STATE OF MICHIGAN

COURT OF APPEALS

JOHN J. FOWLER,

Plaintiff-Appellee/Cross-Appellant,

v

BENEFIT TRUST LIFE INSURANCE COMPANY and LUTHERAN BROTHERHOOD,

Defendants-Appellants/Cross-Appellees,

and

MARK SANZI,

Defendant/Cross-Appellee.

UNPUBLISHED
December 4, 1998

No. 200770
Jackson Circuit Court
LC No. 94-069737 CK

Before: Corrigan, C.J., and Hoekstra and Young, Jr., JJ.

PER CURIAM.

Defendants Benefit Trust Life Insurance Company and Lutheran Brotherhood[1] appeal as of right an order granting plaintiff summary disposition. Plaintiff cross-appeals, claiming that if this Court reverses the lower court's grant of summary disposition in his favor and against defendants, this Court must also reverse the trial court's order of summary disposition in favor of defendants' agent, defendant Mark Sanzi. We affirm.

The parties do not dispute the facts of this case. In April 1987, plaintiff purchased a major medical insurance policy from defendants. In September 1987, plaintiff lost his leg in an industrial accident. He made a claim for worker's compensation benefits and brought a products liability action against the manufacturer of the equipment that caused his injuries. In July 1991, plaintiff and the worker's compensation carrier entered into a settlement agreement that redeemed any and all liability of the carrier for past, present and future wage and medical claims arising from plaintiff's employment in exchange for a payment of $55,000 to plaintiff.[2] Additionally, the worker's compensation carrier waived its entire lien for all benefits incurred or paid to the date of redemption, which as of June 1991

included worker's compensation benefits of $57,999 for indemnity and $227,985 for past medical bills associated with plaintiff's injuries. Consequently, the $825,000 award in plaintiff's products liability action was not reduced for reimbursement to the worker's compensation carrier.

In September 1992, after undergoing a procedure to receive a prosthesis, plaintiff submitted a claim to defendants for reimbursement of the associated medical expenses. A provision of plaintiff's policy states that covered expenses included medical care, treatment, services and supplies in connection with "artificial limbs or eyes if they replace natural limbs or eyes lost while this coverage is in force." However, defendants denied plaintiff coverage, relying on the following exception in the policy:

> 6.1 EXCEPTIONS This contract does not cover expenses due to:
>
> * * *
>
> 6) Sickness or injury for which the Covered Family Member is eligible to receive benefits under any workers' compensation, occupational disease, employer's liability or similar act of law of any government.

Defendants claimed that plaintiff's medical expenses were caused by an injury for which he was eligible to receive worker's compensation benefits.

Plaintiff brought this suit, claiming that defendants' denial of coverage under the policy constituted a breach of contract because he was no longer eligible for worker's compensation benefits and, thus, was not excluded from coverage. In the alternative, plaintiff brought claims for fraud and/or misrepresentations and promissory estoppel based upon the conduct of defendant Sanzi. Defendants moved for summary disposition, but the lower court held that the exclusion was inapplicable because plaintiff had redeemed his worker's compensation claim and, therefore, was no longer eligible for worker's compensation benefits. Accordingly, the court granted summary disposition in favor of plaintiff and against defendants pursuant to MCR 2.116(I)(2) and MCR 2.116(C)(10).

A motion for summary disposition under MCR 2.116(C)(10) tests the factual support for a claim. *Marx v Dep't of Commerce*, 220 Mich App 66, 70; 558 NW2d 460 (1996). The court must consider the pleadings, affidavits, depositions, and other documentary evidence available to it, and grant summary disposition if there is no genuine issue regarding any material fact, and the moving party is entitled to judgment as a matter of law. *Id.* If it appears to the court that the opposing party, rather than the moving party, is entitled to judgment, then the court may render judgment for the opposing party pursuant to MCR 2.116(I)(2). *Id.* We review summary disposition decisions de novo, to determine "whether the prevailing party was entitled to judgment as a matter of law." *Id.* at 70.

The parties do not dispute whether the insurance policy at issue provides coverage for expenses related to prosthetics. Their dispute is whether the quoted exception to the policy excludes plaintiff from the coverage. Both parties claim to apply a plain reading of the exception, yet each interprets the language differently. Plaintiff concedes that defendants' interpretation is reasonable but argues that

because the provision is subject to at least two reasonable interpretations, the provision is invalid due to its ambiguity and does not exclude him from coverage. We agree.

Any clause in an insurance policy is valid as long as it is clear, unambiguous and not in contravention of public policy. *Raska v Farm Bureau Mut Ins Co,* 412 Mich 355, 361-362; 314 NW2d 440 (1982). Initially, we find that the exclusionary clause is not void as against public policy. As defendants point out, health and accident insurance policies typically exclude coverage or coordinate benefits where the insured receives payments from other sources. Thus, we focus our analysis on the clarity of the exclusion. An insurance contract is clear if it fairly admits but one interpretation. *Farm Bureau Mut Ins Co v Stark,* 437 Mich 175, 182; 468 NW2d 498 (1991). Conversely, an insurance contract is ambiguous if, after reading the entire contract, its language can be reasonably understood in differing ways. *Bianchi v Automobile Club of Michigan,* 437 Mich 65, 70; 467 NW2d 17 (1991).

The parties' interpretations of the exclusion are as follows. Plaintiff points out that the exclusion uses the present tense of the word "is" in the phrase "is eligible," and that he is not presently eligible to receive worker's compensation benefits as a result of the redemption of his worker's compensation claim. Therefore, plaintiff opines that the provision does not exclude him from coverage and that defendants' denial was a breach of their contract with him. In contrast, defendants assert that the phrase "for which the [insured] is eligible" modifies the word "injury," such that the exclusion applies to all claims arising from an injury for which worker's compensation coverage is available. Therefore, defendants assert that plaintiff's receipt of worker's compensation benefits in the form of the redemption agreement belies plaintiff's claim that he is not eligible to receive benefits because the receipt of those benefits fixed plaintiff's eligibility. For support of their assertion, defendants quote language of this Court in *Gretzinger v Equitable Life Assurance Society,* 159 Mich App 25, 28; 406 NW2d 230 (1987), that the plaintiff's receipt of benefits was "sufficient proof" that he was "eligible" to receive benefits.[3]

For the very reason that these two reasonable interpretations are possible, albeit with dramatically different results, we hold that the exclusion is invalid because it is ambiguous. "[W]herever there are two constructions that can be placed upon the policy, the construction most favorable to the policyholder will be adopted." *DeLand v Fidelity Health & Accident Mut Ins Co,* 325 Mich 9, 18; 37 NW2d 693 (1949). See generally *Powers v Detroit Automobile Inter-Ins Exchange,* 427 Mich 602, 624; 398 NW2d 411 (1986) (Williams, C.J.) (culling six rules of contract interpretation from previous decisions of our Supreme Court). It is well-settled that an insurance contract ambiguity is construed against the insurer, *State Farm Mutual Automobile Ins Co v Enterprise Leasing Co,* 452 Mich 25, 38; 549 NW2d 345 (1996); *Pietrantonio v Travelers Ins Co,* 282 Mich 111, 116; 275 NW 786 (1937); *Benike v Scarborough Ins Trust,* 150 Mich App 710, 715; 389 NW2d 156 (1986), and, in particular, exclusionary clauses in insurance policies are to be strictly construed against the insurer, *Fire Ins Exchange v Diehl,* 450 Mich 678, 687; 545 NW2d 602 (1996). Thus, an insurer may not "escape liability by taking advantage of an ambiguity." *Hooper v State Mut Life Assurance Co,* 318 Mich 384, 393; 28 NW2d 331 (1947). The invalidity of the exception to this policy precludes defendants from denying plaintiff coverage pursuant to the exception.

Defendants claim that a finding of coverage contravenes a policy of the worker's compensation scheme against double recoveries as expressed in *Treadeau v Wausau Area Contractors, Inc*, 112 Mich App 130, 141; 316 NW2d 231 (1982) (concerning a worker's compensation carrier's attempt to seek reimbursement), and *Thick v Lapeer Metal Products*, 419 Mich 342, 346-347; 353 NW2d 464 (1984) (same). In support of this argument, defendants state that plaintiff has already recovered lump sum payments for his future medical expenses from his employer's worker's compensation carrier and the third-party tortfeasor.

However, neither defendants' brief on appeal nor our search of the record below reveals facts upon which a double recovery in this case can be established. There is no evidence to establish what amount of plaintiff's portion of the products liability award was to compensate him for future medical expenses, such as the expenses associated with a prosthesis. Additionally, there is no evidence that the redemption agreement contemplated that the consideration plaintiff received was in satisfaction of plaintiff's future expenses. The agreement in this case refers to "*liability* for . . . future weekly compensation, medical care and expenses" (emphasis added). Thus, the consideration plaintiff received was in exchange for plaintiff's waiver of his legal right to bring claims against the carrier at some time in the future. In other words, the redemption agreement, which is entitled "Agreement to Redeem Liability," merely establishes that the carrier purchased peace of mind for $50,000 and a waiver of its lien. The agreement does establish that plaintiff has already recovered payments for his future medical expenses.

Even assuming plaintiff receives a double recovery as a result of our holding, the onus is not on courts to modify or interpret an ambiguous provision so as to align it with the policy against double recoveries; rather, private medical insurance carriers such as defendants bear the responsibility of drafting their policies so as to make clear the extent of nonliability under any exclusion. *Francis v Scheper*, 326 Mich 441, 447-448; 40 NW2d 214 (1949). Thus, while defendants' intent may have been to draft a provision that excluded coverage for medical expenses arising out of injuries where worker's compensation insurance is available, the exclusion, as written, excludes only expenses due to sickness or injury for which the insured "is eligible" to receive benefits under any workers' compensation.[4] In so finding, we reiterate the observation made in *Powers, supra* at 608:

> This Court, in approaching the problem, must recognize an insurance contract for what it is. It is not a hard-bargained contract drafted after mutual consideration of the positions of two negotiators with equal or substantially equal skills and resources. What is involved is a contract of adhesion, a take-it-or-leave-it insurance policy not drafted by the buyer or even by the seller of the policy, but by insurance and legal experts of a state, national, or international organization, hundreds and maybe thousands of miles away. It is fatuous to suppose the policy owner had any part in the language of the policy besides filling in the blanks, and the problem in question involves not the blanks, but the established text of the printed form.

Therefore, we construe the exception in question in the light most favorable to the insured, and we find, in accordance with plaintiff's interpretation, that the phrase "is eligible to receive benefits under

any workers' compensation" is inapplicable to plaintiff. We hold that the lower court properly found that plaintiff was entitled to judgment as a matter of law.

Because we conclude that plaintiff is not excluded from coverage under the policy as it is written, it is unnecessary to address either defendants' alternative basis for reversal or plaintiff's cross-appeal.

Affirmed.

/s/ Maura D. Corrigan
/s/ Joel P. Hoekstra
/s/ Robert P. Young, Jr.

[1] The plural term "defendants" will hereinafter be used to refer to defendants BTL and Lutheran Brotherhood.

[2] A redemption agreement is a method of settling a dispute without an adjudication or a determination of the rights of the parties under the Worker's Disability Compensation Act, MCL 418.101 *et seq.;* MSA 17.237(101) *et seq. Allen v Garden Orchards, Inc,* 437 Mich 417, 433; 471 NW2d 352 (1991); *National Union Fire Ins Co v Richman,* 205 Mich App 162, 166; 517 NW2d 278 (1994). See MCL 418.835; MSA 17.237(835), MCL 418.836; MSA 17.237(836).

[3] Defendants similarly claim that plaintiff's reading of the policy has the impermissible effect of entirely negating the exclusion. However, the exclusion, even as interpreted by plaintiff, did not permit plaintiff to make a claim under the insurance policy for the medical care expenses he incurred before the redemption of his worker's compensation claim, which totaled more than $225,000. Therefore, this argument is not persuasive.

[4] We do not attempt to draft such an exclusion for defendants nor predict what type of language would survive a challenge; however, to support our holding that the provision in this case is invalid because it is ambiguous, we merely point out that other insurance companies have drafted anti-duplication provisions differently. See generally the cases assembled in 15 Couch, Insurance, 2d (rev ed), § 53.363; 40 ALR3d 1012, § 6b; 44 Am Jur 2d, Insurance, § 1464. A more generous use of words may avoid attempts by paid insurers to escape liability by taking advantage of an ambiguity, a hidden meaning, or a forced construction of the language in a policy. *Hooper, supra* at 393.