr. Culhane to the insurance company in March of 2013. Take a minute and look at that, if you would, sir.
A (Witness complies with request.) Yeah.
Q Is it fair to say that after you got Exhibit 7 that said that we've paid you according to the policy, that you went to see Mr. Culhane sometime after that?
A Yes.
Q After you went and saw Mr. Culhane, did you have any further contact with Protective Life or anyone at Protective Life, or did you just leave it up to him?
A I don't know. I don't remember that they contacted me, but I'm sure they did him.
Q No, no. And I know that. I'm just saying that basically, after you got Exhibit 7, did you just turn it all over to your lawyer to handle?
A Well, more or less, yes.
Q I mean, there's a lot more correspondence and things between your lawyer and Protective Life. And

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I just wondered if you knew anything about that or if you basically said I just turned it over to the lawyer and let him handle it?
A Well, no. That was his job. He was supposed to handle it.
Q Okay. So as far as furnishing them information or doing whatever needed to be done, that was -- you just left that to the lawyer?
A I -- I guess so. I didn't have any other information.
Q Okay. I mean, do you recall you having any further contact at all with Protective Life after you got the letter in December of 2012, Exhibit 7?
A No. I don't remember. If I did, I don't remember it.
Q Okay.
A My wife died shortly after.
Q I think in August -- early August 2012, did she?
A Yeah. The 2nd of August.
Q And -- and what was her -- what caused her to pass on?
A They took her down to the -- see, the home in Webster is right part of the hospital. They took her down there and said they couldn't do anything

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with her. And they called me and wanted to know if she should go to Watertown. And I said, well, yes, get going and I'll be down there. And when I got to Watertown, Dr. Feeney was the one looking after her up there. And he met me before I went up there, and he told me she wasn't going to make it. She was already dead.
Q Kind of an overwhelming infection of some kind, was it, that got her?
A She was so full of infection that nothing would -- they couldn't make anything respond anymore.
MR. CULHANE: I believe you said 2012, but that's not right.
MR. EVANS: I'm sorry. 2013.
MR. CULHANE: I think it was '13.
MR. EVANS: 2013. Yeah.
A Yeah. She was cold when I got there.
Q (By Mr. Evans) Any further cancer treatment that she had after she had those surgeries in the summer of 2012?
A No. I think she had some infection once.
Q But, I mean, no more treatment for her cancer.
A No. No. She came up clean as far as the cancer goes.

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Q And she never -- I notice she never had chemotherapy or anything like that?
A No, no. They -- he had a doctor in Watertown at this Cancer Center, Sanford's here, working with him and advising him, too. No. No, they got --
Q So they decided no chemotherapy drugs or --
A No. They said she didn't need it. They got it all.
Q Okay. And no radiation as far as --
A No.
Q -- that they have sometimes?
A No.
Q None of that. Okay.
A They could answer those questions better than I can.
Q No. I understand. I'm just trying to get a general idea as long as we're here, sir, but I appreciate you trying to help me, but I understand that you aren't a physician and neither am I.
Do you know, did this Exhibit 8 where your -- Mr. Culhane writes Protective Life Insurance in March of 2013, it shows you got a copy of that letter. So he's sending copies of the letters to you. Do you know if he ever got an answer to this letter from Protective Life?

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A If he did?
Q Yeah.
A I don't know. I can't say that I saw that, that I remember. I don't know.
Q Okay. Again, after this, the correspondence or the dealings between the insurance company were between the insurance company and Mr. Culhane and you just were having him handle it?
A Yeah.
Q Showing you Exhibit 9, it looks like in May of 2013 you got another check from Protective Life; is that correct?
MR. CULHANE: The exhibit's over the Bates. What is that Bates?
MR. EVANS: Well, it's whatever check is dated -- processed on May 9th, 2013.
MR. CULHANE: I've got one from May 13th.
MR. EVANS: That's May 13th. That's what I'm saying.
MR. CULHANE: I thought you said May 9th. I'm sorry. Okay. Yes, I think that's Bates number 32, I believe.
Q (By Mr. Evans) Do you recall getting that check?
A I don't remember that check exactly, but did I

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cash it?
Q That was going to be my next question. But if you don't remember whether you got it or not you probably don't remember if you cashed it.
A Well, you should know if they got the check back.
Q Well, I understand. I'm just asking you. I haven't asked them if the check was ever cashed. I was just asking you since I'm here, but that's a good point. I can ask them.
A Well, I don't remember getting it, but if I got it I most likely cashed it.
Q I understand. Just a few general questions and I'm done.
Did you ever express any objection to Protective Life Insurance Company to having to furnish them a copy of the bills from the hospital and the doctor to review before they paid them, or paid -- issued a check to you? Did you ever object to that?
A Did I what?
Q Ever object to having to send in these bills and information that the insurance company wanted?
A Well, I don't think so. I don't know.
Q Okay. I mean, I just wondered if you ever

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said, I'm not doing this, or, This isn't reasonable, or, I object to doing this; did you ever do that?
A I don't think so, but --
Q Okay.
A -- I don't remember doing it.
Q Well, in fact, you did submit some of the bills when they asked you to, didn't you?
A Well, I'm sure they got copies of any bills they wanted.
Q I understand. I mean, when they asked you for copies of the bills, or the pathology report, or whatever, you made arrangements for those to be sent to them; correct?
A Yeah.
Q And that was okay with you; you didn't have a problem with that?
A No, no.
Q And then after you turned it over to Mr. Culhane, it was up to him to submit what the insurance company wanted?
A Yes.
MR. EVANS: That's all I have. Thank you.
MR. CULHANE: Ivan, I want to ask you a few questions. Do we need to take a bathroom break? We'll take a bathroom break and switch places.

Benefits and Health Administration

P.O. Box 10807 Birmingham, AL 35202
Toll Free 1-800-866-3808

August 17, 2012

Claim Form Request

Leonard Zochert
13758 441st Ave
Webster, SD 57274-5707

RE: Protective Life Insurance Company
Insured: Ivan E. Zochert
Patient: Ivan E. Zochert
Policy Number: D00054903

Dear Insured:

This letter acknowledges receipt of your request for claim form(s). Enclosed you will find the claim form(s) you have requested. We strive to provide the best customer service by processing this completed claim according to the policy provisions as quickly as possible.

If you have any questions concerning the above, please do not hesitate to contact us at our toll-free number of 1-800-866-3808. We are available Monday through Thursday from 8:00 AM to 5:00 PM CST and on Friday from 8:00 AM to 3:00 PM CST.

Sincerely,

Debi Henry
Benefits Department

Protective Life Insurance Company
P. O. Box 10807
Birmingham, AL 35202
1-800-866-3808

Failure to complete this form in its entirety may result in a delay in processing this claim.
Please include your policy number on all documents.

Policy Number _____ Insured's Name _____ Patient Name _____

☐ Cancer Policy ☐ Hospital Intensive Care Policy ☐ Dread Disease

CANCER CLAIMS:

- **A PATHOLOGY REPORT diagnosing cancer MUST accompany your first claim.** The hospital or doctor will furnish this report to you at your request. If the diagnosis of cancer was made clinically instead of pathologically, please submit the clinical evidence that established the diagnosis of cancer.
- Submit all bills related to this cancer claim. All bills should be itemized and should include the Diagnosis, Services rendered, and actual Charges for the service, Provider's Name, Address, Phone Number and Provider's Federal Tax Identification Number.
- Please have your doctor complete section B: Physician's Statement.

DREAD DISEASE:

- Submit all bills related to this Dread Disease. All bills should be itemized and should include the diagnosis, services rendered, and actual charges for the service, provider's name valid address, phone number and Tax ID #.
- Please have your doctor complete section B: Physician's Statement.

HOSPITAL INTENSIVE CARE CLAIMS:

- Send a copy of your hospital bill that lists the number of days confined in the Intensive Care Unit.
- This bill should include the diagnosis, services rendered, and actual charges for the service, Provider's Name Address, Phone Number and Provider's Federal Tax Identification Number.
- If your confinement is due to an accident, please have your doctor complete section B: Physician's Statement.
- If you policy has been issued within the last 24 months, please have your doctor complete section B: Physician's Statement.

DECEASED

- Please include a copy of the death certificate if the Insured/patient is deceased.

SECTION A: PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ ( ) New Address please check box

City _____ State _____ Zip _____

Social Security Number (optional) ____/____/____ Date of Birth____/__/____ Sex: M ☐ F ☐

Phone Number (____) _____-_____ RELATIONSHIP: ☐ Self ☐ Spouse ☐ Dependent

Dependent Full Time Student ☐ Y ☐ N, Is Dependent Married? ☐ Y ☐ N

☐ **Eligible for Medicare Benefits: Effective Date if Applicable:** _____
☐ **Eligible for Federal or State Medicaid Benefits: Effective Date if Applicable:** _____

_____ _____ ____/____/____
INSURED / PATIENT SIGNATURE Relationship if other than Insured Date

ProtectiveLife 0175

PHYSICIAN STATEMENT

POLICY NUMBER _____ **PATIENT NAME**_____

Failure to complete this form in its entirety may result in a delay in processing this claim.
Please include your policy number on all documents.

SECTION B: PHYSICIAN'S STATEMENT (To be completed by your treating physician)

1. Has patient been diagnosed with Cancer : Y ☐ N ☐
2. Date of initial diagnosis: ____/____/_____
3. Patient first consulted with you for this condition on:____/_____/____
4. Has patient ever had same or similar symptoms : Y ☐ N ☐
5. Did any other Physician previously treat the patient: Y ☐ N ☐
   If Yes, Physician's Name _____

   Referring Physician's Address_____

   Referring Physician's Phone Number _____

- **Hospitalization Information:**

1. Admission Date: ___/___/____ Discharge Date___/___/_____ Diagnosis / ICD Code _____

   Hospital Name: _____

   Hospital Address: _____City_____State_____
2. Admission Date: ___/___/____ Discharge Date___/___/_____ Diagnosis / ICD Code _____

   Hospital Name: _____

   Hospital Address: _____City_____State_____

- **Surgery Information:**

  Date: ___/___/___ CPT Code: _____ Description: _____Charge_____

  Date: ___/___/___ CPT Code: _____ Description: _____Charge_____

- **Physician Information:**

Physician's Name_____
(PLEASE PRINT)

Physician's Address_____

City _____ State_____ Zip _____

Physician's TAX ID # _____ Phone Number _____ Fax Number _____

Physician's Signature _____ Date _____

ProtectiveLife 0176

Benefits and Health Administration

Division of Protective Life Insurance Company

PO Box 10807 Birmingham, AL 35202 Toll Free 1-800-866-3808

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION FOR EVALUATION OF CLAIM

1 Authorization and Purpose I, _____ the owner of Policy #_____ authorize Protective Life Insurance Company and its reinsurers to obtain and use information about or relating to the insured that is relevant to evaluating a claim for benefits of a Protective policy insuring the life of the insured. With this authorization, Protective may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical diseases and illness. With this authorization Protective may also obtain information about mental diseases and illness including psychiatric disorders.

2 Persons and Organizations Authorized to Release and Disclose Information I authorize the following person(s) and organization(s) to release and disclose the information described in paragraph 1 to Protective or its agents acting on its behalf: (i) doctor(s); (ii) medical practitioners; (iii) pharmacists; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) employers of the insured; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** (such as Equifax Medical Services) acting for Protective. **MIB** may not release the information described in paragraph 1 to a **CRA**. I authorize Protective to release and disclose any information obtained through this authorization to its reinsurers, its affiliated companies, the insured's insurance agent or agents servicing the insured's Protective policy or policies and persons or organizations providing services, including legal and investigative services, to Protective relating to claims administration.

3 Expiration of this Authorization This authorization shall be valid from the date signed for the duration of a claim for the benefits of a Protective Insurance policy. This authorization shall expire on the earlier of the date the claim for which this authorization is given is either paid or denied or twenty-four months from the date this authorization is signed.

4 Revocation of this Authorization I understand that I have the right to revoke this authorization by writing to Claims Administration P.O. Box 3129 Brentwood TN 37024-3129. I also understand that revocation of this authorization will not affect any action taken in reliance on this authorization before Protective receives written notice of the revocation nor will the revocation be effective to the extent other law provides Protective with the right to contest a claim under the policy or the policy itself.

Signature and Date of Authorization

I have had full opportunity to read and consider the contents of this authorization. I understand that I may refuse to sign this authorization and that Protective does not condition payment of a claim for benefits on whether or not I sign this authorization. I further understand that pursuant to the policy, Protective is eligible to require written proof of loss in order to process a claim under the policy. I also understand that by signing this form I am granting to Protective the authority to obtain, use and disclose information as described for the purposes stated in this form. I further understand that if the persons or organization I authorize to obtain or use the information through this authorization are not subject to federal health information privacy laws, they may disclose the information, and it may no longer be protected by the federal health information privacy laws.

Signature_____, Policy Owner

Signature _____, Insured (if different from owner)

Date _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

ProtectiveLife 0177

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For you protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to civil and criminal penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Washington DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false incomplete, or misleading information is guilty of a felony in the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company of other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. "MD code Ann. Ins. HB 301, 27-805."

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with intention of defrauding presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia, Washington: It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (NAIC Model)

TURBAK LAW OFFICE, P.C.

March 13, 2013

Protective Life Insurance Co.
P.O. Box 10807
Birmingham, SD 35202
Examiner TN S01

Re:

Your Insured:	Ivan & Lenore Zochert
Policy Number:	D00054903
Date of Injury:	8/14/2012
Claim #:	LV1C02324-00

Dear Protective Life Insurance Co.:

I've been asked to look into the cancer policy claim filed by Ivan and his wife Lenore following breast cancer, cancer surgery and a hospital stay endured by Lenore Zochert.

What did Protective Life rely upon in paying $300 in surgical benefit for Lenore's surgery?

Under the schedule of benefits it indicates that the standard value for surgical benefits is $50 per unit and the "Surgical Value" is 8.0. It appears to me that Lenore should have been paid $400 in surgical benefit.

What is the reason that benefits were not paid under other provisions in the policy such as the "**In-Hospital Room and Board Benefit**"; or the "**In-Hospital Attending Physician Benefit**"?

Please let me hear from you promptly,

Best Regards,

Seamus W. Culhane

Cc: Ivan Zochert

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1301 4th Street NE · Watertown, SD 57201-1206
(605)886-8361 · FAX (605)886-8383 · nancy@turbaklaw.com

ProtectiveLife 0219

TURBAK LAW OFFICE, P.C.

May 6, 2013

Lia Velez
Benefits Department
Benefits and Health Administration
Division of Protective Life Insurance
P.O. Box 10807
Birmingham, SD 35202

Re:

Your Insured:	Ivan & Lenore Zochert
Policy Number:	D00054903
Date of Injury:	8/14/2012
Claim #:	LV1C02324-00

Dear Lia:

Pursuant to your letter of March 22, 2013, enclosed please find a CD containing copies of the following:

1. *Billing from Prairie Lakes Healthcare dated 8/14/2012 for OR services, including lab and pharmacy*
2. *Billing of Edward Wegner for services rendered to Mrs. Zochert while she was hospitalized*
3. *Billing for Keith Wanner for services rendered to Mrs. Zochert while she was hospitalized*
4. *Prairie Lakes Healthcare (hospital) records for Mrs. Zochert dated 8/14/2012 and 8/15/2012*

If anything further is required for processing, please contact me. Thank you.

Best regards.

TURBAK LAW OFFICE, P.C.

Seamus W. Culhane
seamus@turbaklaw.com

Enc.

Cc: Ivan Zochert

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1301 4th Street NE · Watertown, SD 57201-1206
(605)886-8361 · FAX (605)886-8383 · nancy@turbaklaw.com

Henry, Debi

From: Henry, Debi
Sent: Monday, August 26, 2013 12:11 PM
To: 'seamus@turbaklaw.com'
Subject: ApplicationXtender - AppXtender - POLICY - HEALTH
Attachments: AppXtender - POLICY - HEALTH.pdf

Mr. Culhane, please find attached, our response to your letter dated March 13, 2013 regarding D00054903 Ivan and Lenore Zochert. Since this letter we have processed the room and board benefit on May 13, 2013 when the itemized bills were presented on May 9, 2013. We have not processed any Attending Physician Benefits because we have yet to receive any itemized bills for August 12, 2012 through August 16, 2012 from the physician.

There is no timely filing for a cancer claim, once we receive any/all itemized bills pertaining to cancer treatment, we will process according to policy provisions. If you have any further questions, please do not hesitate to contact us at 800-866-3808.

Henry, Debi

From: Henry, Debi
Sent: Tuesday, August 27, 2013 10:55 AM
To: 'Seamus Culhane'
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

Mr. Culhane,

The surgical benefits are based on California Relative Value Schedule with a unit value according to the procedure code the surgeon's indicate on their itemized bills. When the procedure code is put into the system, it calculates the benefits based on relative value schedule. Each procedure code is given a Unit Value (exp: 5.0, 0.72, 12.0, etc) these units are based on $50.00 per unit value. This is why we need the itemized bills from physician so a benefit can be determined on all procedures.

The procedure codes we used for the two surgeries below were the ones from Dr. Alan Christinson based on the Physician's Statement he filled out. (19301 and 12035)
Thank you

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Tuesday, August 27, 2013 9:23 AM
To: Henry, Debi
Cc: Seamus Culhane
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

Ms. Henry,

I am trying to understand the first Explanation of Benefit Form and the payments:

There was a $300 surgical benefit – what code and procedure did you use to process that benefit?

Then there was another $120 surgical benefit - what code and procedure did you use to process that benefit?

Thanks in advance,

Seamus

From: Henry, Debi [mailto:Debi.Henry@protective.com]
Sent: Tuesday, August 27, 2013 6:14 AM
To: Seamus Culhane
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

1. Page 10 under "Claim Provisions" Written notice of claim but be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice must be given to us at our Home Office or to any authorized agent.
2. This is an independent cancer policy with an intensive care rider. The intensive care rider pays from the first day confined due to accident or second day for illness and pays $600.00 per day and reduces by 50% after age 65.
3. Page 8 under Surgical Expense Benefit. "we will pay for charges incurred for such operation and anesthesia in accordance with the California Relative Value Schedule.

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Monday, August 26, 2013 2:37 PM
To: Henry, Debi
Cc: Seamus Culhane
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

Ms. Henry,

Can you point me to where in the policy it says that the insured has to submit the bills? I can't seem to find it. All I can seem to find is that the insured must file a proof of loss, which I believe the Zocherts have now done. I thought it was the insurer's job to investigate the claim, not the policy holder. Has Protective life changed that somehow?

What about other coverage? Does the policy holder have to figure out what coverage might apply or does Protective Life do that for the policy holder?

I realize that you base payment on policy provisions, what I am curious about is what formula and code you used to calculate the payments made to the Zocherts. I can't seem to make the math work out under the codes listed in the policy with what you actually paid and I like some help explaining to the Ivan why they are being paid what they were paid.

Thanks in advance,

Seamus

From: Henry, Debi [mailto:Debi.Henry@protective.com]
Sent: Monday, August 26, 2013 2:26 PM
To: Seamus Culhane
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

Mr. Culhane:

Protective Life has not requested billing from the physician, it is the insured's responsibility to submit any/all itemized bills pertaining to cancer treatment.

Benefits eligibility are based on itemized bills submitted for review by the insured or providers.

We based benefits according to policy provisions. (see previous attachment)

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Monday, August 26, 2013 1:56 PM
To: Henry, Debi
Cc: Seamus Culhane
Subject: RE: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

Ms. Henry,

Have you requested an itemized billing from the physician? If so, when?

What else have you done to determine what other benefits Ivan would be eligible for?

How did you determine the amount of money that the Zocherts were eligible for under the policy?

Best Regards,

Seamus Culhane

From: debi.henry@protective.com [mailto:debi.henry@protective.com]
Sent: Monday, August 26, 2013 12:11 PM
To: Seamus Culhane
Subject: Secure Message: ApplicationXtender - AppXtender - POLICY - HEALTH

From: debi.henry@protective.com

Subject: ApplicationXtender - AppXtender - POLICY - HEALTH

Click the "View Message" link to view your secure email message. The message will be available for 30 days. To access this message after 30 days or to save this message, select the "Secure Envelope" attachment at the bottom of this message. For issues, questions, or additional information, please contact Protective Life's Secure Email Support at 1-877-507-7732.

View Message

Henry, Debi

From: Henry, Debi on behalf of Health Claims
Sent: Wednesday, September 11, 2013 8:00 AM
To: 'Seamus Culhane'
Subject: RE: Secure Message: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903

Mr. Culhane,

When a physician sends us an itemized bill for services, the procedure code is what determines the benefit to the insured.....not the physician's charges, since the benefit is based on values; then anything more than that would be excluded. Please refer to my email of August 27, 2013 for explanation of how benefits are calculated. In our cancer policies under SCHEDULE OF OPERATIIONS; this is only an example, since there are hundreds of procedure codes, we could not list them all.
Thank you

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Tuesday, September 10, 2013 11:48 AM
To: Henry, Debi
Cc: Seamus Culhane
Subject: RE: Secure Message: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903

Ms. Henry,

Thank you. I was able to open it this time. Procedure Code 19301 appears to be a procedure with a unit value determined by report. In the instance of Lenore Zochert, the physician's report indicates a charge of $2,371. What is the basis for excluding the remaining $2,071.00 in additional charges for this procedure?

Likewise, I do not see the procedure code 12035 in the Policy. How did you determine the benefit amount for this procedure? Why was $892 excluded?

Best Regards,

Seamus Culhane

From: debi.henry@protective.com [mailto:debi.henry@protective.com]
Sent: Tuesday, September 10, 2013 11:22 AM
To: Seamus Culhane
Subject: Secure Message: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903

From: debi.henry@protective.com<\p>

Subject: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903<\p>

Click the "View Message" link to view your secure email message. The message will be available for 30 days. To access this message after 30 days or to save this message, select the "Secure Envelope" attachment at the bottom of this message. For issues, questions, or additional information, please contact Protective Life's Secure Email Support at 1-877-507-7732.<\p>

View Message

Henry, Debi

From: seamus@turbaklaw.com
Sent: Wednesday, September 11, 2013 9:25 AM
To: Henry, Debi
Subject: RE: RE: Secure Message: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903

Ms. Henry,

The Sscheudle of Benefits says, "Benefits are payable for those expenses incurred by an insured from 10 days preceding the date of positive diagnosis of Cancer or from the first day of a period of Hospital confinement during which the positive diagnosis is made, whichever is more favorable to you. **Such expenses will consist of the actual charges by the Hospital, Physician, or ofter provider subject to the limitations stated herein**." The particular code that you refer to is not listed in the policy. Therefore, there appears to be no limitation placed on it up to the maximum benefit of $2,500 for surgery and $630 for anesthesia listed in the Surgical Expense Benefit.

Please pay the remainder of the Surgical Expense benefit for procedure code 19301, $2,030 by my calculation.

Best Regards,

Seamus Culhane

From: debi.henry@protective.com
Sent: Wed Sep 11 08:00:30 CDT 2013
To: seamus@turbaklaw.com
Subject: RE: Secure Message: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903

Mr. Culhane,

When a physician sends us an itemized bill for services, the procedure code is what determines the benefit to the insured.....not the physician's charges, since the benefit is based on values; then anything more than that would be excluded. Please refer to my email of August 27, 2013 for explanation of how benefits are calculated. In our cancer policies under SCHEDULE OF OPERATIONS; this is only an example, since there are hundreds of procedure codes, we could not list them all.
Thank you

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Tuesday, September 10, 2013 11:48 AM
To: Henry, Debi
Cc: Seamus Culhane
Subject: RE: Secure Message: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903

Ms. Henry,

Thank you. I was able to open it this time. Procedure Code 19301 appears to be a procedure with a unit value determined by report. In the instance of Lenore Zochert, the physician's report indicates a charge of $2,371. What is the basis for excluding the remaining $2,071.00 in additional charges for this procedure?

Likewise, I do not see the procedure code 12035 in the Policy. How did you determine the benefit amount for this procedure? Why was $892 excluded?

Best Regards,

Seamus Culhane

From: debi.henry@protective.com [mailto:debi.henry@protective.com]
Sent: Tuesday, September 10, 2013 11:22 AM
To: Seamus Culhane
Subject: Secure Message: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903

From: debi.henry@protective.com<\p>

Subject: FW: ApplicationXtender - AppXtender - POLICY - HEALTH D00054903<\p>

Click the "View Message" link to view your secure email message. The message will be available for 30 days. To access this message after 30 days or to save this message, select the "Secure Envelope" attachment at the bottom of this message. For issues, questions, or additional information, please contact Protective Life's Secure Email Support at 1-877-507-7732.<\p>

View Message

Velez, Lia

From: Health Claims
Sent: Wednesday, September 18, 2013 8:26 AM
To: 'seamus@turbaklaw.com'
Subject: Zochert - D00054903

Hello Mr. Cuhane,

Please accept our apologies as Debi Henry is currently out of the office. I will be glad to assist in any way I can. I am responding to your inquiry regarding the surgical benefits paid on claim # LV1C02324-00 for policy D00054903.

In response to your question of limitations for the policy sectioned Surgical Expense Benefit. The policy states; *"Examples of various type operations are listed in the Schedule of Operations. We will be glad to furnish you the benefit amount for any operation not listed."* The maximum benefit for surgery is $2500.00 and $630.00 for anesthesia.

Although I understand the particular procedure code (19301 – partial mastectomy) performed on Mrs. Zochert was not listed, this does not mean there are no limitations for such procedure, as you have referenced in your inquiry. Per the California Relative Value Schedule, procedure code 19301 has a value of 6.0. When paying for this procedure at $50.00 per value, the maximum benefit is $300.00.

An example of the difference in value on surgical procedures is listed:
Procedure code 19180 (simple mastectomy), valued at 8.0, maximum benefit $400.00 vs. procedure code 19301 (partial mastectomy), valued at 6.0, maximum benefit $300.00.

With regards to the second surgery in question, procedure code 12035; has a value of 2.40. When paying for this procedure at $50.00 per value, the maximum benefit is $120.00.

Please note, the Schedule of Operations is placed in the policy as an example, and by no means lists all of the procedures that may be performed. The policy makes this clear by use of the language "example of various types of operations are..." and "we will be glad to furnish you the benefit amount of any procedure not listed."

We have paid the maximum benefit allowed for both procedures, 19301 – partial mastectomy and 12035 – repair, closure of wounds on scalp.

Should you have any further question, please do not hesitate in contacting me.

Thank you,

Lia Velez
Claims Examiner

Protective.

Protective Life Insurance Company
Post Office Box 10807
Birmingham, AL 35202
Phone 800 866 3808
Fax 205 268 6833
health.claims@protective.com

Velez, Lia

From:	Health Claims
Sent:	Wednesday, September 18, 2013 2:59 PM
To:	'Seamus Culhane'
Cc:	'Bonnie Neuberger'
Subject:	RE: Zochert - D00054903
Attachments:	Values.pdf

Hello Mr. Culhane,

It is my understanding our database is loaded with the information from the California Relative Value Schedule. Please find the attached print screens from our database, showing the value for both procedure codes (19301 and 12035).

Thank you,

Lia Velez
Claims Examiner

Protective.

Protective Life Insurance Company
Post Office Box 10807
Birmingham, AL 35202
Phone 800 866 3808
Fax 205 268 6833
health.claims@protective.com

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Wednesday, September 18, 2013 2:12 PM
To: Health Claims
Cc: Bonnie Neuberger
Subject: Re: Zochert - D00054903

Ms.Velez,

Please provide me with a copy of whatever document you've looked at in the California Relative Value Schedule or the physician report to find the value limitations that you refer to.

Best regards,

Seamus Culhane

Sent from my iPad

On Sep 18, 2013, at 7:26 AM, "Health Claims" <Health.claims@protective.com> wrote:

Hello Mr. Cuhane,

Please accept our apologies as Debi Henry is currently out of the office. I will be glad to assist in any way I can. I am responding to your inquiry regarding the surgical benefits paid on claim # LV1C02324-00 for policy D00054903.

In response to your question of limitations for the policy sectioned Surgical Expense Benefit. The policy states; *"Examples of various type operations are listed in the Schedule of Operations. We will be glad to furnish you the benefit amount for any operation not listed."* The maximum benefit for surgery is $2500.00 and $630.00 for anesthesia.

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We have paid the maximum benefit allowed for both procedures, 19301 – partial mastectomy and 12035 – repair, closure of wounds on scalp.

Should you have any further question, please do not hesitate in contacting me.

Thank you,

Lia Velez
Claims Examiner

<image001.png>

Protective Life Insurance Company
Post Office Box 10807
Birmingham, AL 35202
Phone 800 866 3808
Fax 205 268 6833
health.claims@protective.com

above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify me immediately by replying to this message and deleting it from your computer. Thank you.

Velez, Lia

From: Health Claims
Sent: Monday, September 23, 2013 11:34 AM
To: 'Seamus Culhane'
Subject: RE: Zochert - D00054903

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Lia Velez
Claims Examiner

Protective.

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Sent: Wednesday, September 18, 2013 3:10 PM
To: Health Claims
Subject: Re: Zochert - D00054903

Ms. Valdez,
Are there any additional physician reports your company relied on besides the one already provided in determining the value of benefits to be paid?

Best regards,
Seamus Culhane

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ProtectiveLife 0333

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Lia Velez
Claims Examiner

Protective.

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From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Wednesday, September 18, 2013 2:12 PM
To: Health Claims
Cc: Bonnie Neuberger
Subject: Re: Zochert - D00054903

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<image001.png>
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health.claims@protective.com

Velez, Lia

From: Health Claims
Sent: Friday, September 27, 2013 9:40 AM
To: 'Seamus Culhane'
Cc: 'Bonnie Neuberger'
Subject: RE: Zochert - D00054903

Hello Mr. Culhane,

I apologize for the delay. I have submitted your concerns and questions for additional review.

Thank you,

Lia Velez
Claims Examiner

Protective.

Protective Life Insurance Company
Post Office Box 10807
Birmingham, AL 35202
Phone 800 866 3808
Fax 205 268 6833
health.claims@protective.com

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Monday, September 23, 2013 3:09 PM
To: Health Claims
Cc: Seamus Culhane; Bonnie Neuberger
Subject: RE: Zochert - D00054903

Ms. Velez,

Do you have a copy of that – it must have been used to program your computer system?

The policy holder's claim should not be limited by a computer program when the policy says that:

1.) "[W]e will pay for charges incurred for such operation . . .";
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4.) The reported charges exceed the maximum benefit surgical benefit limit which does apply is $2,500.

Thus, by my math, Protective Life owes Ivan Zochert the difference between $2,500 and the amount already paid($420) toward surgical expenses. Please remit payment.

Best Regards,

Seamus Culhane

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Subject: RE: Zochert - D00054903

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Claims Examiner

Protective.

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Claims Examiner

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Velez, Lia

From: Health Claims
Sent: Wednesday, November 20, 2013 11:15 AM
To: 'Seamus Culhane'
Subject: RE: Zochert - D00054903

Mr. Culhane,

I apologize for the delayed response as your additional inquiries needed further review. In regards to surgery 19301; it is listed in the California Relative Value Systems (CRVS) as +BR. It is my understanding the procedure code used as a comparability is 19160. There are also documents (see below links) found that as of January 1, 2007 code 19301 replaced code 19160. If you review the CRVS book, you will notice code 19160 has a unit value of 6.0. Our system is paying surgery code 19301 with a unit value of 6.0.

A few Links to reference: http://www.healthleadersmedia.com/content/HOM-205269/Replacement-code-19302.html

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http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/breast_surgeries.pdf - page 12 of 14

With regards to surgery code 12035, the comparability code used was 13140 with a unit value of 2.40.

At this time we feel the procedure codes have been valued and paid correctly, according to the policy, "we will pay for charges incurred for such operation and anesthesia in accordance to the California Relative Value Schedule".

Thank you,

Lia Velez
Claims Examiner

Protective.

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TURBAK LAW OFFICE, P.C.

July 21, 2014

Protective Life Insurance Co.
P.O. Box 10807
Birmingham, AL 35202
Examiner TN S01

Re:

Your Insured:	Ivan & Lenore Zochert
Policy Number:	D00054903
Claim #:	LV1C02324-00

Dear Protective Life Insurance Co.:

After looking further into the denied portions of Lenore's claim for cancer insurance benefits the billings related to her breast cancer show many charges which there appears to been coverage for but were never paid under the policy.

Please find enclosed a spreadsheet that we've created using Lenore's billings and medical records associated with various actual charges by the Hospital, Physician, or other providers associated with expenses incurred by Lenore from 10 days preceding the date of her positive diagnosis of Cancer.

I've also attached a copy of the complaint that we intend to file at the end of the month. Please forward this to your legal counsel and have them get in contact with me.

Best Regards,

Seamus W. Culhane

cc: Ivan Zochert

26 S. Broadway, Suite 100 · Watertown, SD 57201-3670
(605) 886-8361 · FAX (605) 886-8383 · eFax (605) 415-4499 · www.turbaklaw.com
nancy@turbaklaw.com · seamus@turbaklaw.com

Velez, Lia

From: Health Claims
Sent: Friday, July 25, 2014 11:31 AM
To: 'Seamus Culhane'
Cc: 'Nancy Turbak'
Subject: RE: Zochert - D00054903

Hello Mr. Culhane,

In response to your email and upon reviewing the attached spreadsheet, please review the below findings.

Our records indicate the only pathology report we received was for diagnosis made on 8/14/12 for Left Breast cancer. In order for any claims, prior to this date be considered, please submit a pathology report for first diagnosis of cancer. Per your spreadsheet a biopsy was performed on 7/5/12. Should there be any additional pathology reports, please include them for review.

Also, in order to review and process the claims in question, it is necessary to have the bills submitted. The last claim submitted was received in our office on 5/9/13.
We have only received bills for date of service 8/14/12, which were processed according to the policy provisions.

At this time, please submit all itemized bills to include the diagnosis, procedure codes and charges for the following dates of service (referenced in your spreadsheet):

06/11/12
06/26/12
07/05/12
07/08/12
07/16/12
07/18/12
07/19/12
08/21/12
08/31/12 – from both Dr. Christensen and the hospital (name not indicated on spreadsheet)
09/13/12
09/25/12
10/23/12
11/19/12
11/27/12

Once the pathology reports and bills are received in our office, we will be able review and process them according to the policy provisions.

I will forward you a copy of this email to the address listed on your letter.

Please let me know if I can be of further assistance.

Thank you,

Lia Velez
Claims Specialist

Velez, Lia

From: Health Claims
Sent: Wednesday, July 30, 2014 4:51 PM
To: 'Seamus Culhane'
Subject: RE: Zochert - D00054903

Hello Mr. Culhane,

Thank you for your email. Mr. Bill McCarty will be responding to your inquiries upon review.

Thank you,

Lia Velez
Claims Specialist

Protective.

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Sent: Tuesday, July 29, 2014 2:47 PM
To: Health Claims
Cc: Seamus Culhane
Subject: RE: Zochert - D00054903

Ms. Velez,

Are you in a position to do any investigation into treatment, records or bills once you aware someone has cancer? Did you independently request any billings or records at all?

Best Regards,

Seamus Culhane

From: Health Claims [mailto:Health.claims@protective.com]
Sent: Tuesday, July 29, 2014 2:40 PM
To: Seamus Culhane
Cc: Therese
Subject: RE: Zochert - D00054903

Hello Mr. Seamus,

In response to your inquiry; as indicated by our claim form, we rely on the insured to send the bills and other pertinent records to us. We are not in a position to know all of the providers that may have billed the insured, nor would we know the pertinent dates of service as relates to the particular diagnosis. For example, in this case, we did not know until you referenced some bills that there was a biopsy performed prior to the date of the pathology report we had previously been sent. If the insured has difficulty obtaining a bill, we will assist the insured, but, in this case, we were not aware of any difficulty the insured was having.

Upon receipt of the additional pathology report and itemized bills, we will be more than happy to review and process them according to the policy provisions.

Thank you,

Lia Velez
Claims Specialist

Protective.

Protective Life Insurance Company
Post Office Box 10807
Birmingham, AL 35202
Phone 800 866 3808
Fax 205 268 6833
health.claims@protective.com

From: Seamus Culhane [mailto:Seamus@turbaklaw.com]
Sent: Friday, July 25, 2014 11:36 AM
To: Health Claims
Cc: Seamus Culhane; Therese
Subject: RE: Zochert - D00054903

Ms. Velez,

I spoke with Mr. McCarty this morning and he told me you would be in contact with me. We will happily provide you with the itemized billings.

Why is it that you did not previously request these billings or records while processing and adjusting the claim directly from the providers?

Best Regards,

Seamus Culhane

From: Health Claims [mailto:Health.claims@protective.com]
Sent: Friday, July 25, 2014 11:31 AM
To: Seamus Culhane
Cc: Nancy Turbak
Subject: RE: Zochert - D00054903

Hello Mr. Culhane,

TURBAK

LAW OFFICE, P.C.

August 4, 2014

Ms. Lia Velez
Claims Specialist
Protective Life
Post Office Box 10807
Birmingham, AL 35202

Re:

Your Insured:	Ivan & Lenore Zochert
Policy Number:	D00054903
Date of Injury:	8/14/2012
Claim #:	LV1C02324-00

Dear Lia:

Enclosed is a copy of the pathology report for the first diagnosis of cancer and copies of itemized bills for the dates that you requested in your e-mail dated July 25, 2014.

I expect to hear from you soon regarding the progress.

Best regards,

Seamus Culhane

Seamus W. Culhane
SWC/tks

Enclosures

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26 S. Broadway, Suite 100 · Watertown, SD 57201-3670
(605)886-8361 · FAX (605)886-8383 · eFax (605)415-4499 · www.turbaklaw.com
nancy@turbaklaw.com · seamus@turbaklaw.com

Order-Level Documents - 07/05/2012: (continued)

345-4273 Evan
880-4292
345-3301-NH

PRAIRIE LAKES HEALTHCARE SYSTEM, INC
DEPARTMENT OF SURGICAL PATHOLOGY
401 9TH AVE NW
WATERTOWN, SD 57201
605-882-7750

PATHOLOGY REPORT

Patient Name: ZOCHERT LENORE K
DOB: [redacted]
ORDER PHY: CHRISTENSEN ALAN
ADMIT DATE: 07/05/12
RECEIVED DATE: 07/06/12 13:24

AGE: 51 SEX: F
STAY TYPE: OP

ACCT NUMBER: 481170
MR NUMBER: 004251
ADMIT PHY: CHRISTENSEN ALAN
DISCH DATE: 07/05/12
ORDER NUM: 18611

Unsigned Transcriptions represent a preliminary report and do not represent a medical or legal document*

ACCESSION NUMBER: S12-1035

Called 7-11-12

FINAL DIAGNOSIS:

NEEDLE CORE BIOPSIES LEFT BREAST - Invasive ductal carcinoma, nuclear grade 2-3, overall grade 2 of 3 (Nottingham grade).
- Largest tumor focus 0.5 cm.
- No angiolymphatic invasion identified.
- ER/PR/HER2 studies - results pending per separate report.

CLINICAL DIAGNOSIS & HISTORY: Left breast mass.

TISSUE SOURCE: Left breast mass needle core biopsies (formalin time 1700 hrs on 7/5).

GROSS DESCRIPTION: Submitted for microscopic exam in one cassette are three four, five cut needle core biopsy fragments measuring up to 0.6 x 0.1 cm.

MICROSCOPIC DESCRIPTION: Four of four fragmented needle core biopsy fragments display invasive ductal carcinoma. Tumor consists predominantly of solid nests and infiltrating cords of malignant cells with individual tubule formation. The tumor cells are discohesive in some areas. There is moderate nuclear pleomorphism, but low mitotic activity, less than five mitotic figures per 10 high power field in the most active areas. Focal microcalcifications are suggested. The largest tumor focus measures 0.5 cm.

Reviewed and Electronically Signed by:

E. L. Wagner, M.D.
Pathologist
07/09/12 16:18

Transcription Date: 7/09/12
Transcription Time: 08:41
Transcription Initials: JH
Dictating Initials: ELW

Copy for: Film copy printed @ 502
Copy for: CHRISTENSEN ALAN via fax
Copy for: DAVLEY ELIZABETH via fax
Copy for: 136 HEALTH INFORMATION

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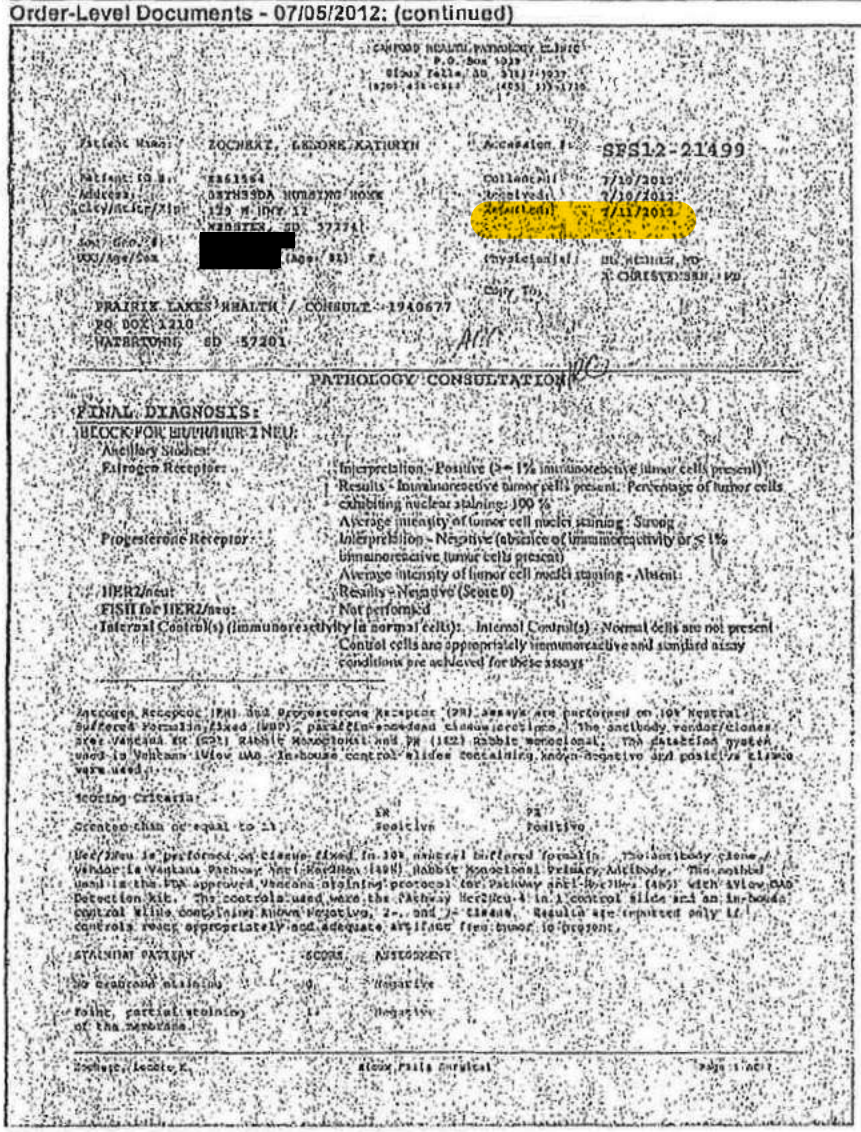
Scan on 7/5/2012 12:00 AM by Binde, Kristi L : 7/10/12 SanfordHealthPathologyClinic/PLH Pathology Consultation (below)

Order-Level Documents - 07/05/2012: (continued)



PATHOLOGY CONSULTATION

FINAL DIAGNOSIS:

BLOCK FOR HER/NEU 2 NEU:
Ancillary Studies:
Estrogen Receptor: Interpretation - Positive (> 1% immunoreactive tumor cells present)
Results - Immunoreactive tumor cells present. Percentage of tumor cells exhibiting nuclear staining: 100 %
Average intensity of tumor cell nuclei staining: Strong
Progesterone Receptor: Interpretation - Negative (absence of immunoreactivity or ≤ 1% immunoreactive tumor cells present)
Average intensity of tumor cell nuclei staining - Absent
HER2/neu: Results - Negative (Score 0)
FISH for HER2/neu: Not performed
Internal Control(s) (immunoreactivity in normal cells): Internal Control(s) - Normal cells are not present. Control cells are appropriately immunoreactive and similar assay conditions are achieved for these assays

Estrogen Receptor (ER) and Progesterone Receptor (PR) assays are performed on 10% Neutral Buffered Formalin fixed (NBF) - paraffin-embedded tissue sections. The antibody vendor/clones are Ventana ER (SP1) Rabbit Monoclonal and PR (1E2) Rabbit Monoclonal. The detection system used is Ventana iView DAB. In-house control slides containing known negative and positive tissue were used.

Scoring Criteria:

	ER	PR
Greater than or equal to 1%	Positive	Positive

Her2/neu is performed on tissue fixed in 10% neutral buffered formalin. The antibody clone / vendor is Ventana Pathway Anti-HER2/neu (4B5) Rabbit Monoclonal Primary Antibody. The method used is the FDA approved Ventana staining protocol for Pathway anti-HER2/neu (4B5) with iView DAB Detection kit. The controls used were the Pathway Her2/neu 4 in 1 control slide and an in-house control slide containing known negative, 2+, and 3+ tissue. Results are reported only if controls react appropriately and adequate evidence for tumor is present.

STAINING PATTERN	SCORE	INTERPRETATION
No membrane staining	0	Negative
Faint, partial staining of the membrane	1+	Negative

Pathologist: Lecate, K. Avera Falls Surgical Page 1 of 2

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Scan on 7/5/2012 12:00 AM by Binde, Kristi L : 7/10/12 SanfordHealthPathologyClinic/PLH Pathology Consultation (below)

Order-Level Documents - 07/05/2012: (continued)

ZOCHERT, LENORE K. Sioux Falls Histolog Report SFS12-21493

Weak complete staining of the membrane >10-30% of cancer cells	2+	Equivocal-FISH will be performed.
Intense, complete staining of membrane > 30% of cancer cells	3+	Positive

[illegible]/2012

Electronically Signed Out By
DH [illegible], MD

SPECIMEN(S):
BLOCK FOR ER/PR/HER-2 [illegible]

CLINICAL HISTORY:
ER, PR, Her-2/neu studies.

SLIDE/BLOCK DESCRIPTION:
Received is one block labeled S12-1035 from Dr. Ed Wegner, Prairie Lakes Health, Watertown, South Dakota.

MICROSCOPIC DESCRIPTION:
MICROSCOPIC EXAMINATION PERFORMED BY: D. H. Whitehead, M.D.

DHW/7/11/2012

ICD-9(s): 174.9

Zochert, Lenore K. Sioux Falls Histolog[illegible] Page 3 of 3

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PRAIRIE LAKES HEALTHCARE SYSTEM, INC
DEPARTMENT OF SURGICAL PATHOLOGY
401 9TH AVE NW
WATERTOWN, SD 57201
605-882-7750

PATHOLOGY REPORT

Patient Name: ZOCHERT LENORE K
DOB: [redacted]
ORDER PHY: CHRISTENSEN ALAN
ADMIT DATE: 08/14/12
RECEIVED DATE: 08/14/12 11:40

AGE: 81 SEX: F
STAY TYPE: O/P

ACCT NUMBER: 484558
MR NUMBER: 064251
ADMIT PHY: CHRISTENSEN ALAN
DISCH DATE:
ORDER NUM: 37807

Unsigned Transcriptions represent a preliminary report and do not represent a medical or legal document

ACCESSION NUMBER: S12-1208

RECEIVED
AUG 15 2012

FINAL DIAGNOSIS:

LEFT BREAST (LUMPECTOMY) - Invasive ductal carcinoma, nuclear grade 3, overall grade 2 of 3 with specific features and extracellular mucinous component.
- **Tumor measures 2.3cm (single slide measurement).**
- **No angiolymphatic invasion identified.**
- **Inked surgical margins negative for malignancy.**
- **Minimal radial margin at least 1 cm from inked posterior (deep) margin.**
- **Adjacent fibrocystic changes.**
- **AJCC pathologic stage - pT2 pNX.**

CH

CLINICAL DIAGNOSIS & HISTORY: Left breast mass.

TISSUE SOURCE: Left breast tissue (lumpectomy) (formalin added @ 0948)

GROSS DESCRIPTION: A fragment of breast tissue designated left measures 17.2 x 15.5 x 3.5 cm. Located on the anterior surface of the specimen is a 15.3 x 8.7 cm ellipse of generally unremarkable tan skin without nipple. A mass is vaguely palpable in the midportion of the specimen. A surgical suture indicates the superior margin of the specimen. The specimen is oriented and marked using the following color code: superior margin blue ink, deep margin black ink, inferior margin green ink. Serial sections display areas of dense, white, fibrous tissue intertwined with yellow adipose. Located in the midportion of the specimen is a previous biopsy site and residual mass measuring approximately 2.4 x 2.2 x 1.7 cm. The tumor appears to approach within 1 cm of the inked deep (posterior) resection margin. No additional tumor masses are identified. Representative sections are used following the key code: cassettes A - H sections of tumor, cassettes I, J and K closest posterior (deep) inked margin to tumor, cassette L random sections breast parenchyma.

Located in the same container is an additional irregular ellipse of tan skin and underlying subcutaneous fat designated lateral ellipse measuring 2.8 x 2.5 x 0.7 cm. The skin and fat are both unremarkable.

MICROSCOPIC DESCRIPTION: Sections of breast tissue display invasive ductal carcinoma. Tumor consists predominantly of solid nests of tumor cells with generous eosinophilic cytoplasm. No tubule formation is present. Moderate nuclear pleomorphism is present with generally prominent eosinophilic nucleoli. Mitotic activity is low with less than 5 mitotic figures per 10 high powered field found in the most active areas. Minimal peritumoral lymphocytic proliferation is evident. No angiolymphatic invasion is appreciated. Tumor displays a minor extracellular mucinous component. Sections of random breast tissue show benign fibrocystic changes. Inked surgical resection margins are negative for malignancy.

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PRAIRIE LAKES HEALTHCARE SYSTEM, INC
DEPARTMENT OF SURGICAL PATHOLOGY
401 9TH AVE NW
WATERTOWN, SD 57201
605-882-7750

RECEIVED
AUG 15 2012

PATHOLOGY REPORT

Patient Name: ZOCHERT LENORE K AGE: 81 SEX: F ACCT NUMBER: 484538
DOB: [redacted] STAY TYPE: OP MR NUMBER: 064251
ORDER PHY: CHRISTENSEN ALAN ADMIT PHY: CHRISTENSEN ALAN
ADMIT DATE: 08/14/12 DISCH DATE:
RECEIVED DATE: 08/14/12 11:40 ORDER NUM: 37807

Unsigned Transcriptions represent a preliminary report and do not represent a medical or legal document

Reviewed and Electronically Signed by:

R. L. Wegner, M.D.
Pathologist
08/15/12 14:36

Transcription Date: 8/14/12
Transcription Time: 16:32
Transcription Initials: JH
Dictating Initials: RLW

Copy for: File copy printer # 592
Copy for: CHRISTENSEN ALAN via fax
Copy for: GRAVLEY ELIZABETH via fax
Copy for: 134 HEALTH INFORMATION

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SANFORD HEALTH

REFER TO 500 53805

Sanford Clinic Watertown
901 4th Street NW
Watertown, SD 57201-1558

PRSRT AUTO
FIRST-CLASS

US POSTAGE $00.35⁰
OCT 24 2012
ZIP 57201
0801 1052322

Protective Life Insurance Co
PO Box 10807
Birmingham AL 35202

HAUQ95B 35202

10 29 12
11 37

Protective Life 0204

STATE OF SOUTH DAKOTA
COUNTY OF MOODY

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert,	)	
Plaintiff,	)	No. 50CIV14000061
vs.	)	
Protective Life Insurance Company,	)	
Defendant.	)	

Videotaped Deposition of:

DEBRA L. TURNER

Taken on behalf of the Plaintiff

November 9, 2016

CLEETON DAVIS COURT REPORTERS, LLC
402 BNA Drive, Suite 108
Nashville, Tennessee 37217
(615) 726-2737
www.cleetondavis.com

for a -- we were an outsourcing company that would take care of the business office for different hospitals.

Q. Okay. And when you say "the system," what system are you referring to that you were trained on when you started as an auditor?

A. ClaimFacts.

Q. And ClaimFacts is the system that Protective Life uses to process cancer insurance claims?

A. Yes.

Q. Do they use it to process other claims at Protective Life?

A. No.

MS. WEBER: I'm sorry, did you answer out loud. You have to answer out loud.

THE WITNESS: I did, I said no.

MS. WEBER: Okay, sorry.

BY MR. CULHANE:

Q. What other training -- did you have any training or were you provided any training in insurance generally, insurance law, insurance standards, best practices, things like that?

A. When -- gosh, I'm trying to remember. When I came in as an auditor, I wasn't trained on any of the life product at all. I was just trained on the medical as far as how she audits a claim, you know, what we

THE WITNESS: Yes.

BY MR. CULHANE:

Q. And when an insurance company is conducting an investigation, that means they must look for reasons to support paying claims, not just reasons for denying claims?

A. I'm not real sure where you are going with investigation, because we don't investigate a claim. We review the bill that we receive from the insured against the policy to determine the payable amount.

So I'm not really sure what you mean by "investigation." If you can explain that, that would help.

Q. Well, the insurance company has to -- they are being prepaid by the policyholder every month when every policyholder pays premiums to provide service, right?

A. Correct.

Q. And that service includes providing investigation when a claim is made?

MS. WEBER: Object to the form.

Are you now talking about cancer or are you talking about life, or are you talking about all insurance --

THE WITNESS: Right.

MS. WEBER: -- protective issues.
BY MR. CULHANE:
Q. Well, do you understand my question?
A. You are asking me about if I investigate a claim or if my examiner investigates a claim for -- I'm assuming the cancer for Mr. Zochert's policy. I'm assuming you are speaking of that.
So when you say that we investigate a claim, maybe it's just the wording here, but we process a claim in accordance to the policy. So the bills that we receive, we review the policy to determine which portion of the bill is payable.
Q. So -- and we'll get into the specifics. I just want to -- want to get some general history from you right now about your training.
And you are -- you are a manager in terms of the claims department, right?
A. Correct.
Q. And there's 20-some claim handlers under you?
A. Approximately, yes.
Q. About how many claims a month does your -- does your department handle?
A. Life or medical?
Q. Well, medical. Is cancer insurance a medical claim?

it's used in all cancer claim form packets?
A. Unless I see a claim form packet, I don't know.
MR. CULHANE: Excuse me, I'll take another little break.
THE VIDEOGRAPHER: We are off the record at 10:39 a.m.
(Discussion off the record.)
THE VIDEOGRAPHER: We are back on the record.
BY MR. CULHANE:
Q. We talked earlier about ClaimFacts; I think we kind of glossed over it a little bit. So it's a software, right?
A. Yes.
Q. And it's used to process medical claims, including cancer claims?
A. Yes.
Q. And the software works by taking numbered billing codes off of bills and then spitting out relative value units, right?
A. Yes. That's simplified, but yes.
Q. Okay. Well, if I'm missing something, tell me. The software is preprogrammed with how many units?
A. Yes.

Q. Which is an RVU, right, relative value unit?
A. Yes.
Q. How many units different procedures take basically, right?
A. Correct.
Q. How much time, how much expertise, things like that, right?
A. Yes.
Q. And so a claim handler takes the numbered code, plugs it into ClaimFacts, right?
A. Yes.
Q. And ClaimFacts spits out how much money should be written on the check for the policyholder based on what's plugged in, right?
A. Yes.
Q. And because billings -- if -- because it's based on codes that are based on billings, the claim handler needs to have the codes to get the policyholder paid, right?
A. Correct.
Q. And the units themselves are actually programmed into the software, how many units a procedure might take by somebody at Protective Life?
A. I don't know.
Q. It was just that way when you got there?

STATE OF SOUTH DAKOTA
COUNTY OF MOODY

Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert,	)	
Plaintiff,	)	No. 50CIV14000061
vs.	)	
Protective Life Insurance Company,	)	
Defendant.	)	

Videotaped Deposition of:

LIA M. VALEZ

Taken on behalf of the Plaintiff

November 9, 2016

CLEETON DAVIS COURT REPORTERS, LLC
402 BNA Drive, Suite 108
Nashville, Tennessee 37217
(615) 726-2737
www.cleetondavis.com

supplemental policy that they are paying for. It's in addition to whatever policy they have, whether it's Medicare, Blue Cross Blue Shield, primary insurance. So this is something that they are investing in, per se. So if they don't get cancer, there's no claim to ever file. They never use the policy.

Q. So once they get a -- once they get cancer and file a written proof of loss, that is filing a claim, right?

A. Yes. What they have to do with filing a claim is they have to submit the proof of loss which is a pathology report showing the diagnosis of the cancer along with their itemized bills.

Q. Do you ever look for itemized bills? Do you ever call the facilities, send out requests?

A. No.

Q. Why not?

A. We wouldn't know who -- what dates their appointments are, who their doctors are, what facility they go to. It's not -- unfortunately, it's not up to us to manage.

We can't say, oh, you have got cancer, so I'm going to guess that you went to -- you know, you'll go once a month and you are going to go on this date.

We don't know that. So in order for us to

provide good customer service to those submitting their claims, submitting what they are required to submit on the claim forms, it gives them that information.

We have to be able to provide good customer service to everybody, which, unfortunately, if we don't know, you know, what your bills are and what your diagnosis is and when you are going to the doctor, there's no way for us to try and even get that information, let alone whether or not they are going to release that to us.

Q. Well, I'm glad you brought that up, the release. You normally get a release as a part of the claim form, don't you?

A. Yes.

Q. Why do you get a release if you don't use it to get any records or bills?

A. In the event there's a discrepancy on the claim, on the bill itself and we need clarification.

Q. Okay. So you don't use it --

A. Because sometimes the physicians -- I apologize. Sometimes they don't necessarily provide a description of the procedures they are going to give us, and that procedure may not go towards that type of cancer that they have been diagnosed with, so we just need to make sure that everything is correct on that

went deeper and it was positive, it may be to where we'll pay that biopsy. Even though the path report said negative, we may pay it because they did find cancer when they went a little deeper. So that --

BY MR. CULHANE:

Q. That's not criteria in the policy, though. The policy just says whichever is more favorable to you, the policyholder; whichever is more favorable to the policyholder --

A. Right.

Q. -- 10 days preceding that.

It doesn't have to be how deep they go in the body or anything like that, does it?

A. No, but at that time we hadn't received anything either.

Q. You mean besides the physician's report that said the first date of diagnosis was --

A. Was 7-11. But we didn't get any bills.

Q. I think we have adequately established that you didn't have any bills.

And for that reason, you diagnosed -- or you denied claims earlier on for a procedure on the 5th. The pathology lab and the needle core biopsy, you denied those claims, right?

A. Right. We said we needed the pathology report

and the bills. We can't pay off of a spreadsheet.

Q. Fair enough. But at this point you knew -- you knew that these things were out there?

MS. WEBER: Objection to the form.

THE WITNESS: Right. And we, I believe, responded to you in an email telling you what we needed.

BY MR. CULHANE:

Q. And eventually my office worked with you to try to get you things that you wanted, but you still opted not to pay for the pathology?

A. The pathology is not a covered benefit.

Q. It's not?

A. No.

Q. Have you ever read the CE 21 endorsement?

A. Yes.

Q. I'm going to draw some lines on here so you don't have to read the whole thing, but I'm handing you page 0017, which is a copy of the endorsement.

A. Okay.

Q. And where I drew the brackets, what does that say?

A. It says this includes -- "This also includes such treatments designed to prevent a recurrence of cancer for a period of up to six consecutive months,

IN THE SUPREME COURT
STATE OF SOUTH DAKOTA

No. 28467

IVAN ZOCHERT
Plaintiff/Appellant,

vs.

PROTECTIVE LIFE INSURANCE COMPANY,
Defendant/Appellee.

Appeal from the Circuit Court
Third Judicial Circuit
Moody County, South Dakota

The Honorable Patrick Pardy, Presiding

REPLY BRIEF OF APPELLANT IVAN ZOCHERT

Seamus W. Culhane
Nancy J. Turbak Berry
Turbak Law Office, P.C.
26 S. Broadway, Suite 100
Watertown, SD 57201
(605) 886-8361

Attorneys for Appellant

Edwin E. Evans
Ryan W. Redd
Evans Haigh & Hinton, LLP
101 North Main Avenue, Suite 213
P.O. Box 2790
Sioux Falls, SD 57101-2790
(605)275-9599

Attorneys for Appellee

Notice of Appeal filed December 5, 2017

TABLE OF CONTENTS

TABLE OF AUTHORITIES

REMAINING LEGAL ISSUES

Insurer abandoned its argument and the trial court's ruling that South Dakota does not recognize the independent tort of insurance bad faith, leaving only two issues remaining:

1. **Do undisputed facts show Insurer breached the contract?**
2. **Could reasonable jurors conclude Insurer violated duties of good faith?**

Insurer's position on both issues relies largely on suggestions that Lenore Zochert and her husband Ivan were unreasonable and uncooperative throughout the processing of Lenore's claim. The opposite is true. Despite Zocherts' cooperation, however, Insurer did not pay the full benefits Lenore deserved until over two years after Zocherts filed Lenore's insurance claim. Insurer's payment of all but the most minimal benefits occurred only after Zocherts hired an attorney to identify what benefits Lenore qualified for and figure out exactly what might prompt Insurer to pay. Ultimately, it was only *after a lawsuit* was filed, well after Lenore's death, that Insurer paid the rest of the benefits Lenore had been entitled to from early on.

Insurer falsely claims Ivan accepts the trial court's finding that Insurer made timely payment of benefits. Nothing could be further from the truth. Ivan clearly complains about Insurer's failure to make timely payments. (Appellant's Brief, p. 21-25) Are there benefits still outstanding *today*? No. But that does not excuse the fact that full payment was not made when owed, and still had not been made at the time this lawsuit was started, due to Insurer's willful ignorance and passive claim handling. Insurer errs when it contends the only breach of contract issue is whether Insurer breached its duty of good faith; as set out in Appellant's Brief, pages 13-25, Ivan contends Insurer breached

its contract *both* by breaching its duty of good faith *and* by failing to pay benefits when due.

Ivan further contends that when Insurer violated its duty of good faith and fair dealing, it breached the contract *and* committed a tort.

REPLY TO APPELLEE'S ARGUMENTS

1. Do undisputed facts show Insurer breached its contract?

A. Insurer cannot excuse its breach by claiming Zocherts provided insufficient proofs of loss.

According to policy language, "Proofs of Loss" include "written proof of loss [. . .] within 90 days after the occurrence or commencement of any loss covered by the policy," and pathological confirmation of the cancer diagnosis. (SR 1021, App. 82) Ivan fulfilled that requirement on Lenore's behalf. By October 29, 2012, Zocherts provided sufficient proofs of loss to make Lenore's claim and trigger Insurer's duties to conduct a reasonable investigation, consider facts supporting the claim, disclose coverage, and pay.

On August 17, 2012, Ivan contacts Insurer to open a claim. Insurer sends Ivan three forms to be completed: a Physician Statement for the treating surgeon to complete and sign; a general proof of loss form; and a medical authorization release. Lenore's surgeon, Dr. Christensen, completes and signs the Physician Statement, reporting that Lenore's cancer was diagnosed July 11, 2012. Dr. Christensen also confirms the surgical procedures (partial lumpectomy and layered closure) he performed on August 14, 2012, informs Insurer that Lenore was hospitalized for several days related to the surgery, and provides the hospital's name and address. (SR 1324) Ivan fills out and signs Insurer's

general proof of loss form. (SR 1325) Ivan also completes and signs the medical authorization release. (SR 1328)

Ivan puts all those things in an envelope, hand addresses the envelope, and mails it to Insurer. (SR 1323-28, App. 102-107) Insurer now *knows* when Lenore's breast cancer was diagnosed, knows Lenore has had a partial mastectomy, knows Lenore was hospitalized for several days at the time, knows the name and address of the hospital where she was hospitalized, and knows the name, address, phone number and fax number of Lenore's surgeon. (SR 1324, App. 106) Insurer also has a billing document showing some of Lenore's treatment expenses – $3,383 in surgical charges, consisting of $2,371 for the partial mastectomy and $1,012 for the layered closure. (SR 1326, App. 107) Insurer also has the signed authorization *it affirmatively requested*, allowing it to obtain whatever additional records or bills are necessary to identify and document Lenore's cancer treatment. (SR 1328, App.104) The only hold-up at that point was that 87-year-old Ivan missed the requirement to provide "pathologic proof" to Insurer. However, by October 29, 2012, Sanford Health sends Insurer a pathology report corroborating the diagnosis Dr. Christensen had confirmed two months earlier. (SR 1002) Ivan contends that taken together, these documents amount to sufficient *proofs of loss* per the policy language to trigger coverage.

Proof of loss is effectively *a notice requirement* that allows the insurer to prepare a defense. The proof of loss requirement is intended to cue the insurer to do an investigation – to protect both insurer and insured. *Auto-Owners Ins. Co. v. Hansen Housing, Inc.* 2000 S.D. 13, ¶ 31, 604 N.W. 2d 504, citing *City of Ft. Pierre v. United Fire and Casualty Co.*, 463 N.W. 2d 845 (S.D. 1990). Proofs of loss and the notice they

serve are not supposed to provide some technical escape hatch for insurers to use to avoid paying claims. *Id.*

Insurer argues Lenore was obliged to do more. According to Insurer, Lenore was supposed to produce each and every itemized bill Zocherts contend should have been covered by the policy. To make this argument, Insurer first changes the reading of the policy significantly, then engages in a sleight of hand.

First, Insurer changes the reading of the policy by inserting the term "itemized bill." Nowhere in the policy does that term actually appear. If the parties' contract was to provide that benefits are triggered only by the insured submitting each and every "itemized bill," Insurer should have said so when it drafted the contract. It did not.

Then Insurer attempts a sleight of hand by substituting "claims" for "claim." Zocherts only made one insurance claim: Lenore's claim for cancer-related benefits, outlined above and in Appellant's Brief. Insurer now pretends that each and every single bill was a *separate* insurance claim. It argues that before Lenore was entitled to benefits for any aspect of her cancer care, she had to submit a separate "proof of loss" for each particular treatment, as if each medical bill were a new claim.

It is misleading to suggest insureds must provide Insurer with individual "proofs of loss" for each separate incident of treatment; the policy says no such thing. Unquestionably, Lenore's treatments were part of a single, ongoing course of care. All addressed the cancer diagnosed July 11, 2012 and all occurred in the course of a few consecutive months. Besides the patent absurdity of arguing that each bill represents a new claim for which an insured must submit a separate "proof of loss," Insurer's conduct at the time reveals that the notion of considering each treatment a separate "claim" is an

idea cooked up later, in the course of constructing a legal defense. After all, when Insurer learned of Lenore's cancer, it sent Zocherts a *single set* of proof of loss forms: one Physician Statement, one general proof of loss form, and one authorization for the release of medical information.

Similarly, Insurer falsely suggests there is no "loss" without an itemized bill. That is not true. Insurer admits in its Brief at pages 16-17 that a "loss" is the same as an "occurrence" or a "covered event." The fact that those terms are interchangeable illustrates the impropriety of Insurer's argument. An "occurrence" is "[s]omething that happens or takes place; specif., an accident, event, or continuing condition that results in personal injury or property damage that is neither expected nor intended from the standpoint of an insured party." Black's Law Dictionary (10th ed. 2014), occurrence. The unexpected event or "occurrence" that Zocherts bought cancer insurance to cover was *cancer*. To collect under their policy, Zocherts were supposed to provide proof of the occurrence, the covered event: cancer. That is exactly what they did.

Zocherts' efforts to get their benefits without litigation continued through counsel, starting in March 2013 and continuing for nearly a year and a half, even beyond suit being filed August 25, 2014. Meanwhile, Zocherts produced *many* itemized bills to Insurer on May 6, 2013. (SR 1338 - 1396) However, none of the information submitted triggered full payment – or even any investigation – of all benefits due Lenore. Yes, Insurer mailed a check in response to *some* itemized bills, but it ignored all facts that revealed Lenore's entitlement to various other benefits. Not until July 23, 2014, after Zocherts' counsel had gone through nearly $34,000 worth of itemized bills line by line,

compared them to policy language, and provided a detailed spreadsheet to the claims handler, did Insurer come anywhere near paying all benefits owed Lenore. (SR 1154)

Even then, Insurer refused to pay some bills because the pathology report from Sanford Health was dated August 14, 2012. Insurer already *knew* cancer had been diagnosed July 11, 2012, given Dr. Christensen's signed Physician Statement. (SR 1324) The policy does not require that the *first* pathology report be provided, only that "pathologic proof must be submitted." (SR 1021; App. 82) It was. Insurer had pathologic proof and knew from Lenore's doctor that cancer was diagnosed earlier than Sanford Health's report date. This is exactly the kind of "discrepancy" that even a cursory investigation using the signed medical authorization release would have resolved, if it really were important. Instead, when confronted with two different dates of diagnosis, Insurer chose to ignore the earlier date and rely on the later one – which favored Insurer – to avoid paying earlier benefits to its cancer-stricken policyholder.

B. Insurer had a duty to make a reasonable investigation of the claim.

State statutes, South Dakota caselaw, and insurance industry standards all require insurers to make a reasonable investigation of insurance claims. SDCL §58-12-34(3),(6); §58-33-67(1); *Dakota, Minn. & E. R.R. Corp. v. Acuity,* 2009 SD 69, ¶19; SR 1139. However, Insurer cleverly imagines a severe limitation on the scope of "reasonable investigation," arguing that the investigation need only determine "validity" of a claim. (Appellee's Brief, p.17) Nowhere do statutes, caselaw, or industry standards impose that limitation on the duty to investigate, which in reality is a duty intended to serve *both* parties, insurer *and insured*. Sure, an Insurer is entitled to check whether the claim is "valid," but that is hardly where the duty ends. (If that were all the "duty to investigate"

entailed, there would be no need for a duty, as insurers will always be motivated by their own interests to determine validity.)

Statutory law *requiring* insurers to create and adhere to standards for the prompt investigation of claims obviously is intended to protect *insureds*. It is an *unfair claims practices* for an insurer *to fail to adopt and adhere to reasonable standards for the prompt investigation of claims.* SDCL §58-33-67(1). Likewise, "[b]ad faith conduct may include the failure to conduct a reasonable investigation concerning the claim." *Dakota, Minn. & E. R.R. Corp.* at ¶19. While Insurer wants to severely limit provisions protecting insureds to avoid any further duty to investigate once it knows Lenore's claim is "valid," that is not the law in South Dakota. Insurer also had the duty to consider evidence supporting its insured's claim, not just evidence seeming to contradict it. *Id.* at ¶22-24, 27. By the time of Lenore's claim, Zocherts had paid Insurer with their premiums to perform claims handling service, which inherently includes conducting reasonable investigation. (SR 1750, App. 130) Zocherts should not have had to hire an attorney to do what Insurer already had been paid to do.

Insurer's claims manager confirms Insurer does not investigate, saying, "We don't investigate a claim." (SR 1750, App.30) Now Insurer argues the witness uses the term "process" (Appellee's Brief at p.32) to refer to what the law requires as "investigation." Yet when Insurer describes what that process entails, it amounts only to looking at Insurer's own file, which is not an investigation at all. The Court has considered this kind of ineffective, internal, head-in-the-sand "investigation" before. In *Dakota, Minn. & E.R.R. Corp.,* an attorney retained to consider a UIM claim came to the faulty conclusion that there was no additional evidence beyond the existing claim file. ¶22 Finding the

insurer's conduct inadequate, this Court noted that "Acuity has not shown that it made attempts to interview the insured, interview the eye-witnesses to the accident that it knew existed or investigate any of the actual facts of the accident." *Id.* at ¶ 24. A claims handler cannot simply sit in her own office, look at the company file, do little or nothing to gather evidence, deny the claim for lacking evidence, and then on appeal claim that she completed a reasonable investigation by looking at the file and "processing" it. *Id.* at ¶ 23. That is by law unfair claims conduct and evidence of bad faith, which is both a breach of contract and a tort.

C. Insurers are duty-bound to disclose coverages to insureds.

Insurer concedes that insurers are duty-bound to disclose some coverages. Inexplicably, Insurer contends the duty does not apply unless the claim involves indemnity insurance for an insured's liability. Trying to make this argument, Insurer cites *Isaac v. State Farm Mut. Auto. Ins. Co.*, where this Court upheld a bad faith verdict against an insurer that failed to disclose UIM coverage, then tried to excuse its nondisclosure by arguing that workers comp benefits were to be set off against UIM coverage. 522 NW2d 752, 754 (S.D. 1994) In that case, Isaac was entitled to coverage for UIM [money] benefits and State Farm knew it, but did not disclose the coverage to Isaac. That is *exactly* what happened here. Lenore was entitled to cancer [money] benefits, Insurer knew it, and did not disclose the coverage to its insureds. *Isaac* is not distinguishable in any meaningful way.

In *Biegler v American Family Mut. Ins. Co.,* essentially the same thing happened: an insurer did not disclose that by procuring a few particular documents, *Biegler* would be entitled to coverage – in that case, a legal defense. 2001 S.D. 13. Instead of policy

benefits in the form of money paid directly to Biegler, benefits were supposed to be paid to an attorney to represent Biegler. Insurer injects the term "third-party" bad faith to confuse the issue, but the point of "bad faith" law is the same whether the policy benefit is money for cancer treatment, money to compensate for damages caused by an underinsured driver, or money to pay for a legal defense. Biegler and Isaac both had first-party relationships with their insurers.

The term "third-party" bad faith, though used customarily, can be somewhat misleading because in *every* case (except workers comp), the bad faith claim is by an insured – not some third party – against the insured's own insurer. What is common among all these cases is the first-party relationship between the insurer and insured. The particular elements of the cause of action against an insurer may vary between what we call "first-party" and "third-party" bad faith claims, but in *either instance* there is a first-party insurer/insured relationship from which the good faith duty arises. Neither *Biegler* nor *Isaac* is distinguishable in this critical respect.

Insurer also cites Federal District Court case *Plucker v. United Fire & Casualty Co.*, 412-CIV-04075-KES, 2016 WL5415655 to question the proposition that an insurer must disclose coverages to its insureds. *Plucker* is notably different. In *Plucker* the insured *refused* to sign and return a medical authorization form to let the insurer obtain what it wanted to investigate and process the claim. In this case, the requested medical release authorization was completed, signed, and enclosed in the very first envelope Ivan sent Insurer; Insurer just chose to not use it, except to *limit* its payments. (SR 1579, App. 116)

Insurer also argues that an insurer is not obligated to disclose benefits because the insured is charged with knowing the policy, citing *American Family Mut. Ins. Co. v. Elliot*, 523 N.W. 2d 100 (S.D. 1994). However, the situation in *Elliot* was much different. There, the insured was claiming a "reasonable expectation" of coverage the policy *did not* provide. The Court ruled that in the instance of an unambiguous policy provision, an insured cannot maintain a claim based on "reasonable expectation." Here, the policy provides benefits Insurer knew Lenore was entitled to. There is no exclusion or lack of coverage, as in *Elliot.* Insurer admits that good faith precludes an insurer from exploiting an insured's ignorance of his rights. *Allen D. Windt, 1 Insurance Claims and Disputes §2.2* (6th ed.) Yet that is exactly what Insurer did here, exploiting the fact that the advocate for its 81-year-old cancer-stricken insured was her 87-year-old husband who was known to have a hard time understanding Insurer's actions. (SR 1006, App.115)

Insurer's claims handler could have written Ivan, saying, "It appears Lenore will qualify for the following benefits under your policy: … We need to have itemized bills for all these items of treatment submitted to us. Take this letter to the medical billing departments of Lenore's clinic and hospital and have them fax these bills to me." Or better yet, she could have used the signed medical release authorization she had by September 19, 2012, all her knowledge and training about the insurance policy and her knowledge about Lenore's cancer treatment, and called or faxed the facilities herself to get what she knew Insurer required to fully pay Lenore's claim. She did neither. Instead, while Lenore perished and her grieving husband grew frustrated, Insurer stubbornly played a game of feigned ignorance about Lenore's claim. Lenore never lived to see most of the policy benefits she and her husband had, for 22 years, faithfully paid for.

2. Could reasonable jurors conclude Insurer violated duties of good faith?

A. Insurer owed the duty of good faith and fair dealing, and was required to act "fiduciary-like."

Ivan agrees that insurers may not be fiduciaries *per se*, but this Court has said on numerous occasions that insurers *are* "fiduciary-like." See *Helmbolt v. LeMars*, 404 N.W.2d 55, 58 (S.D. 1987) (refers to insurer's "fiduciary relationship to *one or both* of its insureds" – one with a "first-party" claim and the other a "third-party" claim); *Crabb v. National Indem. Co.*, 205 N.W.2d 633, 637 (S.D. 1973) (refers to insurer's "fiduciary relationship" with insured); *Bertelsen v. Allstate Ins. Co.*, 2011 S.D. 13 ¶ 47, 796 N.W.2d 685, 700 (describes insurer's role as "like that of a fiduciary"). The Court explained an insurer's fiduciary-like duties this way:

> "The insurer's obligations are ... rooted in their status as purveyors of a vital service labeled quasi-public in nature. [They] must take the public's interest seriously, *where necessary placing it before their interest in maximizing gains and limiting disbursements*.... [A]s a supplier of a public service…, the obligations of insurers go beyond meeting reasonable expectations of coverage. *The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary.* Insurers hold themselves out as fiduciaries, and with the public's trust must go private responsibility consonant with that trust." (emphases added) *Trouten v. Heritage Mutual*, 2001 SD 106, ¶31 citing *Egan*, 24 Cal. 3d 809 (1979).

Hoping to shirk its fiduciary-like duties and obligations of decency and humanity, Insurer cites *Hein v. Acuity*, 2007 SD 40, ¶10, 731 N.W.2d 231 to claim that an insurer and insured are complete adversaries. *Hein* noted that parties can be adversaries to the extent an insurer is entitled to challenge fairly debatable claims, but Insurer takes that observation out of context and ignores the whole point of *Hein* – to distinguish worker's compensation situations from other "first-party" cases because worker's compensation claimants have no first-party relationship to the insurer. Hein had not paid insurance

premiums. *Hein* focused on whether a worker's compensation claimant could claim "bad faith" absent a denial of benefits due. Given the indirect insurer/claimant relationship, the Court simply ruled that such a claimant could not maintain a bad faith claim without proving wrongful denial of benefits. While limiting bad faith claims in that context, the *Hein* court otherwise confirmed its earlier holding that unfair claim processing can violate the duty of good faith, whether or not benefits eventually are paid. *Id.* at 235.

Bertlesen did not negate decades of South Dakota bad faith law based on the fiduciary-like insurer/insured relationship in most first-party settings. *Bertelsen* merely noted that *some* aspects of the insurer/insured relationship can be adversarial, while discussing whether an insurer could obtain independent legal counsel and whether an insured could discover that attorney's opinions. *Bertelsen* held that the insured was not entitled to such discovery, but that issue has no bearing here, and the *Bertelsen* holding never abrogated other duties in the context of "first-party" bad faith claims. *Bertelsen* at ¶48. The Court neither abolished the duties of good faith and fair dealing, nor said that first-party insurer/insured relationships are now viewed as completely adversarial, not fiduciary-like.

Citing *Hein* and *Bertelsen* to claim Insured was entitled to treat Zocherts as adversaries is misleading. *Hein* and *Bertelsen* both confirmed that despite some limited adversarial aspects of the relationship that make it less than fully fiduciary, an insurer *still owes its insured the duty of good faith and fair dealing*, and *a cause of action still exists* for breach of that duty. At the least, Insurers still have the duties to investigate, disclose coverage, consider evidence supporting payment of the claim, and pay benefits when due.

Insurer's own claims handlers confirm that Insurer's "adversarial" argument is nonsense:

> "Q: So when you were trained, were you trained that at Protective Life about insurance claim handling that the claim handler and the insurance company must treat policyholder's interests with equal regard as they do their own interests?
>
> A: Absolutely.
>
> Q: It's not supposed to be an adversarial or competitive process?
>
> A: No.
>
> Q: And an insurance company is hired to and paid to assist the policy holder with the claim?
>
> A: Yes." (SR 000897)

Insurers are allowed to advance their own interests, not ignore insureds' interests or the duties they owe insureds. No one is saying Insurer cannot do anything for its own benefit; it just cannot act *only* for its own benefit, leaving its insureds out to dry by refusing claims handling services its insureds had paid for.

Insurer erroneously claims the "equal consideration" duty applies only in excess verdict ("third-party") cases. While "equal consideration" is highly relevant to such claims, it *also* describes how insurers must treat *all* first-party beneficiaries of insurance contracts. Insurers may not be true fiduciaries who must put insureds' interests *ahead* of their own, but insurers *do* have to treat their insureds' interests at least *equally,* and that duty is <u>not</u> limited to "third-party" situations. *Helmbolt v. LeMars,* 404 N.W.2d 55, 58 (SD 1987). In *Helmbolt,* one insured was liable for the collision and another claimed UIM benefits from the same insurer. The Court criticized LeMars for not giving equal consideration to *either* insured – including the "first-party" insured with the UIM claim.

Id. ("There was ample evidence of LeMars' bad faith and violation of its fiduciary relationship to *one or both* of its insureds. 'Equal consideration' was not given to the interests *of these insureds."* (latter emphasis added))

In a case like *Helmbolt,* where an insurer owes duties to both parties in a lawsuit, it is easy to see the purpose of good faith duties and how they apply to respective insureds. An insurer owes a duty to defend and indemnify the at-fault driver, and simultaneously owes a duty to investigate a claim and pay UIM benefits due another insured. There are various good faith duties, and in various settings an insurer must treat its insured's interests with at least equal consideration.

B. Insurer's other assertions also are false.

Insurer's bonus program* is *relevant to the bad faith claim.

Insurer's bonus program incentivizes claims handlers to not investigate or pay claims by tying their bonuses to company profit. Insurer is wrong when it contends evidence of how that plan works is irrelevant and raises no genuine issue of fact material to Ivan's bad faith claim. Insurer's bonus plan corroborates the intentional nature of claims handlers' conduct by revealing *why* claims handlers avoid contacting hospitals and doctors and avoid information supporting an insured's claim. It shows why claims handlers do not want to assist insureds, document claims, or take initiative to investigate a claim.

Insurance claims are supposed to be paid based on fair, honest claim handling, regardless of corporate profit. Claims are what claims are, and they must be paid according to policy terms. Insurer's claims handlers do not price insurance policies, determine how company financial resources earmarked as claims reserves are invested, or

or sell insurance (and therefore cannot affect how big the Insurer's book of business is). The only thing claims handlers can affect with regard to Insurer's profit is whether and when they pay a claim.

The bonus plan is evidence of Insurer's bad faith. The premise is simple. If there is more documentation in the file, Insurer has to pay more benefits. If Insurer pays more benefits, corporate profits drop and claims handlers (and others, including the company president) get less in bonuses. This is why bonus programs at insurance companies are looked upon with such suspicion, particularly when claims handlers are eligible for the bonuses. The major problem with incentivizing claims handlers is that the only real influence they have on corporate profits is by determining claims payments. This kind of bonus plan undisputedly puts claims handlers in a conflicted position by encouraging them to violate their fiduciary-like duties. (SR 1141)

Ivan argued contractual breach of good faith at the trial court.

Insurer falsely claims Ivan failed to argue contractual breach of the good faith duty in the court below. The record shows otherwise. Requesting summary judgment in *his* favor on breach of contract, Ivan argued that besides failing to pay benefits, "Protective Life also breached its contractual duties to investigate its insureds' claim, advise its insureds of applicable coverage, and process their claim fairly." (SR 869) Resisting Defendant's summary judgment motion, Ivan further argued, "Protective Life breached multiple duties of good faith. Duties of good faith are contractual duties, and violating them constitutes breach of contract…." (Plaintiff's Brief Opposing Defendant's Motion for Summary Judgment, page 30, Reply Appendix) Breach of the duty of good faith is both a breach of contract and tort; the trial court ruled on both. (SR 1723-1724)

Insurer's related arguments urging dismissal of the claim for attorney's fees under SDCL §58-12-3 is misplaced. Evidence would support a finding that Insurer's pre-litigation conduct amounted to a vexatious and unreasonable refusal to pay benefits. By the time of suit, Zocherts' attorney had spent dozens of hours performing claim handling services Zocherts already had paid Insurer to provide. The claim for attorney's fees should not be dismissed, as there is evidence Insurer's conduct was vexatious and unreasonable.

CONCLUSION

Undisputed evidence demonstrates Insurer breached its contractual duties of good faith by failing to investigate Lenore's claim, disclose coverage to Zocherts, and pay benefits when due. Rather than grant Insurer summary judgment on breach of contract, judgment in Ivan's favor should have been entered on that count.

Insurer was not entitled to summary judgment on the tort claim. For purposes of Insurer's motion, all reasonable inferences drawn from the facts had to be viewed in Ivan's favor. *Dakota, Minn. & E.R.R. Corp*, 2009 S.D. 69 at ¶ 14. At the very least, genuine issues of material fact remain as to whether Insurer violated its duties of good faith and fair dealing by failing to investigate and pay Lenore's claim, whether Insurer knew it lacked a reasonable basis for failing to pay or acted in reckless disregard of that lack, and the issue of damages. There also remains a question of whether Insurer acted unreasonably and vexatiously in failing to pay Lenore benefits, such that it also was improper for the trial court to grant Insurer summary judgment on the attorney's fees claims.

CERTIFICATE OF COMPLIANCE

The above brief complies with the type-volume limitation imposed by SDCL 15-26A-66(b)(2) by containing 4,805 words.

April 13, 2018 TURBAK LAW OFFICE, P.C.

By: Nancy J. Turbak Berry
Seamus W. Culhane
Attorneys for Plaintiff
26 S. Broadway, Suite 1100
Watertown, SD 57201
(605) 886-8361
nancy@turbaklaw.com
seamus@turbaklaw.com

CERTIFICATE OF SERVICE

I, Nancy J. Turbak Berry, hereby certify that on April 13, 2018, pursuant to SDCL §15-26C-4, I electronically served the above Brief on Edwin E. Evans and Ryann W. Redd by transmitting electronic copies to them at the following respective addresses: eevans@ehhlawyers.com; rredd@ehhlawyers.com.

April 13, 2018 TURBAK LAW OFFICE, P.C.

By: Nancy J. Turbak Berry
Seamus W. Culhane
Attorneys for Plaintiff
26 S. Broadway, Suite 1100
Watertown, SD 57201
(605) 886-8361
nancy@turbaklaw.com
seamus@turbaklaw.com

APPELLANT'S REPLY APPENDIX

As indicated on the following document and on the Clerk's Index, this Brief was filed with the Moody County Clerk of Courts on October 18, 2017. When the Clerk prepared the Settled Record, she listed this Brief in the Clerk's index, supposedly included at SR 1482. However, it appears from the electronic record supplied to the Plaintiff that the Moody County Clerk did not actually include this Brief in the settled record, and instead included a duplicate copy of an earlier brief Plaintiff had filed (in support of his own motion for summary judgment).

APPENDIX

As indicated on the following document and on the Clerk's Index, this Brief was filed with the Moody County Clerk of Courts on October 18, 2017. When the Clerk prepared the Settled Record, she listed this Brief in the Clerk's index, supposedly included at SR 1482. However, it appears from the electronic record supplied to the Plaintiff that the Moody County Clerk did not actually include this Brief in the settled record, and instead included a duplicate copy of an earlier brief Plaintiff had filed (in support of his own motion for summary judgment).

STATE OF SOUTH DAKOTA	IN CIRCUIT COURT
COUNTY OF MOODY	THIRD JUDICIAL CIRCUIT
Ivan Zochert individually and as Administrator for the Estate of Lenore Zochert, Plaintiff, vs. Protective Life Insurance Company, Defendant.	50CIV14-000061 PLAINTIFF'S BRIEF IN OPPOSITION TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Contents

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Introduction

The court is well versed in the specific factual sequence of this claim. For that reason, the sequence will not be repeated again here except to draw focus to important facts and distinctions.

Protective Life Breaches the Contract of Cancer Insurance.[1]

As soon as Ivan provided notice and proof of loss to Protective Life, Protective Life was obligated to pay "all benefits then due." Protective Life paid almost no benefits then due, and instead spent the next year dragging its feet and doing little to move Ivan's claim forward. Protective Life cannot possibly demonstrate that there are no genuine issues of material fact to be tried, especially when considering the following must be viewed in a light most favorable to Ivan:

- Protective Life had a contractual duty of good faith and fair dealing, which demands that Protective Life make a reasonable investigation. There are also statutory obligations of insurers to investigate insurance claims. Protective Life did not make a reasonable investigation.

- South Dakota law requires that Protective Life disclose coverage, as insureds are not expected to elect upon which coverage their benefits be based. Protective Life never disclosed many different coverage(s) to Ivan that he clearly qualified for.

[1] Ivan filed his own motion for summary judgment RE: Breach of Contract and included 38 pages of briefing. To avoid duplication, the level of detail and specific examples of the breach(s) of contract are not repeated again here.

- Protective Life did not make any payment correctly until Ivan and his Counsel started doing Protective Life's job.

- Protective Life's improper, passive claims handling approach led to incorrect payment in some instances, delayed payment in some instances, and no payment in other instances.

- Protective Life admits it owes surgical benefit(s), and paid $420 toward that but the amount is incorrect and has never been reconciled.

- Every dollar ever paid by Protective Life beyond the $420 initial payment was delayed longer that it should have been due to the unfair, improper claims processing scheme at Protective Life. Many of the benefits that were eventually paid by Protective Life that were clearly owed under the policy from the beginning were not even paid until after suit was filed. (See fn. 13 in *BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT.*")[2]

- There are outstanding benefits related to Lenore Zochert's Cancer care that that total more than $33,943.[3] The billings have been provided to Protective Life long ago and should be paid under the broad grant of coverage. The benefits have not been paid.

Protective Life has two main ways of avoiding having to pay claims. Protective Life's first method of avoiding paying benefits is to take a completely passive claims handling approach.[4] Protective Life's second line of defense is to twist words and concepts in the policy to justify specifically requested benefits that remain unpaid. Protective Life is supposed to be forthcoming, fair, honest, and generally act in good faith.[5] Protective Life is not supposed to use

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[2] Note: By the time suit was served upon the SD Director of Insurance on August 25, 2014, Protective Life *still* had not made this payment. The Director admitted Service the next day, August 26th, 2014. Yet, Protective Life wants credit for contractual benefits paid three days later.

[3] See *Second Affidavit of Seamus W. Culhane*, Exhibit 57: Protective Life Bates No.'s 0031-0034.

[4] See *Second Affidavit of Seamus W. Culhane*, Exhibit 62: Second Declaration of Elliott S. Flood for details about this improper approach.

[5] *Weber v. State Farm Mut. Auto. Ins. Co.*, 873 F. Supp. 20, 209 (S.D. Iowa 1994) (a party to a business transaction has a duty to disclose "matters known to him that the other is entitled to know because of fiduciary or other similar relation of trust and confidence between them.) (Once an insurer has received notice of an occurrence, there is no reason to restrict the obligation to disclose relevant information about the insured's rights and duties. If the insurer's employees or claims representatives process the claim without additional input from the claimants, full responsibility rests on those individuals. If additional actions by claimants or beneficiaries are

potentially different meanings of words in its own policy to avoid paying benefits, either. But, it does.

Protective Life Reads Ambiguous Terms in its Own Favor.

Ambiguity in an insurance contract "is to be construed liberally in favor of the insured and strictly against an insurer [. . .] *St. Paul Fire & Marine In.s Co., v. Schilling,* 520 N.W.2d 884, 887 (S.D. 1994); *Alverson v. Northwestern Nat'l Cas. Co.* 1997 SD, 559 N.W.2d 234, 235 ("It is our long-standing rule that 'where provisions of an insurance contract are fairly susceptible of different interpretations, the interpretations most favorable to the insured should be adopted.'") *Auto-Owners Insurance Company v. Hansen Housing, Inc.,* 2000 SD 13 ¶10, 604 N.W.2d 504 ("If the terms of an insurance contract are susceptible to different interpretations, we adopt the interpretation most favorable to the insured."); *State Farm Mut. Auto. Ins. Co. V. Vostad,* 520 N.W.2d 273, 275 (S.D. 1994). Ambiguity is created when the language in an insurance contract 'is fairly susceptible to two constructions.'" *North Star Mut. Ins. Co. v. Peterson,* 2008 S.D. 36, ¶10. The South Dakota Supreme Court has illustrated in a few cases what ambiguity looks like in insurance policies.

In the case of *Sawyer v. Farm Bureau,* 2000 S.D. 144, the insurer denied an insured's claim arising from the death of livestock by trying to claim that the term "owned" in the context of insurance policy and livestock meant, "100% owned" or "exclusive ownership" of the

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required, the insurer should be obligated to provide them complete information about the coverages that may provide benefits, what needs to be done, when it needs to be done, and all ancillary rights. Anything less falls short of the insurer's contractual obligations.); See also *Dercoli v. Pa. Nat'l Mut. Ins. Co.,* 520 Pa. 471, 554 A.2d 906, 909 (Pa. 1989) (The duty of an insurance company to deal with the *insured* fairly and in good faith includes the duty of full and complete disclosure as to all of the benefits and every coverage that is provided by the applicable policy or policies along with all requirements).

livestock. Correcting the insurer and finding for the insured, the South Dakota Supreme Court explained,

> "We have previously stated that "an insurance policy is ambiguous when it 'is fairly susceptible to two constructions.'" *Id.* When ambiguity is found, "the interpretation most favorable to the insured should be adopted." *Id.* Farm Bureau relies heavily on its interpretation of the term "owned." Yet, the term is not defined anywhere in the policy. While it is reasonable to conclude that ownership implies complete ownership to the exclusion of others, it is equally as reasonable to conclude that the term encompasses an infinite number and combinations of ownership interests so long as *some* ownership interest exists. As such, the policy is ambiguous, and the term will be construed in favor of the insured. Sawyer had at least a 25% ownership interest in the livestock that died during the storms. He is deemed to have "owned" that livestock for purposes of the Farm Bureau policy." *Id* at ¶13.

This is not the only time the South Dakota Supreme Court has illustrated the concept of an insurer improperly construing an ambiguous term in an insurance policy to avoid paying benefits. In another instance, a person was injured while leaning against his employer's vehicle by another motor vehicle. The insured made a claim against the UIM carrier for UIM benefits and the insurer denied the claim, claiming that leaning against the vehicle did not fall within the definition of "occupying." The Court interpreted the meaning of "occupying," liberally to include insured's act of leaning onto his employer's vehicle. *Roden v. General Cas. Co. Of Wisconsin*, 2003 SD 130, 671 N.W.2d 622 (2003).

There are various ambiguities in the Protective Life policy. It is no accident that Protective Life always uses them to avoid paying benefits at various stages of the insurance claim and during litigation.

The policy is "limited" to dealing only with cancer.[6]

Ivan and Lenore bought a policy specifically limited to cancer treatment. The particular policy they bought is known by Protective Life as "Form CA-05-SD." The policy is referred to on page 1 as a "LIMITED POLICY"[7] and the limitations are set forth on page 10:

Exceptions and Limitations

Benefits For Cancer Only. This policy pays only for loss resulting from definitive Cancer treatment, including only direct extension, metastatic spread or recurrence. Pathologic proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness or incapacity.

...

This is a cancer benefits only policy, as opposed to a major medical policy that is not limited by disease (i.e. health insurance/major medical insurance). This policy is *limited* to cancer. Other than an "Intensive Care Benefits Rider" Ivan and Lenore purchased, the policy does not provide benefits for medical conditions like diabetes or heart attacks the way Medicare or other major medical insurance would. Yet, the very word and concept of "LIMITED" is used by Protective Life to justify any exclusions it wants to read into the policy, however obscure the exclusions may be. But, that is not what the policy when read as a whole, suggests. In fact, reading the policy the way Protective Life does creates an absurd result.[8] Likewise, Protective Life's reading is not credible when the grant of coverage/insuring clause in Ivan's policy is read

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[6] The policy its self only deals with cancer, however, an Endorsement was purchased by the Zocherts to cover intensive care confinement for various causes, including accidental injury.

[7] http://www.dictionary.com/browse/limited-policy: noun, Insurance.

1. a policy that covers only certain types of losses within an area of risks.

[8] *Ass Kickin Ranch, LLC v. N. Star Mut. Ins. Co.*, 2012 SD 73, ¶10 citing *Prokop v. N. Star Mut. Ins. Co.*, 457 N.W.2d 862, 864 (S.D. 1990).

and compared with other Protective Life grants of coverage/insuring clauses that actually say (and justify) what Protective Life does in every instance.[9]

Protective Life had formal notice, written proof of loss, a medical authorization release and a completed claim form, but still argues it did not have adequate proof of loss to pay all benefits then due.

The insurance policy requires:

- "**Notice of Claim** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. [. . .]";
- "**Claim Forms.** When we receive a notice of claim we will send you forms for filing proof of loss. [. . .]"
- And, "**Proofs of Loss.** Written proof of loss must be given to use within 90 days after the occurrence or commencement of any loss covered by the policy. [. . .]"

Protective Life uses these provisions to *entirely* shift the burden of investigation, identifying coverage, and documenting facts that trigger coverage onto the policy holder.

Protective Life promised to make timely payment of claims; its policy says that once the company receives necessary proof of loss, it will pay all the benefits *then due*.[10] Ivan made a claim for cancer insurance benefits and promptly submitted the necessary proof of loss, returning every form Protective Life provided him, including the authorization allowing Protective Life to procure medical records and bills,[11] the physician's statement completed by Dr. Christensen,[12] and the general proof of loss form.[13] By October 24, 2012, Ivan also had submitted a pathology

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[9] *PLAINTIFF'S BRIEF IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT*, pp.12-13, 18.

[10] See *Second Affidavit of Seamus W. Culhane*, Exhibit 55: Protective Life Cancer Policy, p. 11, "**Time Payment of Claims.** After we receive written proof of loss, and subject to the terms of this policy, we will pay all benefits then due under this policy."

[11] See *Second Affidavit of Seamus W. Culhane*, Exhibit 41: Protective Life Bates No. 0180.

[12] See *Second Affidavit of Seamus W. Culhane*, Exhibit 42: Protective Life Bates No. 0182.

[13] See *Second Affidavit of Seamus W. Culhane*, Exhibit 43: Protective Life Bates No. 0183.

report confirming the diagnosis of cancer[14] and thereby had completed all his obligations under the contract by providing notice, written proof of loss and completing the claim form. If Protective Life has wished to obtain additional medical documentation, they had the signed release to do so from that moment on. Yet, Protective Life claims that "Proofs of Loss" means something more, and alleges that it can use claims forms that it drafts – without consent nor agreement of the policy holder after the policy is in place, to demand of the policy holder whatever it pleases. This is a breach of the contractual duty of good faith and fair dealing. Insurers are plainly not allowed to shift their duties and obligations onto policy holders.[15]

Not only does Protective Life take the narrower reading of words "notice" and "proof of loss" than the actual policy language by requiring their insured to do the insurer's job, Protective Life uses the term "itemized bills," to mean something more than what it ordinarily means. Even if the policy somehow requires "itemized bills" despite not saying so, Ivan provided "itemized bills" but Protective Life rejects them as being inadequate. Ordinarily, itemized bills include "Health Insurance Claim Forms." Protective Life brief even cites a case where these "1500" claims forms ("HICF 1500") are alleged to be the "standard." *Plucker v. united Fire & Cas. Co.*, 2015 U.S. Dist LEXIS 129819, *2 yet, while these claims forms are the standard for health insurance billing, when Ivan provided them to Protective Life, Protective Life dismisses them as inadequate "itemized billings" because they are for Medicare.[16] That is an unreasonable

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[14] See *Second Affidavit of Seamus W. Culhane*, Exhibits 46-47: Protective Life Bates No. 0202 and 0204; See also *Second Affidavit of Seamus W. Culhane*, Exhibit 32: Deposition of Ivan Zochert, p. 35 lines 3-17.

[15] Bilden v. United Equitable Insruance Company, 921 F. 2d 822, (8th Cir. Ct. of Appeals) ¶ 38 ("(4) That United Equitable attempted to shift the burden of investigating the claim to Mrs. Bilden and her attorney;")

[16] See *Third Affidavit of Seamus W. Culhane*, Exhibit 76: No's 44, 48 and 50 from the *DEFENDANT'S REQUESTS FOR ADMISSIONS (SECOND SET) AND INTERROGATORIES (THIRD SET).*

approach even as applied to the concept of "itemized billings." It is unreasonable to say that these are not itemized billing. For example, the billings itemize the date of service, the place of service, the CPT code, the modifier code, the charges, and the diagnosis. It also lists the provider, i.e. Prairie Lakes Healthcare/Edward Wegner.[17] The diagnosis code "174.9" refers to "Malignant Neoplasm of the Breast." This code appears on the Protective Life Bates No. 0238[18] document and insurance billing clerks and insurance claims handlers are supposed to be familiar with this diagnosis code. It would indicate the underlying diagnosis is clearly cancer, as that is the reason/condition that Lenore Zochert was being treated for at Prairie Lakes Hospital during this time period. Still, Protective Life takes the absurd approach to argue that this is not an "itemized billing" that deserves payment.

This, of course, is beside the point for purposes of the policy because nowhere in the insurance policy does the term, "itemized billing" ever appear. Nor does the word "bill" appear in the policy. Yet, Protective Life interprets their own use and unilateral mandate of "itemized billing" to require something more than HICF 1500 that contains all the information Protective Life could possibly need to be able to process and pay a claim. If Protective Life was going to require "bills" or "itemized bills," to be provided by the insured, why not just say so in the policy?

Protective Life ignores the policy term "expenses" and raises policy unrelated questions of whether the expenses are "treatment charges" or "diagnosis charges", then improperly denies anything it considers "diagnosis charges."

Another example of a way Protective Life twists words in its own policy to mean something other than the ordinary, originally intended meaning is illustrated by the way it treats

[17] See *Third Affidavit of Seamus W. Culhane*, Exhibit 77: Protective Life Bates No. 0237.
[18] See *Third Affidavit of Seamus W. Culhane*, Exhibit 77A: Protective Life Bates No. 0238.

surgical biopsies of cancer. When a doctor meets with a patient believed to have cancer, one of the first steps in the doctor's treatment of the patient is to perform diagnostic tests, likely including a biopsy, to confirm the existence of the cancer and determine its nature. The policy nowhere excludes coverage for diagnosis; in fact, it *requires* that cancer be diagnosed by microscopic pathology and *allows payment for expenses incurred up to 10 days before the diagnosis.*[19] Claim handlers know that the main way to qualify for any policy benefits in the first place is through pathologic proof confirming the diagnosis, and that the biopsies required to procure such proof are surgeries. Even though Protective Life knows a biopsy is surgery, Protective Life does not pay for biopsies as a surgical expense. Worse yet, claim handlers are taught to quibble with policyholders about whether a biopsy is even part of their "treatment." The following is an excerpt from the Deposition of Claims Specialist Lia Valez:

> **Q. And "treatment" could mean just surgery or just chemotherapy, or it could also mean diagnosis, like a biopsy, a needle that gets pushed into somebody's breast to take a tissue sample. Now, one of those favors the policyholder and one doesn't. Were you ever trained that you have to use the one that favors the policyholder?**
>
> **MS. WEBER: Object to form.**
>
> **THE WITNESS: No, because we have to go off of what the word "treatment" means. Having a biopsy isn't treatment."**
>
> **Q. Okay.**
>
> **A. It's surgery.**
>
> **Q. Okay.**
>
> **A. So it's not a form of treatment, because it's not -- a biopsy is for the purposes of diagnosis only, not necessarily to treat or remove their cancer.**

[19] See *Second Affidavit of Seamus W. Culhane*, Exhibit 55: Policy p. 7 "**Schedule of Benefits.**" "Benefits are payable for those expenses incurred by an Insured from 10 days preceding the date of positive diagnosis of Cancer or from the first day of a period of Hospital confinement during which the positive diagnosis is made, whichever is more favorable to you."

Q. Okay.

A. That's a separate surgery.

Q. So you don't think the word "treatment" includes things like a biopsy or mammogram, things that are used before chemotherapy might start?

A. Those are for -- for me personally the way I would view it, and the way the policy dictates from my understanding, is that those are for laboratory purposes.

Q. Okay.

A. Because we are not -- they are not treating the cancer. A form of treatment would be chemotherapy or radiation.

Q. Is surgery treatment?

A. Yes, it can be, if it's going to fully remove their cancer, depending on what type of cancer they have. [. . .]

Q. So, in your mind as you handle claims, surgery is treatment for cancer?

A. Yes, it can be." [20]

Diagnosis or not; surgical biopsy *is* surgery and as long as it occurs no more than ten days prior to the cancer diagnosis, it must be covered under the surgical expense benefit. However, Protective Life refused to pay for Lenore's surgical biopsy until after Ivan filed a lawsuit.

The policy requires "pathologic proof," and Lenore's doctor's office submitted a pathology report, but that report did not meet Protective Life's overly stringent requirements that would trigger all benefits *then due*.

By September 21, 2012, Protective Life denied Ivan's claim because he had not submitted "pathological diagnosis" of cancer.[21] So, Ivan went to Sanford Clinic and requested a

[20] See *Second Affidavit of Seamus W. Culhane*, Exhibit 56: Deposition of Lia Valez, p.10 line 19 – p.11 line 4.

[21] See *Second Affidavit of Seamus W. Culhane*, Exhibit 45: Protective Life Bates No. 0201

pathology report, which Sanford mailed to Protective Life on October 24, 2012.[22] The sample that was confirmed cancerous in that pathology report was taken while the lump was being removed. What Ivan, nor Sanford Clinic understood was that Protective Life interprets the term "pathologic proof" to mean, "first pathologic proof" and it would not pay any benefits that pre-dated the pathology report – even though there was definitive evidence of an earlier of cancer diagnosis by the treating physician in the signed physician's statement. Yes, there was an earlier pathology report arising from the surgical biopsy back in July that arose from the surgical biopsy. But, Protective Life had already internally avoided any mention of the surgical biopsy, as detailed above. Still, the policy says, "This policy pays only for loss resulting from definitive Cancer treatment, including only direct extension, metastatic spread or recurrence. *Pathologic proof* thereof must be submitted." (emphasis added). Like every other term in the policy that can be interpreted two ways, Protective Life adds the word, "first" to the term "pathologic proof" to avoid paying all sorts of benefits.

Protective Life does this so they can later argue, "We didn't know there were charges going back to July." What is inconvenient for Protective Life is the fact that argument is completed undermined by the physician's statement completed by Dr. Christensen[23] that says, "2. Date of Initial Diagnosis: 7/11/2012." That signed physician's statement was in Protective Life's possession from the very beginning, (September 17, 2012). But, by not doing its own job, Protective Life puts its self in a position where if later challenged it gets to feign ignorance about

[22] See *Second Affidavit of Seamus W. Culhane*, Exhibits 46-47: Protective Life Bates No. 0202; 204; See also *Second Affidavit of Seamus W. Culhane*, Exhibit 32: Deposition of Ivan Zochert, p. 35 lines 3-17.
[23] See *Second Affidavit of Seamus W. Culhane*, Exhibit 42: Protective Life Bates No. 0182.

owing for earlier expenses associated with cancer. And, Protective Life can blame the insured for allegedly screwing up the insured's own claim, like they have done here.

Protective Life should not be allowed to write with fuzzy language, then hide behind it and cite it as a reason for not paying benefits. "When the drafter of such a contract leaves an important term undefined, public policy deems that the consequences of the imprecise drafting should fall on the party that drafted the contract, was able to dictate the terms . . . and (almost always) has at its disposal a battery of personnel to serve its interests." *Bjornstad v. Senior Am. Life Ins. Co.*, 599 F.Supp.2d 1165, 1172 (D. Ariz. 2009) *Id.* (citing the *Restatement (Second) of Contracts § 206 cmt. a* (1981). One commentator describes it this way:

> *"Cancer policies are, by their nature, like the old classic medical expense insurance that won't pay for medical expenses unless or until you are hit by a wild buffalo, while on a Pullman, going south. Not satisfied with an inherently narrow coverage, cancer policies add more tricky exclusions. So, you not only have to be hit by a wild buffalo, on a Pullman going south, but the wild buffalo has to be named "Gertrude."* (emphasis added) Joint Hearing before the Subcommittee on Antitrust Monopoly and Business Rights of the Committee on the judiciary United States Senate and Select committee on Aging House of Representatives. P. 34, March 20, 1980.

Insurers should not be allowed to hide behind these kind of tricky exclusions and word games.

"Such treatments" includes surgery that removes cancer.

An endorsement on Ivan's policy expressly covers physical exams, laboratory tests, and diagnostic tests.[24] Protective Life avoids paying benefits by reading the language narrowly so that the term "such treatments" does not include surgery that removes cancer. First, it should be noted that laboratory, other testing is covered under the broad grant of coverage as explained in *PLAINTIFF'S BRIEF IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY*

[24] See *Third Affidavit of Seamus W. Culhane*, Exhibit 78: Protective Life Bates No. 0017, CE-21 Protective Life Endorsement.

JUDGMENT, pp. 19-24. Still, even if the court rules that there is no coverage for pre-operative lab work, x-rays, and so forth associated with cancer treatment under the broad grant of coverage in the schedule of benefits, "...", there is other coverage elsewhere in the policy for the same types of treatments. For example, in the ENDORSEMENT, it says, "This also includes such treatments designed to prevent a reoccurrence of Cancer for a period of up to 6 consecutive months [. . .] While this paragraph of the endorsement is titled "Radiation and Chemotherapy Benefit." When the word, *also* is used, as in "this also includes such treatments [. . .]", that could fairly be read to *also* include surgery. When a woman's breast is cut open and a cancerous lump is removed, that is cancer treatment designed to prevent the reoccurrence of cancer. Thus, at a minimum, least $250 should be paid toward "physical exams, laboratory tests, diagnostic tests and consultations related to such treatments." Protective Life pays nothing.

Protective Life does not interpret that provision liberally, as it must. Such a liberal interpretation of a grant of coverage would require that it pay out benefits. Protective Life chooses to interpret "this also includes such treatments designed to prevent a reoccurrence of cancer [. . .]" narrowly to only refer back to radiation and chemotherapy. Thus, the only "such treatments" Protective Life will pay for physical exams, laboratory tests and so forth, is for radiation and chemotherapy. When Protective Life reads the policy, it ignores the word, "also."

Meanwhile, Protective Life looks elsewhere in the policy to cherry pick exclusionary sounding language to support its denials. For example, in support of their denials of all laboratory testing, Protective Life looks to the "Blood and Plasma Benefits" to find exclusionary language. "No payment will be made under this benefit for laboratory expenses except those described." While that exclusionary language may fairly be said to exclude laboratory, tests associated with blood and plasma transfer, it does not meet the criteria for excluding laboratory

work associated with pre-operative issues and surgery. This language does not meet the criteria of South Dakota law as applied to exclusions. Insurance policy exclusions must be set forth clearly and explicitly.[25]

Courts look unfavorably on methods which "hold out expectations of coverage with one hand and take them away with the other," or which use double talk by "setting forth a promise in one part of the contract and then taking it away somewhere else," *Marriot v. Pacific Natl. Life Assurance Co.*, 467 P.2d 981, 985 (Utah 1970) or in which "the policy on one hand giveth, but on the other hand taketh away." *Allstate Ins. Co. v. Stone*, 863 P.2d 1085, 1087 (N.M. 1993). Ultimately, Protective Life's denials of laboratory work, physical exams are not justified.

Ivan Performed His Obligations under the Contract.

When Ivan called Protective Life to notify it of the loss, Protective Life provided Ivan with these claim forms to be completed:

- AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION FOR EVALUATION OF CLAIM;
- PHYSICIAN STATEMENT; and
- A general proof of loss form.

Ivan completed and signed the medical authorization form, allowing Protective Life to obtain and use health and medical information necessary to evaluate the claim for benefits.[26] He completed and signed the proof of loss form.[27] Dr. Christensen completed and signed the physician's statement, attesting that Lenore was diagnosed with cancer on July 11, 2012, that

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[25] *Alverson v. Northwestern Nat'l Cas. Co.* 1997 SD 9 ¶8, 559 N.W.2d 234, 235, citing *Mid-Century Ins. Co v. Lyon*, 1997 DSD 50 P9 n4, 562 N.W. 2d 888, 891 (citing *Essex Ins. Co. v. Fieldhouse, Inc.*, 506 N.W. 2d 772, 776 (Iowa 1993) (citations omitted).

[26] See *Second Affidavit of Seamus W. Culhane*, Exhibit 41: Protective Life Bates No. 0180.

[27] See *Second Affidavit of Seamus W. Culhane*, Exhibit 43: Protective Life Bates No. 0183.

Lenore had been hospitalized at Prairie Lakes Hospital, and that Dr. Christensen had performed surgical procedures.[28] On September 14, 2012, Ivan put all three completed and signed forms in an envelope, addressed the envelope to Protective Life, enclosed a hospital bill confirming that Lenore had surgical procedures including a partial mastectomy and closure,[29] and mailed it. Protective Life received it on September 17, 2012. Ivan went to Sanford Clinic and requested a pathology report, which Sanford mailed to Protective Life on October 24, 2012.[30] Together, these things amounted to both the necessary "notice" and "written proof of loss," thereby completing Ivan's obligations under the contract. Yet, Protective Life began an extended game of cat and mouse, where Ivan and his counsel had to drag benefits out of Protective Life. That game continues today.

Ivan and his Counsel Attempted in Good Faith to get Ivan's claim paid.

Most of Protective Life's arguments in support of its motion redirect the focus from what Protective Life knew it needed to be able to pay Ivan full benefits under the policy and its obligation and ability to obtain what it needed onto what Ivan or his counsel did (or did not do). While it is a clever attempt, Protective Life's duties of Good Faith and Fair dealing are not delegable. *Eldridge v. Northwest G. F. Mut. Ins. Co.*, 88 S.D. 426 (1974), ¶ 5 (Delegation to independent adjusters does not insulate from duties of good faith); *Scott Wetzel Services Inc. v. Johnson*, 821 P.2d 804 (Colo. en banc 1991) (worker's compensation carrier could not contract out its responsibilities); *Wathor v. Mutual Ins. Admin. Inc.*, 87 P.3d 559, 562 (Ok. 2004)

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[28] See *Second Affidavit of Seamus W. Culhane*, Exhibit 42: Protective Life Bates No. 0182.

[29] See *Second Affidavit of Seamus W. Culhane*, Exhibit 44: Protective Life Bates No. 0184.

[30] See *Second Affidavit of Seamus W. Culhane*, Exhibit 46 and 47: Protective Life Bates No. 0202 and 0204; See also *Second Affidavit of Seamus W. Culhane*, Exhibit 32: Deposition of Ivan Zochert, p. 35 lines 3-17.

(Oklahoma Supreme Court affirmed earlier decision that insurer's duty of good faith is nondelegable; insurer cannot escape bad faith liability by delegating tasks to third parties); *Majorowicz v. Allied Mutual Ins. Co.*, 212 Wis.2d 513, 569 N.W.2d 472 (Wis. App. 1997) (Insurer cannot escape bad faith via delegation to attorney); *Smoot v. State Farm Mutual Auto. Ins. Co.*, 299 F.2d 525, 530 (5th Cir. 1962) ("Those whom the Insurer selects to execute its promises, whether attorneys, physicians, no less than company-employed adjustors, are its agents for whom it has the customary legal liability). If an insurer cannot delegate its duty of good faith to independent adjusters, attorneys, nor doctors, it is hard to imagine how an insurer would be allowed to re-delegate its duty of good faith to its own insured, whom it owed the duty in the first place.

Blaming Ivan does not legally justify Protective Life. Bad faith is not subject to the defense of contributory negligence. Insurance bad faith is an intentional tort. Thus, it is not subject to the defense of contributory negligence. *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 NW2d 752, 754, 760 (SD 1994). Yet, for several pages in Protective Life's brief, it attempts to shift their affirmative burden to investigate[31], timely and fairly process[32] and pay[33] back to Ivan. Simply stated, insurers are paid via premiums for both service and coverage.[34] In this case, Ivan paid for 22 years to have both the coverage and the service should he ever need it. When he needed the service, having proved he had experienced a compensable loss via written notice and proof of loss, Protective Life set in motion their predictable sequence of events that attempts to force the insured do its job for them (or, better yet, not have to pay benefits). Protective Life is

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[31] SDCL §58–12-34(6); *Dakota, Minn. & E. R.R. Corp. v. Acuity*, 2009 SD 69, ¶23.
[32] *Hein v. Acuity*, 2007 SD 40, ¶10.
[33] SDCL §58-33-67(4); SDCL §58-12-34(4).
[34] See *Second Affidavit of Seamus W. Culhane*, Exhibit 62: Second Declaration of Elliott S. Flood.

not entitled to shift the burden to Ivan, nor is Protective Life allowed to expect Ivan nor Ivan's counsel to do Protective Life's job.

The remainder of Protective Life's argument is based on the allegedly lacking, "objection" to this re-delegation of the investigation, coverage analysis and coverage disclosure. Yet, that argument fails for lack of factual support. Neither Ivan nor his Counsel accepted the re-delegation of Protective Life's duties. And, contrary to Protective Life's argument, Ivan, through counsel did "object" to this re-delegation. By August 26, 2013 it started to become obvious that Protective Life was attempting to make the insured effectively handle his own claim by taking a totally passive approach to claims handling. Ivan Zochert and Attorney Culhane were effectively objected to furnishing additional bills.[35]

As a practical matter, this re-delegation of the claim handling function to the insured and his attorney causes contractual damages and it amounts to the commission of an intentional tort. It causes damages because some benefits were not paid at all, some benefits were not paid when they were supposed to, and some benefits were not paid until after suit was filed. Worse yet, the whole process of having an insured's own attorney perform the claim function that Protective Life was already paid to handle is expensive.

Protective Life Committed Insurance Bad Faith

Ivan must show Protective Life (A) denied, failed to process, or failed to pay his claim (B) without a reasonable basis, and (C) either knew it did not have a reasonable basis or acted in reckless disregard of the basis. *Bertelsen v Allstate Ins Co*, 2013 SD 44, ¶17. "Denial of benefits may be inferred from the insurer's failure to process or pay a claim, and the requisite knowledge (or reckless disregard) on the part of the insurer may be inferred when the insurer has exhibited 'a

[35] See *Third Affidavit of Seamus W. Culhane*, Exhibit 79: Protective Life Bates No. 0310.

reckless indifference to facts or to proofs submitted by the insured.' " *Kirchoff v. Am. Cas. Co.*, 997 F 2d 401, 405 (8th Cir. 1993) (applying South Dakota law) (citation omitted.) (quoting *Champion*, 399 N.W.2d at 324).

The facts detailed below demonstrate that there is a genuine issue of material fact to be tried to a jury regarding Protective Life's bad faith. Debra Turner, the manager of the entire claims department[36] at Protective Life confirms how insurers are supposed to act toward insureds.

Q. For example, one of the most basic rules is that an insurance company must treat the policyholder's interests with equal regard as it does its own interests?

A. Right. We pay all the claims the same.

Q. I mean, an insurance company can't put its own interests ahead of the policyholder's interests, can they?

A. No, I never would.

Q. And that's a violation, that would be a violation of insurance standards that protect policyholders?

MS. WEBER: Object to form. You can answer.

THE WITNESS: Yes.

Q. In addition to that, insurance companies are supposed to assist policyholders with claims, aren't they?

A. Yes.

Q. I mean, part of what policyholders buy when they get an insurance policy is not only coverage, but also service?

A. Correct.

Q. And, in addition to that, when the premiums are paid, those premiums actually prepay the insurance company to investigate claims?

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[36] See *Second Affidavit of Seamus W. Culhane*, Exhibit 31: Deposition of Debra L. Turner, p. 5, line 13.

MS. WEBER: Object to form.

BY MR. CULHANE:

Q. Don't they?

A. Yes.

Q. That's part of the service, providing a full and fair investigation when the claims are made?

A. To process the claim according to the policy, yes.[37]

Yet, Protective Life's investigation was both passive and lackadaisical. "[T]he adequacy of the investigation and consideration of the claim by the insurer is relevant in determining whether a claim is fairly debatable." *Dakota, Minn. & E. R.R. Corp.*, ¶ *23, 771 N.W.2d at 630.* "However, a frivolous or unfounded refusal to comply with a duty under an insurance contract constitutes bad faith." *Hein*, ¶ *10, 731 N.W.2d at 235.*

In another South Dakota bad faith claim, the Court found that questions of fact existed as to whether "Acuity failed to conduct a thorough investigation and subject the results of the investigation to "reasonable evaluation and review."" *D, M & E supra.* citing *Trinity Evangelical Lutheran Church & School-Freistadt,* 661 NW2d at 796. The Court found in *D, M & E* that Acuity's reliance on an insufficient investigation did not amount to a reasonable basis for denying benefits.[38] Whether Protective Life conducted a fair investigation and evaluation of Ivan's claim in light of all this evidence is a question for the jury.

Protective Life never really helped Ivan with his claim. Protective Life never went and got the "itemized" bills that it says is necessary to pay benefits. It never told Ivan about

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[37] See *Second Affidavit of Seamus W. Culhane*, Exhibit 31: Deposition of Debra L. Turner, p. 11 line 12 – p. 12. Line 17

[38] D, M, & E at ¶¶22-27.

additional coverages he unquestionably qualified for.[39] Protective Life did not treat Ivan's interests with equal regard, either. In fact, the only time that Protective Life used the medical release authorization that it made him sign was to *minimize* benefits.

When Lenore was in Prairie Lakes Hospital the first time she was there portions of August 14th, August 15th, and a portion of August 16th in 2012.[40] And, claims handlers know they are supposed to use the full range of dates. "If you have a completed Attending Physician Statement call the provider to get range of dates of treatment and actual dates of treatment."[41] If there are only single dates of service on a facility bill, claims handler are taught to "Use a range of all dates of services listed on the bill, not simply the admission and/or discharge date."[42] The only time Protective Life used the medical release authorization to obtain information to aid in the processing of Ivan's claim was in hopes that Protective Life would only have to pay for *two* of the *three* days Lenore was confined in the hospital.[43]

SPOKE W/VICKIE AT PRAIRIE LAKES HOSP. WHO VERIFIED INSURED WAS CONFINED FROM 8-14 @ 11:35 AM AND RELEASED 8-16 @ 13:10 PM I AM PAYING FOR 2 DAYS CONFINEMENT .....DH 5/13/13

There is obviously nothing wrong with an insurer using a medical release form to get accurate information and pay a claim accordingly. That is what is supposed to happen. What is illustrative and important is that this is the *only* time Protective Life used the release – was when there was a chance it could save one days' worth of hospital charges. Protective Life never used the release to get information that would support paying benefits for every other coverage that is unequivocally within the policy:

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[39] See *Second Affidavit of Seamus W. Culhane*, Exhibit 75: Deposition of Lia Valez, p. 48, line 8 – p. 51, line 14.
[40] See *Second Affidavit of Seamus W. Culhane*, Exhibit 42: Protective Life Bates No. 0182.
[41] See *Third Affidavit of Seamus W. Culhane*, Exhibit 80: Protective Life Bates No. 002970.
[42] See *Third Affidavit of Seamus W. Culhane*, Exhibit 81: Protective Life Bates No. 002971.
[43] See *Third Affidavit of Seamus W. Culhane*, Exhibit 82: Protective Life Bates No. 0299.

- **Surgery** for partial mastectomy/lumpectomy
- **Anesthesia** during partial mastectomy/lumpectomy
- **in hospital room in board** (8/14/12-8/16/12)
- **in hospital doctor** visits ($25/ day x 2 days)
- **in hospital nurse** visits ($100/day x 2 days)
- **home recovery** after 8/14/12-8/16/12 hospitalization

Insurers are statutorily required to have standards for claim investigation. Failing to have standards is unfair and deceptive.[44] Protective Life has no standards for prompt and fair claim investigation, except the standards that are in place that lead Protective Life to do exactly what it did in this case – make the insured do the claim investigation and coverage analysis. Not complying with regulations that require standards, is evidence of bad faith.[45]

Protective Life Denied a Large Portion of the Benefits it Owed to Ivan.

Aside from the $420 initial paid toward the surgical expenses[46], Protective Life paid nothing without Ivan's counsel identifying coverages, obtaining records and bills, and submitting them to Protective Life. This led to Protective Life paying $474.56 on May 13, 2013.[47] The remaining $1,820 Protective Life paid that even Protective Life admits was unequivocally

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[44] SDCL 58-33-67 (1) (Failing to [. . .] adopt and adhere to reasonable standards for the prompt investigation of such claims."; SDCL 58-12-34(3)(Unfair to fail to adopt and implement reasonable standards to promptly complete claim investigations and settlement of claims arising under its policies).

[45] See *Moore v. Am. Family Mut. Ins. Co.*, 576 F.3d 781, at 786 2009 U.S. App. LEXIS 18133 (8th Cir. N.D. 2009) ("We believe that evidence that an insurer's conduct violates a statute prohibiting unfair settlement practices is relevant to whether the insurer acted in bad faith.") See also *MacFarland v. United States Fidelity & Guaranty Co.*, 818 F. Supp. 108, 110 (E.D. Pa. 1993) ("the alleged conduct constituting violations of the UIPA and the regulations can be considered in determining whether USF&G acted in bad faith"); *Certainteed Corp. v. Federal Ins. Co.*, 913 F. Supp. 351, 360-61 (E.D. Pa. 1995).

[46] See *Second Affidavit of Seamus W. Culhane*, Exhibit 49: Protective Life Bates No. 0031.

[47] See *Second Affidavit of Seamus W. Culhane*, Exhibit 54: Protective Life Bates No. 0032.

covered under the policy was only paid after suit was filed.[48] As detailed in indicated in *PLAINTIFF'S BRIEF IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT* (pp. 29-31), even the initial payment of $420 is wrong, and Protective Life has never corrected it. This discrepancy was brought directly to Protective Life's attention more than four years ago.[49] To support its contention that the $420 was paid correctly, Protective Life now reverts to a long-dispelled lie - claiming that they used the California Relative Value Schedule to decide how much to pay Ivan. That, is blatantly false and misleading.

On August 27, 2013, one of the claims handlers said that Protective Life used procedure code 19301 to adjust Ivan's claim.[50] Two days later after being asked how the $420 payment amount was calculated, claim handler Debi Henry said she could not produce any page from the California Relative Value Schedule, and that she was merely using a software that was pre-programmed.[51] Unfortunately for Protective Life, the actual California Relative Value Schedule does NOT have a unit value for the procedure code the surgeon listed; the California Relative Value Schedule says the procedure is "BR" or "By Report."[52, 53] On September 18, 2013, Protective Life claim handler Lia Velez doubled down, saying that code 19301 has a unit value of 6.0.[54] But, as can be immediately seen from the California Relative Value Schedule, that could

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[48] See *Second Affidavit of Seamus W. Culhane*, Exhibits 68, 69 and 70: Protective Life Bates No.'s 0033, 0034, and 0035.
[49] See *Second Affidavit of Seamus W. Culhane*, Exhibit 64: Protective Life Bates No. 0317; and Exhibit 65: Protective Life 0319.
[50] See *Third Affidavit of Seamus W. Culhane*, Exhibit 83: Protective Life Bates No. 0309.
[51] See *Second Affidavit of Seamus W. Culhane*, Exhibit 66: Protective Life Bates No. 0314.
[52] *See PLAINTIFF'S BRIEF IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT* (p.30); See also *Second Affidavit of Seamus W. Culhane*, Exhibit 48: Protective Life Bates No. 0062.
[53] See *Second Affidavit of Seamus W. Culhane*, Exhibit 64: Protective Life Bates No. 0317, September 10, 2013 email from Seamus Culhane to Debi Henry.
[54] See *Third Affidavit of Seamus W. Culhane*, Exhibit 84: Protective Life Bates No. 0321.

not be farther from the truth. By November 20, 2013, Protective Life's story fell completely apart.[55] Now, for some strange reason, Protective Life is trying to resurrect that long dispelled nonsense by arguing that the $420 was paid pursuant to the California Relative Value Schedule,[56] when the claims handlers did not have the relative value schedule to begin with; the California Relative Value Schedule says something contrary; and a claims handler has admitted it was paid using a *different* code.

This is just one example of a benefit that was clearly owed that is clearly wrong leading to a $2,071 benefit deficiency – that has never been paid. In addition, Protective Life has in its possession, billings for more than $33,000 related to Ivan's claim – all related to cancer treatment.[57]

Protective Life Fails to Properly Process the Claim.

Delaying a claim unreasonably counts as denying or failing to pay a claim for purposes of bad faith liability. Insurers must offer payment without undue delay. *Bertelsen v. Allstate Ins Co*, 2011 SD 13, P24, See also *McDowell v. Citicorp USA*, 2007 SD 53, P16 (quoting *Kirchoff v. Am. Cas. Co.*, 997 F.2d 401, 405 (8th Cir. 1993)). A "failure to process or pay a claim" includes delays in payment, so that "if defendants unreasonably delayed payment of [benefits due under the 1993 Agreement] with an absence of a reasonable basis for the delay . . . then such conduct might support a claim for bad faith." *Id.* In this case, when Protective Life tried to shift the

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[55] See *Third Affidavit of Seamus W. Culhane*, Exhibit 85: Protective Life Bates No. 0346 (with highlighting).
[56] DEFENDANT'S *BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT*, p. 5.
[57] See *Second Affidavit of Seamus W. Culhane*, Exhibit 57: Protective Life Bates No.'s 0031-0034.

burden onto insured to investigate and adjust his own losses which perpetually deled portions of the claim, Protective Life was thereby failing to properly process the claim.

In the first-party context, "there exists a contractual relationship, whereby the insurer has accepted a premium from its insured to provide coverage." *Id.* P 13, 731 NW2d at 236. Because of the nature of this relationship, "[w]e recognized in *Julson* that bad faith can extend to situations beyond mere denial of policy benefits." *Id.* (citing *Julson v. Federated Mut. Ins. Co.*, 1997 SD 43, P 6, 562 NW2d 117, 119).

Meanwhile, Protective Life does not tell insureds about additional coverages they may qualify for. But, In South Dakota, an insured is "not obliged . . . to elect upon which of the clauses in the policy the claim might be made." *Eide v Southern Sur Co*, 55 SD 405, 409 (1929) In *Isaac* (SD 1994) the court upheld a bad faith verdict where the insurer failed to disclose UIM coverage but, 3 years later, said the reason they didn't disclose the coverage was that workers compensation benefits were set off against it.[58] Insurers must take care to tell the truth.[59] One Protective Life Claims Specialist, Lia Valez, admits that it is part of her job to disclose coverages and benefits[60] but as she admits below, that is something she did not do for Ivan.

Q. You never told Ivan that he might qualify for other benefits like anesthesia, did you?

A. No, not to my knowledge. Not that I can remember.

Q. You never told him that he might qualify for in-hospital room and board benefits, did you?

A. Not that I can remember, no.

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[58] *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 NW2d 752, 754 (SD 1994).
[59] *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 NW2d 752, 754 (SD 1994) (upholding verdict of bad faith where insurer said wrongly that there was no UIM coverage available because workers compensation benefits were set off against UIM benefits).
[60] See *Second Affidavit of Seamus W. Culhane*, Exhibit 56: Deposition of Lia Valez, p. 9 lines 5-8.

Q. You never told him that he might qualify for attending physician benefits, did you?

A. I can't remember any of that, no.[61]

Protective Life does not have a Reasonable Basis for its Denial(s) and Failed Processing

At best, Protective Life can argue at trial all the ambiguous phrases outlined above create a fair debate. But, an ambiguity in its own insurance policy does not give Protective Life a reasonable basis for the denial nor the failed processing. Such arguments do not demonstrate that there is a "fair debate" as a matter of law entitling Protective Life to summary judgment.

Under these circumstances, courts hold that an ambiguity does not make coverage "fairly debatable." *Wolf v. Prudential Ins. Co.*, 50 F.3d 793,800 (10th Cir. 1995) (rejecting insurer's argument that ambiguity in policy language made the claim "fairly debatable," and noting that "under Prudential's argument, an insurer could intentionally insert an ambiguous term into a policy and continually deny coverage based on that term, despite contrary court decisions or its own doubts about the meaning of the term. The insurer could lose coverage cases (though many insureds would not litigate and would accept the insurer's denial of coverage), but would never face a bad faith claim because its ambiguous term would create a 'legitimate dispute.' Such actions by an insurer would not be in good faith and could not be countenanced. Thus, mere ambiguity cannot, as a matter of law, create a valid defense to a bad faith claim."); See also *McElgunn v. CUNA Mutual Group*, 2009 U.S. Dist. LEXIS 46498, *18-19 (D. S.D. 2009) (evidence that defendant's personnel knew that ambiguities must be applied in favor of the policyholder, but failed to provide claim handlers with any training on this rule, is admissible

[61] See *Second Affidavit of Seamus W. Culhane*, Exhibit 56: Deposition of Lia Valez, p. 48 lines 8-17.

because it relates to whether the defendant had a reasonable basis to deny the claim); *Sparks v. Republic National Life Ins. Co.*, 647 P.2d 1127, 539 (AZ 1982) ("if the insurer's interpretation of its own contract as excluding coverage could render an insured's claim 'fairly debatable' then insurers would be encouraged to write ambiguous insurance contracts, secure in the knowledge that an obscure portion of the policy would provide an absolute defense to a claim of bad faith."); *Loan v. The Prudential Ins. Co.*, 788 F.Supp.2d 558, 563 (D. KY 2011) (in an ERISA action, defendant's denial of plaintiffs claim relying on known ambiguous language is evidence that defendant acted in bad faith); *Haas v. Audubon Indemnity Co.*, 722 So.2d 1022, 1029 (LA. App. 3d Cir. 1998) (given well known rule that ambiguities are construed in policyholder's favor, the insurer's interpretation of a patent ambiguity in its own favor is evidence of bad faith); *Sawyer v. Farm Bureau Mutual Ins. Co.*, 619 N.W.2d 644, 650 (S.D. 2000) (jury's award of punitive damages was supported by evidence that the insurer applied a strict reading of an undefined and ambiguous term in a policy, with the knowledge that ambiguous policy terms are construed against the insurer).

Protective Life Knew it was Lacking a Reasonable Basis and acted with Reckless Disregard.

An insurer's knowledge of the lack of a reasonable basis to deny benefits "may be inferred and imputed to an insurance company where there is a ...reckless indifference to facts or to proofs submitted by the insured." *Mordhorst v. Dakota Truck Underwriters*, 2016 SD 70, ¶9, quoting *Champion v. United States Fidelity & Guaranty Co.*, 399 N.W.2d at 324.

Protective Life's defunct claim handling in this case is no accident, coincidence, or anomaly. It was designed to operate exactly the way that it did in this case. Claim handlers are supervised by managers, and managers submit claims to be audited by internal auditors. When a claim is audited, the auditors review pre-set criteria for what Protective Life believes is correct

claim handling.[62] What is illustrative is that claim handlers *never ask* whether they investigated other possible medical providers or other possible hospitalizations, even though cancer is often a chronic condition. The auditor never questions whether a claim handler contacted a medical provider, like a doctor or a hospital. The auditor never asks if claim handler identified or found CPT codes to plug into the software that is supposed to incorporate the California Relative Value Schedule software. The auditor never questions whether the claims handler told the insured about other potential coverages. The only real question auditors ask is whether the claim handler pays the bills that are in the file. By the time an auditor is looking at the file, the only bills/records that are in the file are the ones that the insured retrieved. This is Protective Life's standard procedure, and it is reckless indifference.

Obviously, claims handlers do not want poor audit results on their file. But, Protective Life takes it one step farther toward guaranteeing the audit results it desires. Protective Life uses an incentive plan based on audit results on "value of results delivered to organization" and "overall corporate performance."[63] Funding of the incentive pool for claims handlers is based on performance results vs established goals for the plan year. It is up to 3% of employee's annual salary.[64] The incentive plan is administered by Protective Life's CEO.[65] [redacted]

[62] See *Third Affidavit of Seamus W. Culhane*, Exhibit 86: Protective Life Bates No. 003201-003202 as an example audit form.
[63] See *Third Affidavit of Seamus W. Culhane*, Exhibit 87: Protective Life Bates No. 003176.
[64] See *Third Affidavit of Seamus W. Culhane*, Exhibit 88: Protective Life Bates No. 003177.
[65] See *Third Affidavit of Seamus W. Culhane*, Exhibit 89: Protective Life Bates No. 003179.
[66] See *Third Affidavit of Seamus W. Culhane*, Exhibit 90: Protective Life Bates No. 004417 – CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER.

[redacted]

In an ordinary business setting, incentives and bonuses are common, and there is nothing illicit about incentivizing profitability. Insurance is different. As the South Dakota Supreme Court explained in *Trouten:*

> "The insurer's obligations are ... rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements.... [A]s a supplier of a public service rather than a manufactured product, the obligations of insurers go beyond meeting reasonable expectations of coverage. The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary. Insurers hold themselves out as fiduciaries, and with the public's trust must go private responsibility consonant with that trust." *Trouten v. Heritage Mut. Ins. Co.*, 2001 SD 106 citing *Egan v. Mutual of Omaha Ins. Co,*, 24 Cal. 3d 809 (1979).

Protective Life puts claim handlers, supervisors, and managers in the position of either processing and paying claims fairly pursuant to their fiduciary like duty, or watching corporate performance struggle and receiving a smaller paycheck. The linking of payment to the amount of corporate performance and value pits the claims handlers directly against their insureds. If the claims handlers look for coverage(s) and information that supports paying claims, the corporate results go down. Thus, so does overall funding for the incentive pools. It is no wonder why

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[67] See *Third Affidavit of Seamus W. Culhane*, Exhibit 91: Protective Life Bates No. 004411 – CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER.
[68] See *Third Affidavit of Seamus W. Culhane*, Exhibit 92: Protective Life Bates No. 004412 – CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER.

claims handlers do not go out of their way to help insureds find coverage or document facts that support paying coverage.

Ivan is not the only person who has had a terrible experience with Protective Life's claims process. An email sent from another frustrated claimant to the head of the claims department at Protective Life, says:

> "We have sent your company over 100 pages of pathology reports, doctor reports, statements from physicians, patient bills, copy of our marriage license, Tax ID numbers for hospitals, etc. I have head conflicting statement concerning coding of surgeries, potential amounts of reimbursement, etc. We have spent scores of hours tracking down all the information concerning this claim. Obviously, much time has passed from the time of treatment to the present, but there are still too many hoops that your company is requiring us to jump through to gain reimbursement. For example, your company did not reimburse the anesthesiology bill even though it was included. *Obviously, if a person has their throat cut open, anesthesiology is required* [. . .][69] (emphasis added)

> "I hold an earned doctorate and have had much consternation in trying to wade through your claims process. Your claims agents also have a very difficult job explaining benefits. If you set a dollar amount for treatments there would be much fewer disputes concerning interpretation of the policy language." [70]

Protective Life knows it is denying claims and lacking a reasonable basis to do so.

The Duty of Good Faith is Contractual and the Breach of the Duty of Good Faith is a Breach of Contract and a Tort.

Protective Life breached multiple duties of good faith. Duties of good faith are contractual duties, and violating them constitutes breach of contract, as well as the tort of bad faith. *E.g., Stene v State Farm Mut Auto. Ins. Co.*, 583 NW2d 399, 403 (SD 1998), and *Hammonds v Hartford Fire Ins Co*, 2006 US Dist LEXIS 96730, 12-13 (DSD Sept 14, 2006) (Battey, J). Protective Life's *withholding* information, like the fact(s) that:

- Even though claim handlers at Protective Life know that a policy holder has surgery on a cancerous lump in their breast, Protective Life does not look for and does not tell insureds that there are also anesthesia benefits.

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[69] See *Third Affidavit of Seamus W. Culhane*, Exhibit 93: Protective Life Bates No. 002143.
[70] See *Third Affidavit of Seamus W. Culhane*, Exhibit 94: Protective Life Bates No. 002144.

- Even though Protective Life knows that a cancer stricken claimant has been in a hospital because of cancer, Protective Life does not inquire nor look for evidence that supports paying hospital in-room benefits.

- Even though the policy provides benefits for "home recovery" following a cancer related hospital stay, unless the policy holder specifically asks for benefits related to their, "home recovery" Protective Life does not pay nor tell the insured that the coverage exists.

In *Biegler* (SD 2001), the court held that a verdict of deceit was supported by evidence that an insurer said there was no coverage and failed to tell the insured that coverage would be available if the insured submitted additional information.[71] Courts routinely look to this type of improper conduct when considering the tort of insurance bad faith.[72]

Ivan even consulted an insurance expert, Elliott S. Flood, who has spent his career handling these kinds of issues for insurance companies, and Flood confirms that Protective Life

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[71] *Biegler v American Family Mut. Ins. Co.*, 2001 SD 13, P33-P35.

[72] *See*: *Biegler v American Family Mut. Ins. Co.*, 2001 SD 13, P33-P34, (the Court found it "particularly egregious" when the insurer failed to tell the insured that coverage would be available if he provided certain information to the insurer.); *Hanson v. Mut. of Omaha Ins Co*, 2003 US Dist LEXIS 28242, 10-12 (DSD Apr 29, 2003) (Schreier, J) ("Mutual of Omaha has the duty of gathering the necessary information to determine whether to pay benefits."); *Eide v. Southern Sur. Co.*, 55 SD 405, 409 (1929): (An insured is "not obliged . . . to elect upon which of the clauses in the policy the claim might be made."); *Isaac v. State Farm Mut. Auto. Ins. Co.*, 522 NW2d 752, 754 (SD 1994) (bad faith verdict upheld where the insurer failed to disclose UIM coverage but, 3 years later, said the reason they didn't disclose the coverage was that workers compensation benefits were set off against it.) *See also: Egan v. Mutual of Omaha Ins. Co.*, 2 Cal 3d 809, 819 (relied on by the South Dakota Supreme Court in *Trouten v. Heritage Mut. Ins. Co, 632 N.W. 2d 856 (S.D. 2001), holding that "[to protect these [insured's] interests it is essential that an insurer fully inquire into possible bases that might support the insured's claim."; Athey v. Farmers Ins. Exchange*, 234 f3d 357 (8th Cir. 2000) (applying South Dakota law and finding sufficient evidence to support the jury's verdict of bad faith and punitive damages where there was ample evidence that Farmers had ignored Athey's proofs of losses.)

was acting unreasonably, i.e. without a reasonable basis when it denied and failed to properly process and pay Ivan's claim.[73]

Protective Life's other arguments do not demonstrate that there are no genuine issue of material fact to be tried.

Protective Life argues that a variety of cases justify its passive claims handling approach, essentially by arguing beside the point propositions from the cases. These cited cases do not justify Protective Life's passive approach to claims handling.

On page 15 of Defendant's *BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT*, it argues that the use of the word "limited" in Ivan's policy limits the scope of the policy to whatever Protective Life says the scope of the policy is, rather than limiting the scope of the policy to "Benefits for Cancer Only." In support of that argument, Protective Life cites *Simpson v. Combine Ins. Co. of Am.*, 167 S.E.2d 433, 434-35.

Simpson perfectly illustrates the issues with Protective Life's policy language in this case. The outcome does not favor Protective Life. The policy in *Simpson* said, "This Policy Provides Indemnity for Loss of Life, Limb, Limbs, Sight or Time Caused by Accidental Bodily Injuries, *only to the extent herein limited and provided [. . .]" Id.* That is totally different than the policy in this case. First, the policy in *Simpson* said, "loss of life, limb, limbs, sight or time." In this case, the policy says, it will pay, "Benefits for Cancer Only." Protective Life could have further, expressly and clearly limited the scope of their policy to what it now argues. But, it did not.

The policy in this case <u>does not say</u>,

> "This Policy Provides Indemnity for hospitalization, doctor's visits, home recovery, surgery, anesthesia, ambulance, blood and plasma, and chemotherapy and radiation, and only to the extent herein limited and provided."

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[73] See *Second Affidavit of Seamus W. Culhane*, Exhibit 62: Second Declaration of Elliott S. Flood.

What Ivan's policy does say is:

> **"Benefits are payable for those expenses incurred by an Insured from 10 days preceding the date of positive diagnosis of Cancer or from the first day of a period of Hospital confinement during which the positive diagnosis is made, whichever is more favorable to you. Such expenses will consist of the actual charges by the Hospital, Physician, or other providers subject to the limitations stated herein. No benefit will be paid in excess of the Usual and Customary Charge made by the provider of services or treatment." (emphasis added)**

Second, the policy in *Simpson* said, "only to the extent herein limited and provided." That is a narrow grant of coverage, not a broad grant of coverage. Protective Life has some policies that use this kind of narrow grant of coverage that justify Protective Life's denial of all sorts of unspecified, unlisted cancer treatment related expenses/benefits.[74] But, that is *not* the policy at issue in this case.[75] What is most striking about Protective Life's argument about the use of the word, "limited" is that no matter what the rest of its own policy says, it handles all the claims for cancer benefits the same way despite stark differences among in the language in various policy forms.[76]

Protective Life compares the of the word "LIMITED," that limits the losses to "Benefits for Cancer Only" to disability insurance, where there are specific indemnity payments for particular disabilities/losses, like a person's amputated nose or foot. (*See BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT,* p.16 cites to *Bretton* and *Appleman.*) But, that is comparing apples to oranges. A lost nose, foot or lost sight would cause some level of disability, yet it would be difficult to quantify the exact value of the lost nose or

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[74] See *Second Affidavit of Seamus W. Culhane*, Exhibit 59: Protective Life Bates No. 2680.
[75] Note: See Plaintiff's Brief in Support of Summary Judgment, pp. 12-13, 22.
[76] Note: See Plaintiff's Brief in Support of Summary Judgment, p. 18; See also *Second Affidavit of Seamus W Culhane*, Exhibit 56: Deposition of Lia Velez, p. 34 line 13 - p. 35 line 17.

foot, so the amount of the benefit is agreed upon in advance. Failure to do would require litigation in every case over the value.

Unlike disability policies, with cancer treatment, the extent/value of the losses/expenses are obvious if the insurer just gets the requisite bills it wants. In the instance of this cancer policy, the policy covers the actual charges for expenses resulting from the treatment of cancer, subject only to specific, stated limits on some categories of expenses. Other than those stated limits on some categories of expenses, it should cover expenses resulting from treatment for cancer.

Protective Life cites *Bretton v. Mutual of Omaha Ins. Co.*, 429 N.W.S 2d 46, 47 (N.Y. Spp. Div. 1985), aff'd 499 N.Y.S.2d 397 (N.Y.1985). The *Bretton* policy, much like *Simpson,* specifically itemized "certain specified losses" that would lead to benefits. "Benefits for Loss of Life, Limb or Sight" was further limited to, "[w]hen covered injuries result in any of the specific losses shown below [. . .] the Company will pay the applicable amount shown opposite such loss." *Id.* at 48. In Ivan's policy, there is no such limitation. Protective Life drafted the policy. It could have used this kind of language to only pay for the specifically limited benefits that are listed, and, "*only to the extent herein limited and provided.*" But, it did not use that language.

Protective Life cites *Pierce v. Central united Life Ins. Co.*, No. 07-1023PHX-EHC, 2009 WL 2132690, at *6 for the proposition that once a policy says, "limited," the insurer can read any exclusions into the policy it would like to see. "In Arizona, "limited benefit coverage" is defined as "an insurance policy that is designed, advertised and marketed to supplement major medical insurance and that includes . . . fixed or hospital indemnity, [and] specified disease insurance. . . ." *A.R.S. § 20-1137(B).* Therefore, the purpose of the Policy is to supplement or pay in addition to any other insurance, not merely to indemnify against loss." *Id.* The point is the

same; both *Pierce's* and Ivan's Cancer Insurance is limited – to Cancer. If insurers want to further exclude charges for "*treatment of any other condition(s) or disease(s) directly caused or aggravated by Cancer or the treatment of Cancer*," or "non-medical" charges associated with cancer, it must say so, clearly and explicitly.[77]

Protective Life cites *Plucker v. United Fire & Casualty Co.*, 412-CV-04075-KES, 2016 WL5415655, for the proposition that "obtaining medical records before paying medical bills is a standard practice in the insurance company." And, that is true – something that the parties absolutely agree on. The question is "Why did Protective Life do nothing to obtain what it is that they knew they needed to fully and fairly process and pay Ivan's claim, including getting the medical bills?"

Plucker was not willing to sign the medical release authorization that United Fire sent him. In this case, Ivan immediately signed and returned the medical release authorization to Protective Life. If the parties were arguing about delay as a result of providers not providing records to Protective Life, it would be a different story. That is not the case. Here, Protective Life initiates and institutes delay (general inaction) and then argues its failure to pay benefits is because it did not have the requisite medical records. That is no defense. This is not an arm's length business transaction, it is a fiduciary like transaction, whereby Protective Life has been *pre-paid* to provide service.[78]

Protective Life also cites *Bertelsen v. Allstate Ins. Co.*, 2011 S.D. 13, ¶20, for the proposition that, "it is reasonable for an insurance company to delay processing a claim while it

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[77] *Alverson v. Northwestern Nat'l Cas. Co.* 1997 SD 9 ¶8, 559 N.W.2d 234, 235, citing *Mid-Century Ins. Co v. Lyon*, 1997 DSD 50 P9 n4, 562 N.W. 2d 888, 891 (citing *Essex Ins. Co. v. Fieldhouse, Inc.*, 506 N.W. 2d 772, 776 (Iowa 1993) (citations omitted).

[78] See *Second Affidavit of Seamus W. Culhane*, Exhibit 31: Deposition of Debra L. Turner, p. 11 line 12 – p. 12 line 17; *Trouten*, supra.

waits on the insured's medical records." But, that is beside the point in this case – Protective Life wasn't waiting on medical records, it did not want medical records nor bills. If it did, it had the signed release to go get them along with the treating provider's information, location, dates and so forth all from day 1 of Ivan's claim submissions. Protective Life instead simply denies the claim and puts the burden back on the insured. By the time Protective Life was allegedly waiting on Ivan to submit bills, much of the unfair, unreasonable conduct had already happened. Arguing that it is "reasonable for insurers to wait on medical records" is a broad statement that proves nothing. For example, in the context of adversarial personal injury actions, it *is* commonplace for an injured person's lawyer to obtain records, and send them to the insurer. For reasons that do not be explained here, it is a different story when someone has pre-paid for investigative services for 22 years; then when they need the service, the claims handler writes in the file that, "Ivan will be getting more bills." If that were the case, why would Protective Life even require a medical release? Obviously, Protective Life wants to give claimants the impression that it is doing *something* with the documentation the insured provided. What we now know is that the only thing Protective Life uses the medical release(s) for is minimizing benefits policy holders receive, not helping policy holders obtain benefits.[79]

Protective Life should not be discharged.

Protective Life makes other misleading arguments to try and grasp at summary judgment. For example, they claim the policy says, "We will be discharged to the extent of any such payments made in good faith." But, that provision is talking about a deceased beneficiary, and payment made to the estate. It has no bearing at all on the outcome of this motion or this case.

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[79] See *Third Affidavit of Seamus W. Culhane*, Exhibit 82: Protective Life Bates No. Bates No. 0299.

Both Ivan and Lenore were policy holders, insureds, and claimants. Both were entitled to benefits. Furthermore, there was no "good faith" payment. There is no discharge.

"Bad Faith" *is* the breach of the implied duty of good faith and fair dealing.

Another meritless argument Protective Life makes is that "there is no breach of the implied duty of good faith and fair dealing." If the parties were arguing about an employment contract, Protective Life would be correct. However, insurance contracts are a different story. Insurance policies typically do not expressly promise "good faith," yet, there is absolutely no question that this policy and every other first party insurance policy in South Dakota includes an implied contractual term requiring good faith and fair dealing with its own insureds.[80] The breach of that duty is commonly abbreviated to be called, "bad faith."

Since at least 1969, the duty of an insurer to act in good faith toward its insured has been recognized as an implied term of every insurance contract.[81] The variety of cases involving breach of an insurer's contractual duty of good faith illustrates that the duty is broad. The specific duty first announced in *Kunkel* was the "duty to exercise good faith and give equal consideration" to an insured's interests. 84 S.D. at 122, 168 N.W.2d at 726. The duty also includes the duty to "conduct a reasonable investigation concerning a claim" made under the policy. *Dakota, Minn. & E.R.R. Corp. v. Acuity,* 2009 SD 69, ¶19, 771 N.W.2d 623, 629. The duty further requires that there not be "unreasonable delay in performing under a contract..." *Champion v. United States Fidelity & Guaranty Co.,* 399 N.W.2d 320, 322, quoting 16A J.A. Appleman & J. Appleman, *Insurance Law and Practice,* §8878.15, at 422-24 (1981). Protective

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[80] *Garrett v. Bankwest, Inc.,* 459 N.W.2d 833, 841 (S.D. 1990), citing *Restatement (Second) of Contracts,* §205 (1981).

[81] *Kunkel v. United Sec. Ins. Co.,* 168 N.W.2d 723 (S.D. 1969); *Isaac v. State Farm Mut. Auto. Ins. Co.,* 522 NW2d 752, 754 (S.D. 1994); *Stene v. State Farm Mut. Auto. Ins. Co.,* 583 N.W.2d 399 (S.D. 1998).

Life ignores around 48 different published state and federal court opinions involving the breach of the duty of good faith and faith dealing in insurance contracts, and blankly alleges there is no such thing.[82] It is particularly odd, given that the Protective Life cited several of those published opinions in its own brief.

Protective Life Refuses to Change.

Even after the years of grief and extra work and expense Protective Life caused Ivan, Ivan still gave Protective Life all the information about its ineffective claims process and a chance to change their procedures.[83,84] Protective Life flatly declined, and does not believe that there is anything wrong with the way it does things.[85]

Conclusion

Ivan has demonstrated that there are genuine issues of material fact to be tried (amount of damages) regarding the breach of contract.

There are genuine issues of material fact to be tried as to Protective Life's tortious conduct and to the unreasonable and vexatious nature of Protective Life's conduct. Therefore, summary judgment should not be granted in Protective Life's favor as to the intentional tort claim nor the attorney's fees claim.

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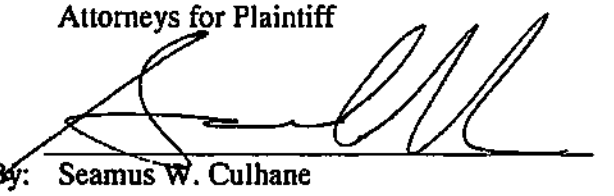
[82] Defendant's *BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT*, p. 33, part IV.
[83] See *Third Affidavit of Seamus W. Culhane*, Exhibit 95: Protective Life Bates No. 0401.
[84] See *Third Affidavit of Seamus W. Culhane*, Exhibit 96: July 29, 2014 Letter from Seamus W. Culhane to Bill McCarty.
[85] See *Third Affidavit of Seamus W. Culhane*, Exhibit 97: Emailed Letter from William L. McCarty of Protective Life to Seamus W. Culhane, dated August 13, 2014.

Dated October 18, 2017

TURBAK LAW OFFICE, P.C.
Attorneys for Plaintiff



By: Seamus W. Culhane
Nancy J. Turbak Berry
26 S. Broadway, Suite 100
Watertown, SD 57201
(605) 886-8361
seamus@turbaklaw.com
nancy@turbaklaw.com