SUPREME COURT OF ARIZONA

Supreme Court No. CV-00-0272-PR

Court of Appeals
No. 1 CA-CV 98-0703

Maricopa County Superior Court
No. CV 96-02918

ELIZABETH HAISCH,
a single person, on behalf of herself and all others similarly situated,

Plaintiff-Appellant,

vs.

ALLSTATE INSURANCE COMPANY,

Defendant-Appellee.

RESPONSE TO UNITED POLICYHOLDERS' *AMICUS CURIAE* BRIEF RE: PETITION FOR REVIEW

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Introduction

The brief submitted by United Policyholders as *amicus curiae* ("Amicus") reiterates the same erroneous factual arguments made by the Petition for Review, and does so primarily to justify the application of two doctrines that have no bearing on Ms. Haisch's fraud claims: the duty of good faith and fair dealing, and the doctrine of reasonable expectations. As the Court of Appeals noted below, Ms. Haisch did not make any argument about the reasonable expectations doctrine until her reply brief on appeal, and never raised it before the Superior Court; as a result, the argument has been waived for purposes of the Petition for Review. *See Haisch v. Allstate Ins. Co.*, 197 Ariz. 606, 611 n.6, 5 P.3d 940, 945 n.6 (Ct. App. 2000). In any event, Amicus's legal arguments have no more merit than its factual premises, and this Court should deny the Petition.

Amicus repeatedly makes four primarily factual assertions that are bereft of supporting evidence, analysis, or authority. These may be treated briefly here, as Allstate has responded to them in greater length in its brief in the Court of Appeals and in its response to Ms. Haisch's petition:

"*Windfall Premiums*": Ms. Haisch presented no evidence concerning how Allstate prices Med Pay coverage, much less evidence that Allstate reaped "windfall" or "excessive" premiums by not paying benefits for HMO-covered services. (Amicus at 2, 3, 4, 10.) The Court of Appeals properly rejected as ungrounded any presumption that "the insurance was expensive and superfluous, resulting in a windfall to Allstate." *Haisch*, 197 Ariz. at 612 ¶ 25, 5 P.3d at 946 ¶ 25. In fact, Allstate prices its coverage based on actual benefit payments in the

state, which accounts for the extent to which insureds receive HMO-covered services.

"*Illusory Value*": Amicus offers no explanation for its assertions that Med Pay coverage has "illusory," "severely limited," "meaningless," or "largely uncollectable" value to HMO enrollees. (Amicus at 2, 3, 4, 6, 10.) Med Pay coverage is valuable to HMO members, and was valuable to Ms. Haisch in particular. It supplements HMO plans by covering co-payments and deductibles, services excluded or limited under HMO plans (including many services commonly required by accident victims), and services of non-HMO providers, as well as by covering permissive drivers, passengers, and other "insured persons." Ms. Haisch herself received substantial benefits under her Med Pay coverage.

"*Obscure Statute*": Amicus asserts that A.R.S. § 20-1072,[1] under which HMO enrollees are not liable for plan-covered services, is an "unknown," "little known," or "obscure state statute" (Amicus at 2, 4, 10, 12, 13, 15), but does not explain how the statute, which merely codifies the distinctive nature of HMO plans as prepaid health plans, is any more obscure than the rest of the Arizona Revised Statutes, *all* of which plaintiffs are presumed to know for purposes of common law and statutory fraud claims.[2]

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[1] *See* A.R.S. § 20-1072(A) & (C) (an HMO "enrollee is not liable to the contracting provider or hospital for any amounts owed by the [HMO]," and no "contracting provider . . . may maintain an action at law against an enrollee to collect any amounts owed by the [HMO]").

[2] *See Irwin v. Murphey*, 81 Ariz. 148, 154, 302 P.2d 534, 538 (1956) (rejecting fraud claim); *School Dist. No. 69 v. Altherr*, 10 Ariz. App. 333, 339, 458

(Continued ...)

"*Hypertechnical Definition*": Like Ms. Haisch, Amicus repeatedly argues that Allstate's interpretation of "actually incurred" in the Med Pay insuring clause as meaning "liable for" is a "hypertechnical definition" or "highly technical boilerplate" (Amicus at 3, 4, 10, 12, 13, 15), but neither has offered an alternative meaning. Allstate has used the common meaning of "incurred" found in the dictionary and at least four decades of nationwide case law.[3]

Even if these erroneous arguments had merit, they do not provide a foundation for application of the duty of good faith and fair dealing or the doctrine of reasonable expectations. As explained below, courts have recognized that the duty of good faith applies to the performance of obligations under insurance contracts (i.e., the processing and payment of claims), not to the marketing of insurance. Instead, fraud claims relating to the marketing and sale of insurance are subject to generally applicable standards for common law and statutory fraud claims, which presume knowledge of the law, not a insurance-specific heightened "duty of disclosure." Moreover, the reasonable expectations doctrine is a rule of contract construction; it does not apply to claims such as Ms. Haisch's that seek to rescind the insurance contract on grounds of fraud and recover premiums paid.

P.2d 537, 543 (Ct. App. 1969) (same); *Pleasants v. Home Fed. Sav. & L. Ass'n*, 116 Ariz. 319, 322, 569 P.2d 261, 264 (Ct. App. 1977) (affirming summary judgment under the Arizona Consumer Fraud Act).

[3] *See Coconino County v. Fund Admin. Ass'n*, 149 Ariz. 427, 430, 719 P.2d 693, 696 (Ct. App. 1986) ("'Incur' is generally accepted to mean 'to bec[o]me liable for . . . .'") (citations omitted); *American Indem. Co. v. Olesijuk*, 353 S.W.2d 71, 72 (Tex. Ct. Civ. App. 1961) ("The word 'incur' is a word of common usage and meaning. . . . The word means to become liable to or subject to[.]").

There is no basis in law for converting nearly every dispute over insurance policy interpretation into a potential fraud claim by using the reasonable expectations doctrine as a standard for fraud. The Court of Appeals acknowledged the applicable legal standards and applied them correctly based on the uncontroverted evidence. This Court should deny review.

I. THE DUTY OF GOOD FAITH AND FAIR DEALING DOES NOT APPLY TO THE SALE OF INSURANCE.

It is well established under Arizona law that Allstate had no duty under generally applicable principles of fraud law to inform purchasers of insurance as to the effect of public statutes or other matters of law. Amicus nevertheless asserts that the Court of Appeals' decision below "ignores and directly contradicts controlling legal precedent imposing a duty of disclosure on insurers when selling, marketing, or interpreting insurance policies." (Amicus at 2.) But the legal precedent Amicus cites concerns the duty of disclosure in the course of performing contractual obligations, not in "selling, marketing, or interpreting" policies. Courts have recognized that the *marketing* of insurance is subject to generally applicable standards, and does not include a special duty of disclosure that would encompass the collateral legal consequences of an insured's independent health care plan on their automobile insurance policy benefits.

A. The Tort Duty of Good Faith Applies to the Handling of Claims, Not the Purchase of Coverage.

As this Court has recognized, "[t]he essence of [the duty of good faith and fair dealing] is that neither party will act to impair the right of the other to receive the benefits which flow from their agreement or contractual relationship."

Rawlings v. Apodaca, 151 Ariz. 149, 153-54, 726 P.2d 565, 569-70 (1986). "'[T]he relevant inquiry always will focus on the contract itself, to determine what the parties did agree to.'" *Id.* (quoting *Wagenseller v. Scottsdale Mem. Hosp.*, 147 Ariz. 370, 385, 710 P.2d 1025, 1040 (1985)); *see generally* Stephen S. Ashley, *Bad Faith Actions: Liability and Damages* § 5.05, at 5-23 (1997 & Supp. 2000) ("The insurer's duty of good faith extends only to its performance of the obligations the policy imposes on it."). Thus, this Court has held that "[t]he tort of bad faith arises when the insurance company intentionally denies, fails to process or pay a claim without a reasonable basis for such action." *Noble v. Nat'l Am. Life Ins. Co.*, 128 Ariz. 188, 190, 624 P.2d 866, 868 (1981); *see Zilisch v. State Farm Mut. Auto. Ins. Co.*, 196 Ariz. 234, 237, 995 P.2d 276, 279 (2000).

Ms. Haisch has not alleged that Allstate failed to live up to its contractual obligations; indeed, she has not argued that the Med Pay provision *in fact* provides benefits for costs that her HMO, but not Ms. Haisch, was liable to pay. Rather, she has sought to rescind the Med Pay coverage contract and recover all of her premiums on a theory of fraud in the inducement. "Where the issue is whether the contract is induced by fraud, and therefore unenforceable, the covenant of good faith and fair dealing is not implicated," because the alleged breach "relates to the preagreement stage of its relationship with the plaintiff" rather than the "performance and enforcement of the contract." *Fireman's Fund Ins. Co. v. State of Conn. Dep't of Pub. Works*, 1996 WL 367795, at *17 (Conn. Super. Ct. June 4, 1996). Because "the covenant of good faith and fair dealing, for breach of which a tort action may arise, extend[s] only to the limits of the insurance coverage

afforded by the insurer to the insured," the duty of good faith is not implicated where the plaintiffs "do not allege that defendant failed in any way to perform pursuant to the terms of the contract," but rather allege that the insurer failed to inform the plaintiffs about *procuring* coverage. *Gibson*, 208 Cal. Rptr. at 513-15 (insurer was not liable for failing to advise insured concerning the inadequacy of current Med Pay policy limits or availability of other coverages).

As a result, courts and leading commentators have recognized that "an insurer does not commit bad faith by failing to advise the insured concerning the wisdom of purchasing additional coverages" or by other alleged acts of misconduct in the sale of insurance. Stephen S. Ashley, *supra*, § 5.05, at 5-22; *see, e.g.*, *Claborn v. Washington Nat'l Ins. Co.*, 910 P.2d 1046, 1051 (Okla. 1996) (rejecting bad faith claim based on sale of policy that did not contain the same benefits as a preexisting policy because "the conduct of the insurer and the agent in selling and issuing the policy, cannot give rise to the tort of bad faith breach of an insurance contract"); *Garrison Contractors, Inc. v. Liberty Mut. Ins. Co.*, 927 S.W.2d 296, 302 (Tex. Ct. App. 1996) (duty of good faith addresses "negotiating and settling a claim" and "does not reach the purchase transaction or the calculation and payment of premiums"); *see generally* Stephen S. Ashley, *supra*, § 5.05, at 5-22 ("The courts have held that the duty of good faith arises out of the policy itself and does not exist until the policy exists.").

In rejecting the duty of good faith in the sales context, courts have recognized that "the same policy considerations [underlying the duty of good faith in claims handling] do not apply beyond the terms of the policy," because "the

insured who may be tied to one insurer for purposes of processing a claim or seeking a defense is not so tied in obtaining insurance." *Gibson v. Gov't Employees Ins. Co.*, 208 Cal. Rptr. 511, 517 (Ct. App. 1984). As a result, "'an insured person's initial decision to obtain insurance and the corresponding decision of an insurer to offer coverage remain, at the inception of the contract at least, an arm's length transaction to be governed by traditional standards of freedom to contract.'" *Hess v. Transamerica Occidental Life Ins. Co.*, 235 Cal. Rptr. 715, 717-18 (Ct. App. 1987) (affirming summary judgment on bad faith claim) (quoting *Gibson*, 208 Cal. Rptr. at 516).

For these reasons, courts have applied the generally applicable standards for common law and statutory fraud and negligent misrepresentation in rejecting claims against insurers for alleged nondisclosures during the sale of insurance coverage. In *Treski v. Kemper Nat'l Ins. Cos.*, 674 A.2d 1106 (Pa. Super. Ct. 1996), for example, the court dismissed a class action for negligent misrepresentation and violation of the Uniform Trade Practices Consumer Protection Law based on allegations similar to those made by Ms. Haisch. The insurers offered Pennsylvania insureds "full tort" coverage, which permitted the recovery of all damages, and a less expensive "limited tort" option that did not provide for recovery of non-economic damages absent a serious injury. The plaintiff alleged that the insurers had failed to advise insureds who elected the more expensive "full tort" option that, if they were injured in an accident in neighboring New Jersey, a New Jersey statute would deem them to have selected

the "limited tort" option. As here, the plaintiffs sought reimbursement for the higher premiums they paid for the "full tort" option.

The *Treski* court sustained the dismissal of the claims because the insured did not have a duty to advise the plaintiffs as to the effect of the New Jersey law. The court could "'find no justification in the law to impose the additional burden on insurers that they anticipate and then counsel their insured on the hypothetical, collateral consequences of the coverage chosen by the insured.'" *Id.* at 1114 (quoting *Kilmore v. Erie Ins. Co.*, 595 A.2d 623, 626-27 (Pa. Super. Ct. 1991)). The court observed that "'[t]he relevant statutes are public information, and if the plaintiff was concerned . . . he could have examined the law.'" *Id.* at 1115 (quoting *Zampirri v. Hartford Ins. Co.*, 1993 WL 516415, at *3 (E.D. Pa. 1993)). The court further reasoned that, despite the "special relationship" of insurers and insureds,

> "the relationship is not so unique as to compel this Court to require an insurer to explain every permutation possible from an insured's choice of coverage. Each insured has the right and obligation to question his insurer at the time the insurance contract is entered into as to the type of coverage desired and the ramifications arising therefrom. Once the insurance contract takes effect, however, the insured must take responsibility for his policy."

Id. at 1114 (quoting *Kilmore*).

Similarly, notwithstanding the decision of the California Supreme Court cited by Amicus,[4] the California Court of Appeal subsequently held that an insurer had no duty "at time of purchase" to advise the insured of an unambiguous suicide exclusion, despite the insurer's asserted knowledge that the insured "was a high suicide risk." *Malcom v. Farmers New World Life Ins. Co.*, 5 Cal. Rptr. 2d 584, 586 (Ct. App. 1992) (rejecting negligent misrepresentation claim under Restatement (Second) of Torts § 551). The court recognized that there was no affirmative duty of disclosure as to the exclusion or its effect on coverage where there was no evidence that the insured asked the insurer about coverage for suicide-related death, and the insured in fact had never "sought clarification of the suicide provision after receiving the policies." *Id.*

Allstate did not, in selling Med Pay coverage, have an obligation to inform Ms. Haisch about the "collateral consequences" of her health plans. Allstate has no control over an insured's health care plan, and may have no knowledge if that plan's benefits—or the plan itself—changes from time to time because of decisions the plan, the insured, or the insured's employer may make. Ms. Haisch was responsible for knowing the extent of her Humana and CIGNA coverage and legal consequences of that coverage. Moreover, Ms. Haisch never sought clarification from Allstate about whether Med Pay would pay benefits for care *covered* by her HMO; indeed, she testified that the concern that led her to maintain Med Pay

[4] *See Sarchett v. Blue Shield*, 729 P.2d 267 (Cal. 1987). As explained below, *Sarchett* concerned the insurer's failure to disclose contractual rights of impartial review to an insured whose claim had been repeatedly denied.

coverage was for the services left *uncovered* by her HMO plan at the time. (CR 62 ¶ 4.) *See Haisch*, 197 Ariz. at 608 ¶ 7, 5 P.3d at 942-43 ¶ 7. In these circumstances, it was simply not Allstate's legal obligation to inform her that her statutory immunity from liability for HMO-covered services would reduce her ability to obtain "a bonus, consisting of payment to Haisch for charges that Haisch was never obligated to pay herself." *Id.* at 611 ¶ 18 n.5, 5 P.3d at 945 ¶ 18 n.5.

B. Amicus's Authority Concerns a Duty of Disclosure During the Settlement of Claims.

Amicus relies on a series of cases that merely stand for the proposition that, in certain circumstances, *once an insured makes a claim*, the insurer has a duty to disclose the availability of coverage for the claim, as well as any steps the insured must take to preserve his eligibility for coverage and thereby "secure rights afforded by the policy." *Sarchett v. Blue Shield*, 729 P.2d 267, 275-77 (Cal. 1987) (insurer acted in bad faith in failing, after denying the hospitalized insured's claim and repeated protests, to advise the insured of his contractual right to impartial review and arbitration of the disputed claim, where "Blue Shield had reason to know that Sarchett was uniformed of his rights"); *see also Anderson v. State Farm Mut. Ins. Co.*, 2 P.3d 1029, 1031, 1034 (Wash. Ct. App. 2000) (in responding to claim, the insurer's letter asserting that only limited benefits were available improperly failed "to disclose the existence of UIM coverage to an injured insured whose damages are substantial and whose account of the accident plausibly indicates another driver is at fault"); *Dercoli v. Penn. Nat'l Mut. Ins. Co.*, 554 A.2d 906, 909-10 (Pa. 1989) (after claim was made, insurer failed to disclose to insured

that she had an apparent right to recover against her decedent husband's estate under the liability provisions of their policy);[5] *Gatlin v. Tenn. Farmers Mut. Ins. Co.*, 741 S.W.23d 324, 326 (Tenn. 1987) (insurance adjuster had good-faith duty to tell the insured, whom he determined to be free from fault, that the insured had coverage under his own policy's UIM provision, not just the tortfeasor's policy issued by the same insurer); *Bowler v. Fidelity & Cas. Co.*, 250 A.2d 580, 588 (N.J. 1969) (once "a loss occurs," the insurer "has the duty to speak and disclose, and to act in accordance with its contractual undertaking" to make payments due); *Ramirez v. USAA Cas. Ins. Co.*, 285 Cal. Rptr. 757, 758, 761 (Ct. App. 1991) (by telling insured that there was no coverage and failing to disclose UIM coverage, insurer breached its duty to disclose the existence and amount of coverage available once a claim is made where "an insured's lack of knowledge may potentially result in a loss of benefits or a forfeiture of rights" under the policy).

Similarly, Ms. Haisch relies on a law journal article which advocates only that courts should impose on insurers a duty, "*[f]ollowing notification of an occurrence*, . . . to disclose all applicable benefits, or to clearly inform insureds about the existence of rights and duties regarding all coverages, or to explain why the insurance benefits will not be paid . . . ." Alan I. Widiss, *Obligating Insurers to Inform Insureds About the Existence of Rights and Duties Regarding Coverage for*

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[5] Even as to disclosures in the context of claim settlement, *Dercoli* was subsequently limited by the Pennsylvania Supreme Court to situations where "the insurer voluntarily assumed to act as the insured's counsel," and had made "knowing and purposeful misrepresentation" that the insured had no claim. *Miller v. Keystone Ins. Co.*, 636 A.2d 1109, 1112-14 (Pa. 1994).

Losses, 1 Conn. Ins. L.J. 67, 70 (Spring 1995) (emphasis added). The duty recognized by the courts and urged by this article reflects the insurer's contractual duty to provide the benefits indisputably required by the insurance policy, and has the objective of ensuring that benefits are not denied simply because the insured fails out of ignorance to claim them or to take the procedural steps necessary for processing the claim. Amicus cites *no* authority imposing a heightened duty of disclosure on insurers in the *sale* of insurance policies, much less a duty to make disclosures concerning the legal consequences of whatever health plan they may have for the dollar value of insurance proceeds they may recover. As the Superior Court and Court of Appeals found below, there is no such duty.

II. THE DOCTRINE OF REASONABLE EXPECTATIONS DOES NOT APPLY TO MS. HAISCH'S CLAIMS.

A. The Doctrine of Reasonable Expectations Does Not Set a Standard for Fraud Claims.

In addition to Ms. Haisch's waiver of any argument as to the reasonable expectations doctrine, Amicus also errs on the merits in advocating the use of that doctrine as a standard for her fraud claims. The reasonable expectations doctrine is not a rule of fraud; it is a *contract* doctrine governing the construction of insurance contracts to ensure "that coverage will not be defeated by the existence of provisions which were not negotiated and in the ordinary case are unknown to the insured." *Zuckerman v. Transamerica Ins. Co.*, 133 Ariz. 139, 146, 650 P.2d 441, 448 (1982); *see also Peterson v. Brown*, 457 N.W.2d 745, 750 (Minn. Ct. App. 1990) ("The reasonable expectations doctrine . . . is a tenet of insurance contract construction, not an independent cause of action."). Ms. Haisch does not seek to

prevent the defeating of coverage; to the contrary, she seeks to rescind coverage and recover her premiums. Thus, the Court of Appeals properly noted that the reasonable expectations doctrine was not at issue in this action. *Haisch*, 197 Ariz. at 611 ¶ 21 & n.6, 5 P.3d at 945 ¶ 21 & n.6 (declining to consider reasonable expectations doctrine because "Haisch acknowledges that she brought no breach of contract claim against Allstate in this action").

Use of reasonable expectations as a standard for fraud would effectively turn every insurance contract dispute involving the doctrine into a potential fraud case. Unambiguous contract provisions, which are subject to a finding of mere unenforceability under the reasonable expectations doctrine, would become the basis for tort liability, in contravention of existing precedent. *See Nataros v. Fine Arts Gallery, Inc.*, 126 Ariz. 44, 48, 612 P.2d 500, 504 (Ct. App. 1980) (where the term in question "has a fixed and readily understandable meaning," its use cannot be fraudulent or deceptive). A rule intended to shield insureds from calamities for which they reasonably expected to have purchased protection, would become a sword for plaintiffs like Ms. Haisch, who faced no unpaid medical bills or other calamity, to seek punitive damages in tort because they were denied bonus compensation. This is not a case of an insured who was left unprotected; Ms. Haisch—and any Med Pay insured who would assert a similar claim—is necessarily seeking *only* an extra commercial advantage. Such circumstances provide a clear example of why the doctrine of reasonable expectations is ill-suited as a benchmark for fraud liability.

B. There Is No Basis in Fact for Application of the Reasonable Expectations Doctrine.

Even if the reasonable expectations doctrine had some bearing on fraud claims, it would have no application in light of the facts of this case. This Court has recognized that "boilerplate" provisions are generally enforceable and that the doctrine must be carefully applied, because, "if not put in proper perspective, the reasonable expectations concept is quite troublesome, since most insureds develop a 'reasonable expectation' that every loss will be covered by their policy." *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 140 Ariz. 383, 390, 682 P.2d 388, 395 (1984). Thus, the doctrine "must be limited by something more than the fervent hope usually engendered by loss." *Id.* Here, there is no evidence that Ms. Haisch actually expected to receive such benefits when she purchased Med Pay coverage. Even if she had subjectively expected such benefits, the expectation would not have been reasonable. In appropriate cases, an insured may reasonably expect that insurance will take care of her *medical bills*; an insured would *not* reasonably expect that insurance would make payments for medical care where there were *no bills*—and as a matter of law could be no bills. That would amount to indemnity without liability, which is contrary to basic principles of law. At most, Ms. Haisch could have had only "fervent hope" of receiving a bonus payment that was not even "engendered by loss." *Darner*, 140 Ariz. at 390, 682 P.2d at 395.

This case does not reflect any of the "*limited* variety of situations" in which Arizona courts have applied the reasonable expectations doctrine. *Gordinier v.*

Aetna Cas. & Sur. Co., 154 Ariz. 266, 272, 742 P.2d 277, 283 (1987) (emphasis original). First, the phrase "actually incurred" in the insuring clause is one that *can* "be understood by the reasonably intelligent consumer who might check on his or her rights." *Id.* Allstate's Med Pay coverage provides ordinary *indemnity* protection; insureds receive benefits for amounts they become liable to pay. Allstate followed the accepted meaning of the term as found in dictionaries and overwhelming case law. Strikingly, neither Ms. Haisch nor Amicus has offered an alternative definition of "actually incurred" that would cover the cost of care provided at no charge to the HMO enrollee.

Second, this is not a situation "[w]here the insured did not receive full and adequate notice of the term in question, and the provision is either unusual or unexpected, or one that emasculates apparent coverage." *Id.* at 274, 742 P.2d at 284. The "actually incurred" provision was not in an obscure exclusion in the policy; to the contrary, it was in the *insuring clause* that defines the scope of coverage. Further, as the Court of Appeals recognized, and the case law bears out, the term is not "unusual or unexpected." Moreover, Ms. Haisch's own recovery and the comparative benefits of her Med Pay and HMO coverage show that the insuring clause did not "emasculate apparent coverage" for HMO members.

Third, it is uncontroverted that there was *no* "activity which can be reasonably attributed to the insurer [that] would create an objective impression of coverage in the mind of a reasonable insured." *Id.* Allstate has never made any suggestion that Med Pay coverage would pay insureds for the cost of services that they received but for which they were never liable.

Finally, it is uncontroverted that there was *no* "activity reasonably attributable to the insurer [that] has induced [Ms. Haisch] to believe that [she] has coverage." *Id.* As the Superior Court found, "[i]t is uncontested that no Allstate agent or representative made any statement on this issue [of Med Pay benefits for HMO-covered services] that was relied upon by Haisch in her decision to purchase or retain her automobile insurance." (CR 75.) Ms. Haisch does not assert that any Allstate agents made any representations about Med Pay benefits for HMO-covered services. Ms. Haisch never claimed to have expected to reap a "commercial advantage" by having Allstate pay for costs her HMO already covered and for which she was never liable. 197 Ariz. at 611 ¶ 18, 5 P.3d at 945 ¶ 18. Rather, Ms. Haisch testified that she maintained Med Pay coverage because her prior HMO plan did not cover much: "at the time I did not have CIGNA, I had Humana . . . another HMO, and they—with Humana, they don't quite pay for everything, and a lot of times they say no, they don't approve it." (CR 62 ¶ 4.) *See Haisch*, 197 Ariz. at 608-09 ¶ 7, 5 P.3d at 942-43 ¶ 7.

In light of Ms. Haisch's testimony, Allstate had no "reason to believe that the adhering party would not have assented to the particular term had he or she known of its presence." *Gordinier*, 154 Ariz. at 272, 742 P.2d at 283. Ms. Haisch maintained Med Pay coverage in order to fill the gaps in her HMO plan, and the Med Pay coverage did just that. Thus, the insuring clause did not "undercut the purpose of the transaction or even the dickered deal between the parties." *Gordinier*, 154 Ariz. at 274, 742 P.2d at 285.

As a result, even if the reasonable expectations doctrine had any bearing on the fraud and misrepresentation claims here, there has been no showing that Ms. Haisch had any reasonable expectations of receiving benefits under the Med Pay provision for costs that she was never liable to pay. Summary judgment for Allstate was properly entered and affirmed below, and that judgment should stand.

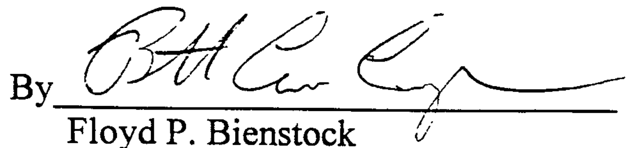
Conclusion

For the reasons set forth above, this Court should deny the Petition for Review.

DATED this 13th day of November, 2000.

Respectfully submitted,

STEPTOE & JOHNSON LLP

By 

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