[Cite as *Nationwide Life Ins. Co. v. Canton*, 2010-Ohio-4088.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Nationwide Life Insurance Company,	:	
Plaintiff-Appellee/ Cross-Appellant,	:	
v.	:	No. 09AP-939
	:	(C.P.C. No. 07CVH-08-11779)
City of Canton, Ohio,	:	(REGULAR CALENDAR)
Defendant/Counterclaim Plaintiff-Appellant/ Cross-Appellee,	:	
RMTS, LLC,	:	
Third Party Defendant-Appellee/ Cross-Appellant,	:	
Benefit Services, Inc.,	:	
Third Party Defendant-Appellee.	:	

D E C I S I O N

Rendered on August 31, 2010

Thompson Hine LLP, Anthony C. White, and *Michele L. Noble*, for Nationwide Life Insurance Company and RMTS, LLC.

Buckingham, Doolittle & Burroughs, LLP, Richard S. Milligan, and *Justin S. Greenfelder*, for City of Canton, Ohio.

APPEAL from the Franklin County Court of Common Pleas.

FRENCH, J.

{¶1} Appellant, City of Canton, Ohio ("Canton"), appeals the Franklin County Court of Common Pleas' entry of summary judgment in favor of appellee, Nationwide Life Insurance Company ("Nationwide"), and third-party defendant-appellee, RMTS, L.L.C. ("RMTS"). Nationwide and RMTS have also filed a conditional cross-appeal from the trial court's decision granting in part Canton's motion for summary judgment. For the following reasons, we affirm the trial court's judgment.

{¶2} Canton is a municipal corporation that provides health insurance benefits to its employees through a self-insured plan. To administer claims under its employee benefit plan, Canton utilized two third-party administrators ("TPAs"), Benefit Services, Inc. ("BSI"), and AultCare Corporation ("AultCare"), each of which handled the claims of a defined group of Canton employees.

{¶3} In the fall of 2005, BSI began shopping for a stop-loss insurer on behalf of Canton. Stop-loss coverage is essentially excess coverage for a self-insured employer, by which the employer and the insurer agree to the amount that the employer will cover with respect to health costs of covered employees, with the insurer covering claims exceeding that amount. See Black's Law Dictionary 807 (7th ed.1999). BSI worked with RMTS, a managing general underwriter, who recommended Nationwide as an ideal stop-loss carrier. Nationwide issued a stop-loss contract to Canton, effective February 1, 2006, and this action involves Nationwide's liability under that contract.

{¶4} Nationwide initiated this action by filing a complaint in the Franklin County Court of Common Pleas on August 31, 2007. Because Nationwide maintains that

Canton failed to disclose one of its employees, Participant C, as a prerequisite to coverage under the stop-loss contract, Nationwide sought a declaratory judgment that it has no liability for medical expenses paid by Canton with respect to Participant C. Along with its answer to Nationwide's complaint, Canton filed counterclaims for breach of contract, bad faith, unfair trade practices, and civil conspiracy. Canton also filed third-party claims for bad faith, unfair trade practices, and civil conspiracy against RMTS and for breach of contract and breach of fiduciary duty against BSI. Nationwide, RMTS, and BSI filed timely responses to Canton's counterclaims and third-party claims.[1]

{¶5} Prior to the effective date of the stop-loss contract, and as a prerequisite to coverage, Nationwide required Canton to complete a Disclosure Statement and to disclose information regarding all known plan participants who fit into any of seven enumerated categories as of the date of disclosure, not more than 30 days prior to the effective date. As relevant here, those categories included the following:

> 2. Eligible persons with health conditions which have the potential to exceed 50% of the Specific Deductible[2] in the next 12 months;
>
> 3. Eligible persons currently hospital or institution confined, or expected to be confined within 90 days of the effective date[.]

In completing the Disclosure Statement, Canton was required "to obtain all available information from a Utilization review firm, case management vendor and any other agent who may have knowledge of claims-related activity." Canton was also required to update its disclosure through January 31, 2006, if its disclosure became inaccurate or

[1] Canton voluntarily dismissed its claims against BSI on February 26, 2009.
[2] The Specific Deductible (per person) in the stop-loss contract was $150,000.

incomplete. Nationwide undisputedly has no obligation to reimburse Canton's payment of medical claims for a plan participant who was required to be, but was not, disclosed.

{¶6} Rose Bresson, Canton's health benefits administrator, was responsible for completing the Disclosure Statement on Canton's behalf. To complete the Disclosure Statement, Bresson gathered information, both internally and from the TPAs, on eligible participants that fit into the enumerated categories. For example, on January 10, 2006, Bresson e-mailed AultCare employee Brenda Basso to inform her that "Nationwide will be Cityof [sic] Canton['s] [s]top loss carrier through [BSI] – for contract year 2/1/06 to 1/31/07" and to request "information on high claims starting with 25% of 150,000.00 (names[,] diagnosis, etc.[,] $ claims paid in last 12 month[s])" in order to complete the Disclosure Statement. In response, AultCare provided a report, dated January 11, 2006, listing enrollees with claims exceeding $37,500 to date in the contract year that began February 1, 2005. Bresson forwarded the completed and signed Disclosure Statement to BSI on January 11, 2006, and BSI forwarded it to Nationwide on January 18, 2006. Bresson could not recall whether she subsequently updated Nationwide with respect to the Disclosure Statement prior to the effective date. Canton did not list Participant C on the Disclosure Statement.

{¶7} The crux of this case is whether Canton was required to disclose Participant C. On January 18, 2006, approximately two weeks before the effective date of the stop-loss contract, Participant C met with Bresson and inquired whether a PET scan he had scheduled for the following day at the Cleveland Clinic would be covered by the health plan. Bresson's notes from that meeting indicate that Participant C was

having trouble with his esophagus, throat, and larynx. Participant C told Bresson that his doctor had diagnosed a growth in his throat as cancer. According to Bresson, Participant C "said there was a problem with his throat and that he was going in for surgery February 13th." (Bresson Depo. 42.) Bresson admitted that, as of January 18, 2006, she knew that Participant C was going to have surgery at the Cleveland Clinic on February 13, 2006.

{¶8} Immediately after her meeting with Participant C, Bresson e-mailed Basso at AultCare and informed her of Participant C's scheduled PET scan and surgery at the Cleveland Clinic. Bresson's e-mail stated, in part, as follows:

> [Participant C] is going to have a "pet" scan at Cleveland Clinic on the 19th. Doctor had faxed info to utilization review and it will be reviewed today per utilization department. He had been approved for a prior test at the "in network" 80/20 plan payment at Clev. Clinic, and will have surgery on Feb[.] 13th also at Clev[.] Clinic.

Bresson inquired whether Participant C was required to obtain pre-authorization for all treatment at the Cleveland Clinic to receive benefits at the "in network" rate. Bresson testified that she would have spoken to someone in AultCare's utilization review department to verify receipt of the information from Participant C's doctor prior to her e-mail to Basso. Basso referred Bresson's inquiry to an AultCare customer service employee.

{¶9} On February 13, 2006, as scheduled, Participant C underwent a thoracic esophagectomy—the removal of part of his esophagus—at the Cleveland Clinic. Participant C experienced purportedly unforeseeable and nearly catastrophic complications from the surgery and, as a result, remained hospitalized at the Cleveland

Clinic until April 17, 2006, after which he was transferred to an intermediate care facility. Participant C's medical expenses exceeded $900,000. Because Participant C was an enrollee in Canton's self-funded benefit plan, Canton paid Participant C's medical expenses out of its general fund.

{¶10} When Canton submitted its payments for Participant C's medical expenses for reimbursement under its stop-loss contract, Nationwide denied coverage, claiming that Canton violated the disclosure requirements by not listing Participant C on its Disclosure Statement. Nationwide initially claimed that Canton was required to disclose Participant C under Category 2, as a person "with health conditions which have the potential to exceed [$75,000] in the next 12 months." In the trial court, Nationwide alternatively argued that Canton was required to disclose Participant C under Category 3, as a plan participant "expected to be [hospital] confined within 90 days of the effective date."

{¶11} On February 17, 2009, Canton filed a motion for summary judgment, arguing that ambiguity in Category 2 of the Disclosure Statement rendered compliance impossible. Accordingly, Canton argued that its non-disclosure did not relieve Nationwide of a duty to provide coverage. On March 20, 2009, Nationwide moved the trial court for leave to file a motion for summary judgment instanter, and, simultaneously, filed its motion for summary judgment. In pertinent part, Nationwide disputed Canton's assertion of ambiguity in Category 2 and argued that Canton was required to disclose Participant C under both Categories 2 and 3. Nationwide also argued that Canton's claims failed, in part, because AultCare compensated Canton in

the amount of $623,918.68 for its alleged damages in this case. Both motions for summary judgment were briefed comprehensively.

{¶12} On September 14, 2009, the trial court issued a decision and entry granting Nationwide's motion for leave to file a motion for summary judgment and a decision granting in part both Nationwide and Canton's motions for summary judgment. Although the trial court agreed with Canton that Category 2 was ambiguous and did not require Canton to disclose Participant C, the court found no ambiguity in Category 3 and concluded that Canton was required, but failed, to disclose Participant C under that category, thus eliminating Nationwide's duty to pay claims based on Participant C's treatment. On September 29, 2009, the trial court filed its final judgment entry, entering summary judgment in favor of Nationwide on its claim for declaratory judgment and on Canton's counterclaims and in favor of RMTS on Canton's third-party claims.

{¶13} Canton filed a timely notice of appeal and presently asserts the following assignment of error for our consideration:

> THE TRIAL COURT ERRED IN GRANTING SUMMARY JUDGMENT IN FAVOR OF [NATIONWIDE].

In their cross-appeal, Nationwide and RMTS assert the following assignments of error:

> 1. The trial court erred in finding that Category 2 of the Disclosure Statement is ambiguous.
>
> 2. The trial court erred by failing to consider extrinsic evidence of the parties' intent regarding Category 2 of the Disclosure Statement, and failing to hold that the extrinsic evidence required the finding that the parties intended Category 2 of the Disclosure Statement to require [Canton] to disclose any eligible participant in its health benefit plan who had a health conditions [sic] with the potential to exceed 50% of the Specific Deductible in the next 12 months.

> 3. The trial court erred when it allowed Canton to seek $623,918.68 in damages allegedly incurred upon Nationwide's refusal to reimburse Canton for medical claims that Canton paid on behalf of Participant C, after [AultCare], Canton's [TPA], paid Canton $623,918.68 as a reimbursement for those exact same claims that Nationwide denied.

Nationwide conceded at oral argument that the cross-appeal is conditional and that this court need address it only if we sustain Canton's assignment of error. Therefore, we turn first to Canton's single assignment of error, which contests the entry of summary judgment in favor of Nationwide.

{¶14} We review a summary judgment de novo. *Koos v. Cent. Ohio Cellular, Inc.* (1994), 94 Ohio App.3d 579, 588, citing *Brown v. Scioto Cty. Bd. of Commrs.* (1993), 87 Ohio App.3d 704, 711. When an appellate court reviews a trial court's disposition of a summary judgment motion, it applies the same standard as the trial court and conducts an independent review, without deference to the trial court's determination. *Maust v. Bank One Columbus, N.A.* (1992), 83 Ohio App.3d 103, 107; *Brown* at 711. We must affirm the trial court's judgment if any grounds the movant raised in the trial court support it. *Coventry Twp. v. Ecker* (1995), 101 Ohio App.3d 38, 41-42.

{¶15} Pursuant to Civ.R. 56(C), summary judgment "shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, written admissions, affidavits, transcripts of evidence, and written stipulations of fact, if any, timely filed in the action, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Accordingly, summary judgment is appropriate

only under the following circumstances: (1) no genuine issue of material fact remains to be litigated; (2) the moving party is entitled to judgment as a matter of law; and (3) viewing the evidence most strongly in favor of the non-moving party, reasonable minds can come to but one conclusion, that conclusion being adverse to the non-moving party. *Harless v. Willis Day Warehousing Co.* (1978), 54 Ohio St.2d 64, 66. Because summary judgment is a procedural device to terminate litigation, courts should award it cautiously after resolving all doubts in favor of the non-moving party. *Murphy v. Reynoldsburg*, 65 Ohio St.3d 356, 358-59, 1992-Ohio-95, quoting *Norris v. Ohio Std. Oil Co.* (1982), 70 Ohio St.2d 1, 2.

{¶16} Canton's arguments on appeal deal solely with the trial court's dispositive conclusion that Canton was required, but failed, to disclose Participant C under Category 3, thus relieving Nationwide of any obligation to reimburse Canton for its payment of Participant C's medical expenses. Category 3 required Canton to disclose "[e]ligible persons currently hospital or institution confined, or expected to be confined within 90 days of the effective date" of the stop-loss contract. Thus, the question resolves to whether Participant C, who was undisputedly an eligible person, was expected to be hospital-confined within 90 days of February 1, 2006.

{¶17} Although Canton argued that Nationwide waived Category 3 as a ground for denying coverage based on its initial reliance on Category 2, the trial court rejected that argument, and Canton assigns no error in that regard. The court next rejected Canton's argument that the term "confined," as used in Category 3, is ambiguous. Based on Bresson and AultCare's knowledge of Participant C's cancer diagnosis and

scheduled surgery in a hospital, the court concluded that Canton was required to disclose Participant C under Category 3 and that Nationwide was entitled to summary judgment as a result of Canton's failure to do so.

{¶18} Canton contends that the trial court's analysis regarding Category 3 is flawed in three respects. First, Canton claims that "confined," as used in Category 3, is ambiguous and maintains that the court erred by finding that Bresson knew that Participant C would be confined. Next, Canton maintains that the record lacked evidence that AultCare knew facts giving rise to an expectation that Participant C would be hospital-confined. Finally, Canton maintains that the court erred in construing the Disclosure Statement as imposing a duty on Canton to disclose knowledge held by its TPAs.

{¶19} Canton's first argument concerns the meaning of the word "confined," which it contends is ambiguous. Canton suggests that the term "confined," which is not defined in the Disclosure Statement, is open to interpretation and that Bresson reasonably interpreted the term to require an overnight hospital stay. Canton argues that Bresson's knowledge of Participant C's scheduled surgery at the Cleveland Clinic within two weeks of the stop-loss contract's effective date does not warrant the conclusion that Canton expected, or should have expected, that Participant C would be hospital-confined. Nationwide, on the other hand, asserts that Category 3 is unambiguous and that the trial court appropriately concluded that Canton and/or AultCare had sufficient knowledge to expect that Participant C would be hospital-confined within the relevant time frame, thus triggering a duty to disclose.

{¶20} The question of whether contract terms are clear or ambiguous is a question of law for the court. *Westfield Ins. Co. v. HULS Am., Inc.* (1998), 128 Ohio App.3d 270, 291. In determining whether contractual language in an insurance policy is ambiguous as a matter of law, our review is limited to the four corners of the policy itself. *Shanton v. United Ohio Ins. Co.*, 4th Dist. No. 07CA766, 2007-Ohio-6379, ¶10, citing *Inland Refuse Transfer Co. v. Browning-Ferris Industries of Ohio, Inc.* (1984), 15 Ohio St.3d 321, 322. The fact that a term in an insurance contract is not defined does not mean that the term is ambiguous. *Chicago Title Ins. Co. v. Huntington Natl. Bank*, 87 Ohio St.3d 270, 273, 1999-Ohio-62. " 'Contractual language is "ambiguous" only where its meaning cannot be determined from the four corners of the agreement or where the language is susceptible of two or more reasonable interpretations.' " *Covington v. Lucia*, 151 Ohio App.3d 409, 2003-Ohio-346, ¶18, quoting *Potti v. Duramed Pharmaceuticals, Inc.* (C.A.6, 1991), 938 F.2d 641, 647. The Supreme Court of Ohio recently warned, however, that the mere possibility of multiple readings of a term does not necessarily warrant a finding of ambiguity. See *State v. Porterfield*, 106 Ohio St.3d 5, 2005-Ohio-3095, ¶11. "The problem with [that] approach is that it results in courts' reading ambiguities into provisions, which creates confusion and uncertainty." Id. The Supreme Court instructed that "a court is to objectively and thoroughly examine the writing to attempt to ascertain its meaning. * * * Only when a definitive meaning proves elusive should rules for construing ambiguous language be employed." Id.

{¶21} We must give contract terms their plain and ordinary meaning. *Lager v. Miller-Gonzalez*, 120 Ohio St.3d 47, 2008-Ohio-4838, ¶15, *Gomolka v. State Auto Mut.*

Ins. Co. (1982), 70 Ohio St.2d 166, 167-68 ("words and phrases used in an insurance policy must be given their natural and commonly accepted meaning, where they in fact possess such meaning"). The trial court looked to Webster's New World College Dictionary for the plain and ordinary meaning of "confine," stating that the term means, in part, "to keep shut up, as in prison, in bed because of illness." Webster's Third New International Dictionary of the English Language Unabridged (G. & C. Merriam Co. 1966) defines "confine," in part, as "to prevent free outward passage or motion of[;] * * * to keep to a certain place or to a limited area." The American Heritage Dictionary of the English Language, New College Edition (1981), includes within its definition, "[t]o keep within bounds; restrict." See also Funk & Wagnalls New International Dictionary of the English Language, *Comprehensive Edition* (1984) ("[t]o restrain or oblige to stay within doors[;] [t]o hold or keep within limits; restrict"). The common thread in each of these definitions is a restriction in movement.

{¶22} Canton suggests that "confined" also could be read to incorporate a minimum time component. For example, Canton asserts that a patient who undergoes surgery in a hospital on an outpatient basis has not been confined. In fact, Canton maintains that Bresson reasonably interpreted "confined" to require an overnight hospital stay and that the trial court's acceptance of a broader definition of "confined" in this context was unreasonable and constitutes error.

{¶23} Although Canton cites several cases in support of its argument that the trial court's definition of "confined" was overbroad and unreasonable, none of those cases is convincing. First, in *McCarty v. United Ins. Co.* (Mo.1953), 259 S.W.2d 91, 92,

the court examined an insurance contract that provided coverage " 'while the insured is necessarily treated and confined as a patient in any hospital.' " There, attempting to restrict the term "confined" to inpatient treatment, the insurance company denied coverage because the insured was treated on an outpatient, emergency basis and remained at the hospital for about five hours. After fracturing her forearm, the insured in *McCarty* was taken to the hospital and x-rayed. The insured then underwent an operation to remove splintered bones and had her arm set and cast. The trial court directed a verdict in favor of the insured, rejecting the insurance company's reading of the policy as requiring inpatient treatment, and the appellate court affirmed. The appellate court did not find the insurance policy ambiguous but, rather, rejected the insurance company's reading of the policy as a matter of law. Stating that "[n]owhere in the policy do the words 'in-patient' or 'out-patient' appear," the appellate court suggested that the distinction between inpatient and outpatient care had no bearing on the requirement of confinement within the policy and concluded that the insured was necessarily treated and confined as a patient in the hospital. Id. at 93.

{¶24} Canton also contends that the court in *Johnson v. Am. Family Life Assur. Co. of Columbus* (D.Colo.1984), 583 F.Supp. 1450, found the term "hospital confinement" in an insurance policy ambiguous and interpreted that term in favor of coverage. The policy in that case provided extended benefits "beginning with the 91st day of uninterrupted covered hospital confinement." Id. at 1451. While the court did find that policy provision ambiguous, the ambiguity resided not in the term "confinement," but in the term "uninterrupted." See id. at 1452-53. Neither *McCarty* nor

Johnson supports Canton's assertion that "confined" is ambiguous as used in the Disclosure Statement or that the term requires either inpatient treatment or an overnight hospital stay.

{¶25} Finally, Canton cites *State v. Nagle* (1986), 23 Ohio St.3d 185, 186-87, which involved confinement in the context of a criminal sentence rather than in the context of medical treatment. The Supreme Court of Ohio concluded that the statutory language in former R.C. 2949.08, which provided time credit for the number of days a prisoner was previously "confined for any reason arising out of the offense for which the prisoner was convicted and sentenced," did not include time spent in a rehabilitation center prior to the commencement of sentence. Based on the examples of confinement in the statute, the Supreme Court construed the term "confined" to involve restrictions upon freedom of movement. The Supreme Court's conclusion lends no credence to Canton's argument that the term "confined" is ambiguous in the current context.

{¶26} A court may not create ambiguity in a contract where there is none. *Lager* at ¶16, citing *Hacker v. Dickman*, 75 Ohio St.3d 118, 119, 1996-Ohio-98. Here, we agree with the trial court that the term "confined," as used in Category 3, is unambiguous. If the language of an insurance contract is clear and unambiguous, courts must enforce the contract as written, giving the contractual language its plain and ordinary meaning. See *Hybud Equip. Corp. v. Sphere Drake Ins. Co., Ltd.* (1992), 64 Ohio St.3d 657, 665. Because nothing in the plain and ordinary meaning of "confined," as set forth in the various definitions quoted above, contains a minimum time requirement, we conclude that Canton's assertion that a patient is not hospital-confined

absent an overnight stay is not a reasonable interpretation of that term, as used in Category 3.

{¶27} We now turn to the evidence of Bresson's knowledge with respect to Participant C. Bresson, who was responsible for preparing the Disclosure Statement on behalf of Canton, read Category 3 to require disclosure of "[a]ny participant who * * * would be going into the hospital within 90 days." (Bresson Depo. 29-30.) As of January 18, 2006, Participant C had told Bresson of his cancer diagnosis, involving his throat, larynx, and esophagus. Bresson testified, "[h]e said there was a problem with his throat and that he was going in for surgery February 13th." (Bresson Depo. 42.) Bresson thus expected Participant C "was going to be in the hospital to have surgery on February the 13th," less than two weeks after the effective date of the stop-loss contract. (Bresson Depo. 58.) Nevertheless, Bresson testified that she did not know that Participant C was going to be confined, stating, "I just thought he was going for, you know, some surgery. I didn't know if he was going to be hospitalized or confined, one-day surgery." (Bresson Depo. 58.)

{¶28} Canton has argued, both to the trial court and on appeal, that the evidence of Bresson's knowledge does not establish that Canton knew or should have expected that Participant C would be hospital-confined on or around February 13, 2006. Canton states that Bresson, who lacked medical training, knew nothing of Participant C's medical history, the extent of his cancer or the nature of his surgery; therefore, she had no way of expecting that Participant C would be hospitalized, so as to trigger the Category 3 disclosure requirement. The trial court stated that Bresson did not need to

know the extent of Participant C's cancer or the nature of his surgery to conclude that Participant C was expected to be hospital-confined on the date of his surgery. We agree. Even lacking medical training or more specific information, under the facts of this case, Canton reasonably should have known that Participant C, having been diagnosed with esophageal cancer and scheduled for throat surgery in a hospital, would be at least temporarily hospital-confined on or around the date of his surgery, regardless of whether the surgery would require an overnight hospital stay. As stated above, any attempt to impose a time requirement on the term "confined" is contrary to the plain and ordinary meaning of that term. Especially in light of her own testimony that Category 3 required disclosure of any participant who "would be going into the hospital within 90 days," Bresson, on behalf of Canton, was required to disclose Participant C. (Bresson Depo. 29-30.)

{¶29} In addition to Bresson's knowledge, AultCare was also aware of Participant C's diagnosis and scheduled surgery. The Disclosure Statement not only required that Canton, as the policyholder, "disclose * * * pertinent information regarding all known eligible persons in the categories listed below," but also required Canton "to obtain all available information" from any agent who may have knowledge of claims-related activity, which Canton admits included its TPAs. Accordingly, Bresson's process in completing the Disclosure Statement included requesting and utilizing information from the TPAs. Nevertheless, Canton contends that the trial court erred by reading the Disclosure Statement to require Canton to disclose Participant C based on AultCare's

knowledge. Specifically, Canton argues that the Disclosure Statement required Canton "to disclose what it knew – not what someone else may have known."

{¶30} Canton recognizes both that contracts are read in conformity with the intentions of the parties, as gathered from the ordinary and commonly understood meaning of the language employed, and that common words in a written instrument will be given their ordinary meaning unless manifest absurdity results or unless some other meaning is clearly evidenced from the face of the instrument. See *King v. Nationwide Ins. Co.* (1988), 35 Ohio St.3d 208, 211; *Alexander v. Buckeye Pipe Line Co.* (1978), 53 Ohio St.2d 241, paragraph two of the syllabus, superseded by statute on other grounds. Here, reading the Disclosure Statement in its entirety reveals the intention that Canton's disclosure of all "pertinent information" was to include "all available information" from its TPAs, including AultCare. It strains credulity to suggest that AultCare's knowledge of information requiring the disclosure of a plan participant, which information Canton was required to obtain from AultCare, was not an integral part of Canton's duty to disclose "pertinent information." To conclude otherwise would encourage an insurer to forsake efforts to obtain the information requested by the Disclosure Statement from its TPA and to then plead ignorance when faced with a claim of non-disclosure.

{¶31} Canton's actions in completing the Disclosure Statement reveal its understanding of the requirement to obtain and incorporate information known by its TPAs into the disclosure. Bresson expressly stated that she relied on the TPAs to tell her which, if any, plan participants were currently in the hospital in order to comply with the first part of Category 3. Bresson also requested from AultCare "information on high

claims starting with 25% of 150,000.00 (names[,] diagnosis, etc.[,] $ claims paid in last 12 month[s])" as part of her completion of the Disclosure Statement, although she admitted that the requested high claims report would not provide all of the information necessary for complete responses to Categories 2 and 3. Bresson did not recall requesting additional information from AultCare in relation to this Disclosure Statement. Canton's failure to request all necessary, available information from its TPA, however, neither results in ambiguity in the Disclosure Statement nor excuses Canton's failure to disclose Participant C under Category 3.

{¶32} In addition to the information conveyed to AultCare in Bresson's January 18, 2006 e-mail, AultCare had additional information relating to Participant C's cancer diagnosis and medical treatment. For example, it is undisputed that AultCare paid claims for Participant C in November and December 2005 that indicated a diagnosis of esophageal cancer or malignant neoplasm of the esophagus. Further, there is no evidence to contradict Bresson's testimony that AultCare's utilization review department received a specific request from Participant C's doctor seeking pre-authorization for, at least, the January 19, 2006 PET scan at the Cleveland Clinic relating to Participant C's cancer. Moreover, all of Participant C's treatment at the Cleveland Clinic, some of which AultCare paid prior to the effective date of the stop-loss contract, was related to his cancer diagnosis. Like Bresson, AultCare had sufficient information to expect that Participant C would be hospital-confined within 90 days of the effective date of the stop-loss contract.

{¶33} Like the trial court, we conclude that, based on Bresson's knowledge and AultCare's knowledge, Canton was required, but failed, to disclose Participant C under Category 3 of the Disclosure Statement. We further conclude that the trial court did not err in determining that Nationwide owed no coverage with respect to Canton's payment for Participant C's medical expenses, as a result of Canton's failure to disclose Participant C. For these reasons, we overrule Canton's single assignment of error, thus rendering the cross-appeal by RMTS and Nationwide moot. We affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

KLATT and SADLER, JJ., concur.