STATE OF MICHIGAN

COURT OF APPEALS

PONTIAC OSTEOPATHIC HOSPITAL,

Plaintiff,

v

JOHN M. POTTER,

Defendant-Third-Party Plaintiff-Appellee,

and

GOLDEN RULE INSURANCE COMPANY,

Third-Party Defendant-Appellant.

UNPUBLISHED
June 25, 1999

No. 200071
Oakland Circuit Court
LC No. 96-006649 AV
Dist. Ct. No. 94-C-1796 GC

Before: Talbot, P.J., and Neff and Smolenski, JJ.

PER CURIAM.

Third-party defendant, Golden Rule Insurance Company, appeals by leave granted from the circuit court opinion and order, affirming the order of the district court, which denied Golden Rule's motion for summary disposition and granted defendant/third-party plaintiff John Potter's motion for summary disposition. We reverse.

This case arises from Golden Rule's refusal to pay a claim for medical expenses incurred by defendant's wife, Sylvia Potter, on the basis that she was treated for a preexisting condition, which is excluded from coverage under the insurance contract. Golden Rule contends that the lower courts erroneously denied its motion for summary disposition and granted defendant's motion. We agree in part and conclude that neither motion should have been granted. This Court reviews a motion for summary disposition de novo. *Pioneer State Mut Ins Co v TIG Ins Co*, 229 Mich App 406, 410; 581 NW2d 802 (1998). "A motion under MCR 2.116(C)(10) tests the factual basis underlying a

claim. This Court's task is to review the record evidence, and all reasonable inferences drawn from it, to decide whether a genuine issue regarding any material fact exists to warrant a trial." *Id.* at 410-411.

Defendant filed an application for insurance with Golden Rule on February 27, 1992, listing himself, his wife, Sylvia Potter and their three children to be covered under the policy. The policy became effective on March 10, 1992 for injuries and March 24, 1992 for illnesses. The cover page of the policy states in relevant part:

> **Preexisting Conditions**: A person is not covered for any illness until the 15th day after he or she became a covered person. A health condition which exists before that 15th day is not covered during the first twelve months of coverage, unless it was fully disclosed to us prior to coverage. See the Preexisting Conditions clause for details.
>
> Certain illnesses are not covered during the first six months a person is insured. See the Waiting Periods Clause in Section 7.
>
> * * *
>
> "*Illness*" means a sickness or disease of a *covered person*. . . . All *illnesses* that exist at the same time and which are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes which are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation of the prior illness and not a separate *illness*.

Section eight of the agreement, entitled "Preexisting Conditions Limitation," provides in relevant part:

> We will not pay any benefits of the *policy* for a *preexisting condition* unless:
>
> (a) the *covered person's preexisting condition* was fully disclosed to us on the person's application for insurance under the *policy*; and
>
> (b) coverage of the *preexisting condition* has not been excluded or limited by name or specific description.
>
> However, this limitation will not apply to a loss incurred more than 12 months after the applicable effective date the *covered person* became insured under the *policy*.
>
> A "*preexisting condition*" means an *injury* or *illness*:
>
> (a) for which the *covered person* received medical advice or treatment within the 24 months immediately preceding the applicable *effective date* the *covered person* became insured under the policy; or
>
> (b) which, in the opinion of a qualified *doctor*:

(1) probably began prior to the applicable *effective date* the *covered person* became insured under the *policy*; and

(2) manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

In addition, the "Waiting Periods Clause" in section seven of the agreement provides an exclusion from the waiting period for certain emergency treatment:

WAITING PERIODS: There is a 14 day waiting period for all *illnesses*, but there is a six month waiting period for certain conditions.

Expenses incurred by a *covered person* for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia or any disorders of the reproductive organs will not be covered during the *covered person's* first six months of coverage under the *policy*. (Note: this exclusion will not apply if the treatment is provided on an *emergency* basis.)

After the six-month period, the condition will be subject to all the terms of the *policy*, just like any other condition.

Finally, the agreement defines "emergency" as "a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the *covered person's* life or limb in danger if medical attention is not provided within 24 hours."

On March 23, 1992, Sylvia Potter visited Dr. Kulick complaining of a sharp pain in her right side. Dr. Kulick testified that he did not think she had an acute, life threatening problem at that time. Dr. Kulick further testified that Sylvia saw his partner, Dr. Haduck, on March 24, that she still had abdominal pain, and that Dr. Haduck sent her to plaintiff hospital for a repeat blood count, complete blood count, abdominal examination, possible surgical consultation and pelvic examination. On March 25, Sylvia was admitted to plaintiff hospital for right lower quadrant pain. Dr. Ketner performed an ultrasound which showed a questionable cystic mass. Dr. Ketner testified that on March 26 he performed a laparoscopy[1] to determine the source of her abdominal pain. Dr. Ketner's postoperative diagnosis was a "ruptured right ovarian cyst with periappendiceal adhesions." Dr. Ketner further testified that in his opinion, the March 26 surgery was an emergency.

"This Court interprets an insurance policy by first reviewing the policy language in an effort to effect the intent of the parties. If the language is clear and unambiguous, we apply the terms as written. If an ambiguity exists, it is resolved in favor of the insured." *Michigan Basic Property Ins Ass'n v Wasarovich*, 214 Mich App 319, 322; 542 NW2d 367 (1995). [Citations omitted.] "Similarly, in applying exclusionary provisions, this Court strictly construes the policy language against the insurer." *Id.* at 323. However, if the policy language is unambiguous it must be applied as written. *Id.*

A plain reading of the waiting periods clause in section seven indicates that while disorders of the reproductive organs will not be covered under the insurance contract until six months after the effective date of coverage, an emergency procedure for a disorder of the reproductive organs will be covered. Thus, the emergency exclusion to the waiting period allows a person requiring emergency treatment for those disorders to be covered, even though they would not normally be covered for six months. Because Sylvia suffered from a ruptured ovarian cyst, we conclude that her treatment could fall within the emergency exception. We agree with Golden Rule that the six-month waiting period would bar coverage if she sought treatment for a preexisting illness. However, because the policy defines a preexisting condition as an "illness" or "injury," and because a reproductive organ disorder "emergency" would be neither an "illness" nor an "injury" as defined by the policy, we conclude that the preexisting conditions clause would not bar coverage for such an emergency which occurred after the policy effective date of March 24.[2]

The record in this case presents a factual question as to whether Sylvia's hospital admission, ultrasound and laparoscopy resulted from a preexisting condition first treated on March 23, or from an emergency which manifested itself on March 25 and 26. Dr. Kulick testified that her condition was a preexisting condition prior to the policy's effective date of March 24, while Dr. Ketner characterized the laparoscopy as an emergency procedure. Thus, while Dr. Kulick did not consider her March 23 abdominal pain to be life threatening, her medical condition changed so that Dr. Ketner performed an emergency procedure on March 26.

Based upon the record before us, we find that a genuine issue of material fact exists in this case, because there is evidence that Sylvia's emergency procedure may have resulted from her preexisting condition, as well as evidence that her ruptured cyst may have been a separate emergency which manifested symptoms after her policy became effective. Accordingly, we hold that the circuit court erred in affirming the district court's grant of defendant's motion for summary disposition.

Finally, defendant contends that he should be awarded attorney fees pursuant to MCR 7.101(P)(1)(a) because Golden Rule's appeals to the circuit court and this Court have been vexatious. We decline to address defendant's contention because this appeal is limited to the issues raised in Golden Rule's application for leave to appeal. MCR 7.205(D)(4). Furthermore, we consider defendant's contention rendered moot by our decision in this case.

Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Michael J. Talbot
/s/ Janet T. Neff
/s/ Michael R. Smolenski

[1] A laparascope is "an endescope equipped for viewing the abdominal cavity through a small incision and for performing local surgery." Random House Webster's College Dictionary (1992).

[2] An "injury" is defined in the policy as "an accidental bodily injury sustained by a *covered person*. . . while a *covered person's* insurance is in force under this *policy*."