EFiled: Mar 20 2025 04:28PM EDT
Filing ID 75901488
Case Number 40,2025

**IN THE SUPREME COURT OF THE STATE OF DELAWARE**

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| BENEFYTT TECHNOLOGIES, INC. (n/k/a BENEFYTT TECHNOLOGIES, LLC),<br><br>Plaintiff Below, Appellant,<br><br>v.<br><br>CERTAIN UNDERWRITERS AT LLOYDS' OF LONDON, XL SPECIALTY INSURANCE COMPANY, EXECUTIVE RISK INDEMNITY, INC., and ENDURANCE ASSURANCE CORPORATION,<br><br>Defendants Below, Appellees. | No. 40,2025<br><br>Court Below – Superior Court of the State of Delaware<br>C.A. No. N21C-02-143 PRW CCLD |

# APPELLANT'S OPENING BRIEF

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Dated: March 20, 2025

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## NATURE OF THE PROCEEDINGS

Benefytt[1] filed this insurance coverage action in the Superior Court on February 15, 2021 seeking, in part, defense and indemnity D&O insurance coverage for a fully settled underlying class action lawsuit initially filed on June 7, 2019, against Benefytt and its former CEO (the "Belin Claim") under its 2018-2019 D&O and E&O insurance programs. Thereafter, Benefytt amended its Complaint to add additional D&O insurers that disputed insurance coverage for a second underlying class action suit—the Keippel Claim.

Several defendants settled with Benefytt and were dismissed from the proceeding (XL remained as a nominal party for purposes of claim placement issues and coverage declarations). The non-settling parties filed competing summary judgment motions in March 2023 regarding D&O coverage obligations and rights for the Keippel and Belin Claims. However, before oral argument, on May 23, 2023, Benefytt filed a Chapter 11 bankruptcy case, and the Superior Court transferred this action to the dormant docket. On September 11, 2023, Benefytt emerged from bankruptcy under a plan of reorganization. On May 30, 2024, the Superior Court restored this action to the active docket. The Superior Court heard oral argument on September 24, 2024.

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[1] Benefytt Technologies, LLC was formerly known as Benefytt Technologies, Inc., and before that was formerly known as Health Insurance Innovations, Inc. ("Benefytt").

On January 2, 2025, the Superior Court issued its Memorandum Opinion and Order. On January 6, 2025, the Superior Court issued its Corrected Memorandum Opinion and Order. *See* Ex. A. Benefytt now appeals the Superior Court's rulings only with respect to its granting Endurance Assurance Corporation's ("Endurance") summary judgment motion regarding placement of the Belin Claim outside the D&O insurance coverage in the 2018-2019 policy period. Ex. A at 31-38.

## SUMMARY OF THE ARGUMENT

1. The Court's holding that the Belin Claim was not first made during the 2018-2019 policy period should be reversed for numerous independent reasons.

2. First, Benefytt exercised its optional right to provide a notice of circumstances under its D&O policies about a specific "situation" involving FTC litigation in December 2018. Contrary to the Superior Court's holding, Benefytt provided a compliant "notice of circumstances" sufficient to lock-in coverage for the ensuing Belin Claim.

(a). The Lloyds' primary policy, to which the excess insurers' policies, including Endurance's, "follow form", gave Benefytt the discretion to provide a notice of circumstances if a "situation" developed during the existing policy period that could lead to a future D&O "Claim". Benefytt did just that by providing a December 2018 notice of "potential claim" after the FTC filed a lawsuit alleging actionable harm to thousands of consumers who bought Benefytt-developed health insurance products through Benefytt's key distributor—Simple Health. Although not named in the suit, Benefytt could well anticipate litigation against it arising from the FTC's allegations and thus require the protection of Benefytt's D&O insurance as a consequence. Despite this, the Superior Court, without citing any supporting authority, found the notice insufficient—even though the primary D&O insurer had accepted the December 2018 notice as a proper notice of circumstances

and Endurance never questioned or rejected the notice. In reaching its conclusion, the Superior Court committed numerous errors, including an interpretation of the notice clause far more stringent than the policy's actual language and contrary to New York's tenets of policy construction.[2]

(b). The Superior Court also neglected to consider how the Belin Claim arose out of the FTC allegations. The Superior Court ignored the close link between the FTC lawsuit against Benefytt's key product distributor (Simple Health) and the Belin Claim allegations that Benefytt and its former CEO managed, directed, operated and developed the very health insurance products that the FTC alleged were harming thousands of consumers. The Superior Court should have found that the D&O policies covered the Belin Claim for the 2018-2019 policy period because the Belin Claim arose from the "situation" involving FTC's claims against Simple Health.

3. Second, the Superior Court erred when it held that the Belin Claim was not "first made" during the 2018-2019 policy period because the original Belin complaint did not yet "trigger" coverage. This was clear error, as the policy's reporting and claim placement provisions are not contingent upon the separate

[2] The Policies require application of New York law. A1152 (Item N).

questions of whether a "Claim" is covered or an insuring clause is "triggered" to require payment.

(a). The Belin Claim was also covered because it was a "Claim" first made in the 2018-2019 policy period. Despite the plain language of the term "Claim", the Superior Court erroneously attempted to determine when a "Claim" is first made by adding coverage conditions not found in the policy; namely, by defining "Claim" to mean a "triggering claim". The Superior Court fixed its conclusion on the fact that the original Belin complaint made in the 2018-2019 policy period did not trigger D&O coverage; only the amended Belin complaint filed after the policy period, adding the former CEO of Benefytt triggered coverage. But the Superior Court reasoned that the amended complaint filed after the policy period could not relate back to the original complaint filed in the policy period because the payment provisions of the policy were not triggered by that original complaint.

(b). This was clear error. Rather than looking at the reporting and "Claim" placement provisions that instruct on when a "Claim" is "first made", the Superior Court instead referred to the policies' loss payment section to reach its conclusion.

(c). The Superior Court, instead, should have found the original complaint was first made during the policy period, as it satisfied the express definition of "Claim"—any civil proceeding against any Insured. In turn, Clauses IV.F. and VI.A. of the Policies address the reporting of "Claims" and placement of multiple

"Claims". Importantly, these policy sections do not require that a first-filed (or subsequently filed) "Claim" be deemed covered or "triggered". Had the Superior Court correctly applied the policy language, it would have found that the original complaint was a "Claim" first made against an Insured during the 2018-2019 policy period and the amended Belin complaint would relate back to the original complaint and be deemed a "single claim".

## STATEMENT OF FACTS

### A. Benefytt's D&O Insurance Policies

Benefytt is a Delaware corporation with its principal place of business in Florida. A1148. At all relevant times, Benefytt operated a "health insurance technology business" (Ex. A at 1) that included developing, distributing and administering affordable individual health and family insurance plans. A1298.

In connection therewith, Benefytt purchased a comprehensive claims-made D&O liability program spanning multiple years and layers. The following chart depicts the 2018-2019 D&O insurance tower:

| Layer | Insurer | Policy Number |
|---|---|---|
| Primary - $10MM | Lloyds' | B0621PHEAL003118 (the "Primary Policy") |
| 1st Excess - $5MM x/s $10MM | XL Specialty | B0621PHEAL003118 |
| 2nd Excess - $5MM x/s $15MM | Argonaut | MLX4209146-0 |
| 3rd Excess - $5MM x/s $240MM | Endurance | DOX10013192200 (the "Endurance Excess Policy") |

Ex. A at 2. Lloyds' wrote the Primary Policy (A1143-1216); the excess policies (including the Endurance Excess Policy (A1217-1235) (together with the Primary Policy, the "Policies") largely follow form to the terms and conditions of the Primary Policy. A1218.

The Policies "appl[y] only to any Claim first made … during the Policy Period provided: (1) such Claim … is reported to [the insurers] in accordance with the terms of Clause VI.A." A1148.

The Policies define "Claim" as "any written demand for monetary damages, non monetary relief, injunctive relief or other relief against any of the Insureds, or any civil … proceeding … initiated against any of the Insureds[.]" A1154. Ínsureds" means "the Company and the Insured Persons." A1158. "Insured Persons" include "all persons who were [or] now are . . . directors, officers or risk managers of the Company[.]" A1157.

The Policies require Insurers to reimburse Benefytt for "Loss … resulting from any Claim first made against Insured Persons during the Policy Period for a Wrongful Act." A1153.

The Policies require Benefytt to give Insurers notice of any claim during the existing policy period. A1148. In addition to covering claims made and reported during the 2018-2019 policy period, the Policies gave Benefytt the option to lock-in coverage under the current policy period for a future claim by submitting a "notice of circumstances." Specifically, if Benefytt "become[s] aware of a specific fact, circumstance or situation which could reasonably give rise to a **Claim** … and during the Policy Period give[s] written notice to the [insurers] of [] the specific fact, circumstance [or] situation[;] . . . the consequences which have resulted or

may result therefrom; and the circumstances [] by which [Benefytt] first became aware thereof, then any **Claim** … made subsequently arising out of such fact, circumstance [or] situation … shall be deemed for the purposes of [the Policies] to have been made … at the time such notice was first given." A1169.

The policies also contain an endorsement to coverage barring insurers from denying insurance coverage for late notice unless they demonstrate material prejudice. A1200.

### B. The Relevant Actions

Three underlying litigations are relevant to this appeal.

#### 1. The Spiewak Complaint

In October 2018, Matthew Spiewak ("Spiewak"), the managing general agent of a health insurance vendor that sold Benefytt's products, sued Benefytt for allegedly breaching the parties' commission agreement (the "Spiewak Complaint"). A710. The Spiewak Complaint details a business relationship among Benefytt, Simple Health Plans LLC (also known as Health Benefits One LLC (together, "Simple Health")), Simple Insurance Leads LLC ("SIL"), and Simple Health's former CEO and founder, Stephen Dorfman. A710-713. It contains the following allegations: Spiewak, with others, formed Simple Health. A711 ¶9; Benefytt supplied health insurance products for Simple Health to sell. A712 ¶10; Spiewak, Simple Health and Benefytt entered into a Managing General

Agent Agreement that allowed Simple Health to promote and sell various health insurance policies marketed by Benefytt. A712 ¶11; because Simple Health needed capital to expand its business, Benefytt agreed to advance commissions to Spiewak pursuant to a Master Commission Advance Agreement. A712 ¶12; thereafter, Benefytt formed a joint venture with Dorfman and SIL to allow Simple Health to set up and grow a marketing company for the products. A712-713 ¶13; and Benefytt later invested further in SIL. A713 ¶14.

### 2. The FTC Complaint

In October 2018, the Federal Trade Commission ("FTC") filed an action alleging that Simple Health, SIL, Dorfman, and related entities engaged in practices that violated the Federal Trade Commission Act ("the FTC Complaint"). A682. The FTC Complaint alleged that the defendants conducted business "through interrelated companies, which have common ownership, officers [and] business functions, and office locations which have commingled assets, and which hold themselves out as Simple Health." A686 ¶13. The suit attacked Simple Health's and Dorfman's alleged practice of selling "[l]imited benefit plans to consumers" who "thought they had purchased comprehensive health insurance" leaving them "without [] coverage." A686-88. The FTC sought an injunction and any relief "necessary to redress injury to consumers." A708.

Seeking to distance itself, Benefytt issued a press release on November 2, 2018, announcing that it had immediately suspended its relationship with Simple Health. A873 ¶3.

### 3. The Belin Claim

The Belin Claim followed on the heels of the FTC Complaint. It was a class action lawsuit filed on June 7, 2019, initially naming only Benefytt as a defendant (the "Initial Belin Complaint"). A890.

The claimants were consumers who "purchased [Benefytt's] limited benefit indemnity plans through Simple Health." A932 ¶172. They alleged damages resulting from a variety of alleged wrongful acts concerning the development, management, sales and marketing of health insurance products developed by Benefytt and purchased through Simple Health. A891 ¶1; A892 ¶3.

The Initial Belin Complaint first describes the allegations in and status of the FTC litigation. It alleges that "[t]wo groups of Florida companies, working together, defrauded hundreds of thousands of consumers nationwide, by leading those consumers to believe that their [health insurance plans] were major medical insurance." A891 ¶2. It describes that the FTC shut down Simple Health, and that a receiver found Simple Health was "'largely a classic bait-and-switch'". A892 ¶2.

It then states that "[t]his lawsuit takes aim at the second group of companies that directed, aided and abetted the Simple Health fraud: [Benefytt]." A892 ¶ 3. It

further alleges that Benefytt loaned Simple Health millions of dollars to fund its operations; allowed Simple Health sales agents to register their licenses through Benefytt; and directed Simple Health to use Benefytt's online platform to quote and sell Benefytt's products. A892 ¶3. It asserts that Benefytt developed the health insurance products and the distribution network through which consumers were defrauded, and that Simple Health was Benefytt's "largest and most profitable" distributor. A893 ¶4. It identifies Simple Health, SIL, and Dorfman as "Relevant Nonparties" who participated in the purported scheme. A897 ¶16-A898 ¶24.

On July 17, 2019, plaintiffs amended their complaint to affirmatively add Michael Kosloske, Benefytt's founder and CEO ("Kosloske") as a defendant (the "Amended Belin Complaint"). A946; A954 ¶20. Spiewak was added as a "relevant nonparty". A956 ¶31. The Amended Belin Complaint alleged that "[Benefytt] and Kosloske developed the limited benefit indemnity plans and the distribution channels through which consumer were defrauded." A947. It further alleged that "[r]egarding Kosloske specifically, he approved the products to be sold; recruited agents like Dorfman, Spiewak[;] developed distribution channels through their companies; approved [Benefytt's] financing of those companies; and participated in [] management and operation[.]" A994 ¶211.

The Amended Belin Complaint was amended twice more (A1008; A1075); the operative complaint is the October 2020 third amended complaint. A1075. Benefytt provided notice of the Belin Claim, along with the Initial and Amended Belin Complaints, on October 31, 2019. A858.

### C. The December 2018 Notice of Circumstances

Although Benefytt was not named in the FTC Complaint, "[it] could foresee their business with Simple Health giving rise to a claim." Ex. A at 11. Accordingly, Benefytt, through its outside defense counsel, Greenspoon Marder, opted to provide written notice of the FTC Complaint and the Spiewak Complaint to its 2018-2019 insurers via a "notice of circumstances" pursuant to Clause VI.C of the Primary Policy (the "December 2018 NOC"). A679-836. Benefytt sent the written notice to Risk Placement Services, Inc. ("RPS") (A835-36) – the "Producer" of the Endurance Excess Policy and the insurance agency that policy indicated could receive reports of loss. A1218.

The December 2018 NOC advised that Benefytt had received the two complaints and was "being proactive to notice the insurers about the FTC's recent lawsuit against HBO/Simple Health." A680. It advised that while there was no current lawsuit against Benefytt, "we want to be proactive in case a claim arises. (HII doesn't want to risk waiving for lack of notice)." A835. Greenspoon Marder requested that RPS send the notice "to all D&O and E&O and excess carriers."

A836. RPS subsequently forwarded a package of materials to the 2018-2019 insurers, including Endurance, consisting of the communications with Benefytt's outside counsel, the FTC Complaint and the Spiewak Complaint, and an internal RPS email (A679-836) stating that "[Benefytt's] outside counsel called me yesterday to let me know about the litigation addressed below. While [Benefytt] is not named directly, they would like to put the E&O and D&O carriers on notice in the event the situation expands. Please notice all of the D&O carriers and the E&O … as a potential claim." A835.

Lloyds' accepted the December 2018 NOC as a notice of circumstances under the Primary Policy. A845. Endurance, however, did not respond to the notice during the 2018-2019 policy period. In fact, throughout most of the insurance coverage litigation, Endurance wrongly asserted that it had not actually received the December 2018 Notice. A419 (Third Affirmative Defense); A505; A860. On November 23, 2022, Endurance finally withdrew its affirmative defense on this issue. A658. At the close of discovery, it conceded that its claims unit received the December 2018 NOC during the 2018-2019 policy period. A659 (Fifth Affirmative Defense); A1275. Simultaneously, Endurance took the position for the first time that the December 2018 NOC was inadequate. A1272-1273.

### D. The Procedural History

After the Insurers denied coverage for the Belin Claim, Benefytt commenced an insurance coverage action in the Superior Court in February 2021. Ex. A at 12.

In February 2023, the parties cross-moved for summary judgment on various issues. Of relevance to this appeal, Benefytt's summary judgment motion asserted that the Belin Claim was first made in the 2018-2019 policy period, while Endurance's summary judgment motion contended that the Belin Claim was first made in the 2019-2020 policy period.

On January 2, 2025, the Superior Court issued its Memorandum Opinion and Order, which was superseded by a Corrected Memorandum Opinion and Order issued on January 6, 2025. *See* Ex. A. The Superior Court found that the Belin Complaint "falls … outside the 2018-2019 policy period and is not interrelated with any other covered claim". Ex. A at 1, 39.

In reaching its conclusion, the Superior Court found the December 2018 NOC insufficient to satisfy the terms of Clause VI.C to be a proper "notice of circumstances", and that the FTC Complaint and the Spiewak Complaint did not give "adequate notice of facts relevant to or incorporated in the Belin Complaint". Ex. A at 38. The Superior Court also ruled that the Initial Belin Complaint was not first made in 2018-19 because it did not trigger coverage, and since it was not a

"covered" claim, the Amended Belin Complaint naming Kosloske could not relate back to it. Ex. A at 32-34.

Benefytt timely filed its Notice of Appeal on January 31, 2025.

## ARGUMENT

### I. THE DECEMBER 2018 NOC GAVE SUFFICIENT NOTICE OF THE BELIN CLAIM UNDER CLAUSE VI.C OF THE PRIMARY POLICY; CONSEQUENTLY, THE BELIN ACTION IS DEEMED FIRST MADE IN THE 2018-2019 POLICY PERIOD.

#### A. Question Presented.

Did the Superior Court err by ruling that the December 2018 NOC did not comply with Clause VI.C of the Primary Policy and that the Belin Claim did not arise out of the circumstances of that notice; therefore, the Belin Claim was not first made in the 2018-2019 policy period? Ex. A at 36-38.

#### B. Standard of Review.

A court's summary judgment decision interpreting a contract, including insurance policy clauses, is reviewed *de novo*. *City of Newark v. Donald M. Durkin Contracting, Inc.*, 305 A.3d 674, 679 (Del. 2023).

#### C. Merits of Argument.

The Superior Court held that the Belin Claim could not be deemed first made in the 2018-2019 policy period because the December 2018 NOC "[gave] no adequate notice of facts relevant to or incorporated in the Belin Action". Ex. A at 37.

But the Superior Court erred in reaching its conclusion. Its holding:

- overlooks the purpose of a notice of circumstances and how it must be construed;

- reads a more stringent notice requirement into Clause VI.C, and does not apply the actual policy language;

- misapprehends how the Belin Claim arose out of the FTC and Spiewak allegations;

- ignores that Endurance never inquired about or questioned the notice's sufficiency for four years;

- disregards that the primary insurer accepted the December 2018 NOC as a notice of circumstances under Clause VI.C, and that no other Insurers challenged the adequacy of that notice.

#### 1. Notice of Circumstances Provisions in Claims-Made Policies Benefit, and Are Construed Liberally in Favor of, Policyholders.

Coverage under a claims-made D&O policy is triggered if a claim is first made during the policy period. Alternatively, a claim may be deemed first made, even if received and reported in a later policy period, if it arose out of a circumstance or situation first noticed during an earlier policy period. *See In re Ambassador Grp., Inc. Litig.*, 830 F. Supp. 147, 157 (E.D.N.Y. 1993) ( "if an insured becomes aware and gives notice to the insurer during the policy period of the occurrence of … of circumstances which could give rise to a claim, a claim subsequently made arising out of such … circumstances will be deemed made 'during the [p]olicy [p]eriod'"); *Federal Ins. Co. v. Safenet, Inc.*, 817 F. Supp. 2d 290, 302-03 (S.D.N.Y. 2011) (where policyholder provided notice of circumstance even though exact issue giving rise to subsequent claim was not discovered until later policy period, policy's relation-back provision broadly included any claim

"alleging, arising out of, based upon, or attributable" to notice of circumstance under prior D&O policy).

As this Court recently held, this option is intended to benefit policyholders:

> The Notice Provision is not limited to mature Claims like filed lawsuits. It includes a "notice of circumstances" where the insured can give notice when it "first become[s] aware of facts or circumstances which may reasonably give rise to a future Claim" under the policy. In claims-made insurance programs, the notice of circumstances benefits the insured. The insured can lock in existing insurance coverage for later related claims even though the facts and circumstances have yet to occur or might be somewhat different.

*In re Alexion Pharms., Inc. Ins. Appeals*, 2024, 2025 WL 383805, at *6 (Del. Feb. 4, 2025) (emphasis added). *See also S & L Oil, Inc. v. Zurich Am. Ins. Co.*, 2009 WL 2050489, at *7 (E.D. Cal. July 10, 2009) (finding that similar provision "affords additional protection to the cautious insured."); John F. Olson, *Director and Officer Liability: Indemnification and Insurance*, § 12:35 (Dec. 2023) ("The advantage to the insured of submitting a notice of circumstances is that it preserves the insured's rights under the existing policy.").

D&O insurers write "Notice of Circumstances" provisions with varying levels of specificity. Many expressly require that the policyholder provide "full particulars" or specificity concerning "wrongful acts" and a description of potential damages. *See, e.g., Benecard Servs., Inc. v. Allied World Specialty Ins. Co.*, 2020 WL 2842570 (D.N.J. May 31, 2020), *aff'd*, 2021 WL 4077047 (3d Cir. Sept. 8,

2021) (requiring "full particulars"); *Alexion*, 2025 WL 383805, at *2 (requiring "description of anticipated Wrongful Acts allegations" and "nature of potential monetary damages and non-monetary relief"). Others, like Clause VI.C here, do not require a high degree of specificity or identify how detailed the notice should be. *See JPMorgan Chase & Co. v. Travelers Indem. Co.*, 880 N.Y.S.2d 224, 2009 WL 137044, at *5 (N.Y. Sup. Ct. 2009), *aff'd*, 897 N.Y.S.2d 405 (App. Div. 2010) (policy did not specify what information should be provided other than written notice of a "Wrongful Act"); *In re Kenai Corp.*, 136 B.R. 59, 62 (S.D.N.Y. 1992) (affirming bankruptcy court finding that notice of circumstances letter to D&O insurer was sufficient where policy "did not explicitly state what constitutes sufficient notice of an occurrence").

Regardless of the specificity required by a particular notice of circumstance, under New York law, "'[n]otice requirements are to be liberally construed in favor of the insured, with substantial, rather than strict, compliance being adequate.'" *Liberty Ins. Underwriters, Inc. v. Perkins Eastman Architects, P.C.*, 929 N.Y.S.2d 200, 2011 WL 1744218, at *7 (Sup. Ct. 2011), *aff'd as modified*, 958 N.Y.S.2d 90 (App. Div. 2012) (*citing Greenburgh Eleven Union Free School Dist. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 758 N.Y.S.2d 291, 293-94 (App. Div. 2003)) (in finding notice of circumstance sufficient, court noted that policyholder need only substantially comply with policy's notice requirements).

Moreover, insurance policies are interpreted according to their plain meaning when that meaning is "clear and unequivocal." *Monzo v. Nationwide Prop. & Cas. Ins. Co.*, 249 A.3d 106, 118 (Del. 2021) (internal quotation marks omitted). That interpretation should account for an understanding of "broad coverage to align with the insured's reasonable expectations." *Jin Ming Chen v. Ins. Co. of the State of Pennsylvania*, 163 N.E.3d 447, 450 (N.Y. 2020); ("[i]t is axiomatic that a contract is to be interpreted so as to give effect to the intention of the parties as expressed in the unequivocal language employed" (quotations and citations omitted); *Cragg v. Allstate Indem. Corp.*, 950 N.E.2d 500, 502 (N.Y. 2011) (insurance policy must be interpreted according to common speech and consistent with insured's reasonable expectations).

To that end, "exclusionary clauses" are given a "strict and narrow construction," and such clauses only exclude coverage if they are "specific, clear, plain, conspicuous, and not contrary to public policy." *RSUI Indem. Co. v. Murdock*, 248 A.3d 887, 906 (Del. 2021); (internal quotation marks omitted); *Seaboard Sur. Co. v. Gillette Co.*, 476 N.E.2d 272, 275 (N.Y. 1984) (policy exclusions "are not to be extended by interpretation or implication, but are to be accorded a strict and narrow construction"). Under New York law, "[t]he burden, a heavy one, is on the insurer, and [i]f the language of the policy is doubtful or uncertain in its meaning, any ambiguity must be resolved in favor of the insured

and against the insurer." *Parks Real Estate Purchasing Grp. v. St. Paul Fire and Marine Ins. Co.*, 472 F.3d 33, 42-43 (2d Cir. 2006) (quotations and citations omitted).

### 2. The December 2018 NOC Complied With Clause VI.C of the Primary Policy.

When Benefytt received the FTC Complaint and Spiewak Complaint attacking the allegedly fraudulent business practices of its largest revenue generating distributor and key business partners, it foresaw a future claim arising out of that "situation" given the nature and volume of business between these entities and the fact that the FTC was claiming wide-spread harm to the thousands of purchasers of these health insurance products. Thus, Benefytt opted to notice this circumstance pursuant to Clause VI.C of the Primary Policy to lock-in coverage in the 2018-2019 policy period for any future claim arising from this "situation".

Clause VI.C provides:

> If the Insureds:
>
> 1. become aware of a specific fact, circumstance or situation which could reasonably give rise to a **Claim** …
>
> [A]nd if the **Insureds** during the **Policy Period** give written notice to Underwriters of:
>
> - The specific fact, circumstance, [or] situation[;]
> - the consequences which have resulted or may result therefrom; and

> - the circumstances by which the **Insureds** first became aware thereof,
>
> then any **Claim …** made subsequently arising out of such fact, circumstance [or] situation … shall be deemed for the purposes of this Policy to have been made or commenced at the time such notice was first given.

A1169 (emphasis added).[3] Unlike more stringent notice of circumstances provisions, Clause VI.C only requires that Benefytt give "written notice" of the three enumerated items; it does not specify any level of detail that Benefytt must provide.

In the December 2018 NOC, Benefytt's outside counsel stated:

> As discussed, [Benefytt] is being proactive to notice the insurers about the FTC's recent lawsuit against HBO/Simple Health.
>
> There is no lawsuit against [Benefytt] at this time, but we want to be proactive in case a claim arises. (HII doesn't want to risk waiving for lack of notice).

A680. Outside counsel discussed the matter with RPS and provided copies of the FTC Complaint and Spiewak Complaint. A679-80. The RPS agent then sent the package as a "Notice of Potential Claim" to "RPS_ExecLines" (A835) and to "RPS_Claims" stating:

> The insured's outside counsel called me yesterday to let me know about the litigation addressed below.

[3] Endurance's Excess Policy imposes no additional substantive requirements for a notice of a potential claim. A1218 (Declarations, Items 8., 9); A1222 § II.C.

> While [Benefytt] is not named directly, they would like to put the E&O and D&O carriers on notice in the event the situation expands.
>
> Please notice all of the D&O carriers and the E&O … as a potential claim.

A679. RPS then sent the package as a "First Notice of Loss" to the D&O and E&O insurers in the 2018-2019 policy period. A679. The package comprising the December 2018 NOC provided the requisite information under the minimal requirements of Clause VI.C.

**(a) The December 2018 NOC Provided Written Notice of the Circumstance or Situation.**

The December 2018 NOC provided written notice to Insurers of the "situation" – that litigation involving allegedly deceptive sales of health insurance products developed by Benefytt to unsuspecting consumers by Simple Health, an entity that it partnered with to distribute the products and propped up with millions in loans, certain affiliates, and an executive alleging improper aspects of their business practices, had commenced. The FTC Complaint alleged that "**Tens of Thousands of Consumers Have Been Harmed by Defendants' Practices.**" A703 (emphasis in original). It contained numerous, detailed allegations about a "situation" in which defendants misled consumers into believing they were buying comprehensive health insurance that would cover preexisting medical conditions, prescription drugs, and other benefits, when instead, most consumers who enrolled

reported paying significant sums for medical discount programs or extremely limited benefit programs that did not deliver the promised benefits.

The Spiewak Complaint that also comprised part of the December 2018 NOC contained detailed allegations about the business relationship among Benefytt, several of the corporate defendants in the FTC Action (including Simple Health, SIL), and Dorfman. Specifically, it asserted that Simple Health and Benefytt had entered into a Managing General Agent Agreement that allowed Simple Health to promote and sell various health insurance policies marketed by Benefytt and, thereafter, Benefytt formed a joint venture with Dorfman and SIL and invested in SIL. A712-A713.

Therefore, the December 2018 NOC provided clear written notice of a circumstance or "situation" of the FTC Complaint claims and the Spiewak Complaint setting forth the detailed relationship between Benefytt and the Simple Health entities and principals. This notice would place any prudent D&O insurer on notice that Benefytt anticipated claims arising from the FTC allegations of harm to thousands of health insurance consumers purchasing their products through the Simple Health network.

### (b) The December 2018 NOC Provided Written Notice of the Circumstances That Resulted or Which May Result From the Circumstance or Situation.

The December 2018 NOC also adequately informed the insurers of "the consequences which have resulted or may result" from the circumstance or situation.

Again, Clause VI.C does not require any heightened level of specificity regarding the actual or potential consequences, only written notice. The December 2018 NOC provided written notice of the already existing consequences of the "situation" -- *i.e.*, litigation against Benefytt's business partners Simple Health, Dorfman, and SIL, *et al*., in connection with the sale of Benefytt's health insurance products had commenced. In particular, when the FTC filed its emergency action to shut down Simple Health it sought to: enjoin Simple Health from conducting its business and freeze its assets; rescind Simple Health's contracts; appoint a receiver; obtain a refund of monies paid and disgorgement; and obtain "an evidence preservation order [and] expedited discovery. A708. The Spiewak Complaint identified several key contracts between Benefytt and the FTC Complaint defendants, including a Master General Agent Agreement and a Master Commission Agreement pursuant to which Simple Health was able to sell the health insurance products developed by Benefytt. A711-12. It also described how Benefytt and Simple Health entered into a joint venture to form SIL, in which

Benefytt initially had a fifty percent interest and in which Benefytt invested further. A712. It further explained that Benefytt advanced commissions to provide additional capital to expand Simple Health. A712.

These two lawsuits cast public light on Benefytt's deep involvement with the defendants targeted by the FTC, heightening the risks to Benefytt for its role in Simple Health's alleged misconduct. Therefore, it was reasonable for Benefytt to believe that a claim against it could follow. Thus, Benefytt's counsel expressly stated that "the FTC's recent lawsuit against HBO/Simple Health" was not "against [Benefytt] at this time[.]" A835 (emphasis added). Endurance and the other insurers were further advised that "we want to be proactive in case a claim arises." Id. (emphasis added). RPS also explained that Benefytt was providing notice "in the event the situation expands." This clearly informed the D&O insurers, including Endurance, that while the FTC had not yet sued Benefytt, the chances were high that it might, given that Benefytt developed and provided the health insurance products at the center of the fraud allegations, and created the distribution networks. While Benefytt could not have known the form or timing of

that future claim, it expressly gave written notice that the current "situation" could expand to envelop Benefytt and/or its officers and directors.[4]

Despite this, years afterward, Endurance concocted the story that the December 2018 NOC was deficient because it did not allow Endurance to connect the dots between Simple Health and the other defendants in the FTC Complaint on the one hand, and Benefytt on the other. The Superior Court committed clear error in accepting this argument from Endurance at face value. The Spiewak Complaint itself identified the business relationship between Benefytt and those entities. A712-A713. And Endurance knew from its claim and underwriting units during the 2018-2019 policy period that Benefytt developed and administered individual health and family insurance plans and used both an internal and external distribution network to market those products—including Simple Health. A1298. Endurance's claims representative conceded that by the time Endurance realized it received the December 2018 NOC, it had received another claim against Benefytt, the Keippel Claim (A1275-76) that specifically identified the relationship between Benefytt and Simple Health and discussed the FTC allegations in detail. A871-89.

[4] Indeed, Benefytt publicly disclosed the same day the FTC Complaint became public "that it had immediately suspended its relationship with [Simple Health] ….." A877.

These facts belie any argument that Endurance was unaware of the connection between Benefytt and the defendants in the FTC Complaint.

**(c) The December 2018 NOC Provided Written Notice of the Circumstances By Which Benefytt First Became Aware of the Circumstance or Situation.**

Endurance did not dispute, and the Superior Court did not hold otherwise, that the December 2018 Notice provided written notice of the "circumstances by which the Insureds first became aware" of the "situation". Nor could they. The notice makes plain on its face that Benefytt's outside counsel received the two complaints – one naming Benefytt as a defendant and the other against Benefytt's business partners.

**(d) The Superior Court Erred in Applying the Terms of Clause VI.C to the December 2018 NOC.**

The Superior Court correctly noted that Benefytt could foresee its extensive business relationship with Simple Health and the other defendants in the FTC Complaint giving rise to a Claim against the company and its executives, including Kosloske. Ex. A at 11. But the Court then wrongly concluded that the December 2018 NOC did not satisfy Clause VI.C's requirements by misapplying the provision in several critical ways.

First, the Superior Court improperly altered the level of specificity required by Clause VI.C. It stated that the "notification provision requires the notice to discuss facts that could 'reasonably give rise to' a later claim." Ex. A at 37

(emphasis added). But Clause VI.C does not require a "discussion"—only "written notice". A1169. The Court's belief that more was required improperly equated Clause VI.C with notice of circumstance clauses in policies requiring greater detail and specificity. As set forth above, some clauses obligate the policyholder to provide "full particulars" or "a description of the anticipated Wrongful Act allegations" or the potential damages the policyholder faces. Those requirements are absent in Clause VI.C.

The Superior Court further altered the applicable language by determining that Clause VI.C required Benefytt to give "adequate notice of facts relevant to or incorporated in the *Belin* action". Ex. A at 38. But Clause VI.C is not limited to a "specific fact"; it includes a "circumstance" or "situation". A1169. Nor does it require that the circumstance or situation be relevant to or incorporated in a later complaint. It only requires written notice of those circumstances or situations that "could reasonably give rise to" a future Claim. A1169 (emphasis added).

The Superior Court also wrongly emphasized that the FTC Complaint "makes no allegations against Benefytt." Ex. A at 38.That interpretation conflates the Policies' notice of circumstance with the notice of claim provisions. Clause VI.C does not require that the fact, circumstance, or situation involve or include allegations against Benefytt, only that it *could reasonably give rise to a future claim*. A1169. The fact that the FTC Complaint does not name or allege wrongful

acts against any "Insured" is what makes it a situation that could grow into a future "Claim", rather than qualify as an actual present "Claim". Unlike a notice of a potential claim, a "Claim", as defined by the Primary Policy, includes a civil proceeding "initiated against any of the Insureds[.]" A1154 (Clause II.B) (emphasis added). Further, as this Court has observed, a notice of circumstances allows the policyholder to "lock in existing insurance coverage for later related claims even though the facts and circumstances have yet to occur or might be somewhat different." *Alexion*, 2025 WL 383805, at *6 (emphasis added).

Fourth, the Superior Court incorrectly concluded that the December 2018 NOC was inadequate because it "didn't state that Benefytt expected some future litigation". Ex. A at 38. Again, this misapplies the policy language. Clause VI.C only required that Benefytt provide written notice of "the consequences which have resulted or may result [from the circumstance or situation]." A1169. The consequences could be anything – a subpoena for testimony or documents issued by the FTC, a request to toll a statute of limitations, or a written demand for non-monetary relief. Clause VI.C does not require Benefytt to state that it expected future litigation.

It strains belief that Endurance could not readily envision consumer class action litigation like the Belin Claim arising from an FTC lawsuit alleging "Tens of Thousands of Consumers Have Been Harmed by Defendants' Practices," when

those "practices" included marketing and selling the products developed by its business partner, Benefytt. Indeed, consumer class actions routinely follow FTC enforcement actions. *See, e.g.,* Dana Rosenthal and Daniel Blynn, *The "Prior Substantiation" Doctrine: An Important Check on the Piggyback Class Action*, 26-FALL Antitrust 69 (2011) (commenting on "increased number of false advertising/consumer protection class action filings . . . that are virtually identical to or rely heavily upon FTC complaint[.]"); *Dial Corp. v. News Corp.*, 317 F.R.D. 426, 434 (S.D.N.Y. 2016) ("[M]any class actions are filed on the heels of a government investigation"); John E. Villafranco, Katherine E. Riley, *So You Want to Self-Regulate? The National Advertising Division As Standard Bearer*, Antitrust, Spring 2013, at 79, 82. ("[p]iggyback class actions are becoming increasing threats in connection with all consumer protection matters, including FTC settlements"). That is precisely the consequence here – the Belin consumer class action followed on the heels of the FTC Complaint.

The Superior Court's misapplication of Clause VI.C violated the principle that the specific language of a notice of circumstance provision must be applied. *See, e.g., Atl. Health Sys., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 463 F. App'x 162, 167 (3d Cir. 2012) (applying NJ law) (unpublished) ("We concurred … that '[b]ecause notice of … potential claim defines coverage under a claims-made policy, we think that the notice provisions of such a policy should be strictly

construed.'"); *W. Am. Ins. Co. v. Yorkville Nat'l Bank*, 939 N.E.2d 288, 293 (Ill. 2010) (explaining that first factor in determining reasonability of notice is "the specific language of the policy's notice provision").

This is especially important in the context of a notice of circumstance, where policyholders are unsure when a future claim might arise or what form it might take. Because Clause VI.C was intended to protect Benefytt for present "situations" that could give rise to future claims, and that notice provisions only require "substantial compliance", the Superior Court erred in giving Endurance free rein to negate coverage by professing ignorance about how a future claim could arise from the December 2018 NOC.

### 3. The Belin Claim Arose Out of the "Situation" Identified in the December 2018 NOC and Should Be Deemed First Made During the 2018-2019 Policy Period.

The Primary Policy provides that if Benefytt submits a notice of circumstance pursuant to Clause VI.C, "any **Claim** or Investigation made subsequently arising out of such … circumstance [or] situation … shall be deemed for the purposes of this Policy to have been made … at the time such notice was first given." A1169 (Clause VI.C). By employing the term "arising out of", Clause VI.C imposes a broad "common nexus" test between the subsequent claim and the notice of circumstance. *See, e.g., Mount Vernon Fire Ins. Co. v. Creative*

*Hous. Ltd.*, 88 N.Y.2d 347, 351 (1996); *City of Newark*, 305 A.3d at 680 (holding that "arising out of" should be interpreted broadly).

The December 2018 NOC incorporating the FTC Complaint, alleging Benefytt's business partners used deceptive sales tactics, among other things, a network of lead generation websites and misleading sales scripts, presaged the Belin Claim. A684-97. The Belin Claim contains scores of these allegations as well. The Belin Claim makes this plain in the first two paragraphs, establishing the common nexus between the FTC Complaint and the Belin Claim:

> A group of Florida companies and individuals, working together, defrauded hundreds of thousands of consumers nationwide by leading those consumers to believe that their limited benefit indemnity plans and medical discount plans were major medical insurance. Recently, a federal judge, prompted by a Federal Trade Commission ("FTC") lawsuit, entered a series of orders restraining one of those companies, Simple Health, from conducting further business. The court installed receiver Michael I. Goldberg, who … reported that Simple Health was "largely a classic bait-and-switch scam whereby unwitting consumers are falsely led to believe that they are purchasing a [PPO] that is compliant with the [ACA], but in reality are sold limited benefit indemnity plans that are not compliant with the ACA."

A947 ¶ 2. The claimants then immediately alleged:

> This lawsuit takes aim at two of the companies that directed, operated, managed, conspired with and/or aided and abetted the enterprise that perpetrated the fraud: [Benefytt] — and [its] founder and former CEO, Michael Kosloske. [Benefytt] and Kosloske developed the limited benefit indemnity plans and the distribution channels through which consumers were defrauded. Simple Health was the largest of those distributors …. [Benefytt]

> loaned Simple Health millions of dollars to fund their operations; trained Simple Health's … tacitly or expressly approved the fraudulent scripts used by Simple Health … to sell the products … allowed dozens of Simple Health sales agents to register their licenses through [Benefytt] … and directed Simple Health … to use [Benefytt's] online platform to quote and sell Benefytt's products.
>
> [Benefytt] paid Simple Health … extremely generous commissions and plied them with millions of dollars in financing. As a result, Simple Health developed into [Benefytt's] largest and most profitable third-party distributor … generating hundreds of millions of dollars in fees and premiums — nearly 50% of all revenues generated by [Benefytt].

A947-48 ¶¶ 3-4. The Complaint further alleged that Benefytt, Kosloske, Spiewak, and Dorfman worked together to sell or distribute limited benefit indemnity plans, medical discount plans, and other non-ACA compliant products to customers who thought they were purchasing comprehensive medical insurance. A959-60. Moreover, the Belin Complaint identified the defendants in the FTC Complaint as "Relevant Nonparties", including the Simple Health entities, Dorfman, and Spiewak. A954-56.

Yet the Superior Court, with limited analysis, concluded that "neither [the FTC action or the Spiewak action] related to *Belin*." Ex. A at 38. This conclusion is puzzling because the Superior Court also described the Belin Claim as "a consumer class action alleging Benefytt orchestrated a bait-and-switch regarding certain Benefytt products" – the same products at issue in the FTC Complaint. Ex. A at 38. Clearly, the Superior Court overlooked that the Simple Health was part of

that alleged "classic bait-and-switch scam", and that the FTC targeted the first group of alleged bad actors – Simple Health, SIL, Dorfman, and Spiewak, while the Belin claimants targeted the second group – Benefytt, its affiliates, and its CEO Kosloske.

Simply put, the Belin Claim "arises out of" the "situation" of which Benefytt noticed in December 2018, where it alleged Kosloske and Benefytt directed, operated, managed, conspired with and/or aided and abetted Simple Health, Benefytt's largest and most profitable distributor.

#### 4. New York Law Requires an Insurance Company to Timely Inform Its Policyholder if a Notice of Circumstances Is "Insufficient"—Otherwise that Coverage Defense is Void.

Because a notice of circumstance benefits policyholders and permits them to to lock-in coverage for potential future claims in the current policy period, New York law obligates an insurer to inform its policyholder if it views a notice of circumstance as too vague or insufficient.

In *JPMorgan Chase*, *supra*, the court held that an insurer that finds a notice of circumstances lacking is duty-bound to ask questions and alert the policyholder of any deficiencies in the notice; if it doesn't, even if a notice was inadequate, the insurer's long silence precludes it from denying coverage:

> If an insurer is aware that the insured is attempting to put it on notice of a potential future claim, but the insurer fails to advise the insured that the notice is deficient because the requisite specifics have not been provided, the insurer will not be

> permitted to subsequently deny coverage based upon the absence of such specifics.

*See JPMorgan Chase & Co.*, 2009 WL 137044, at *5. *See also F.D.I.C. v. Interdonato*, 988 F. Supp. 1, 10 (D.D.C. 1997), *aff'd*, 172 F.3d 919 (D.C. Cir. 1998) (holding that even if policyholder's notice had been insufficient, insurer could not deny coverage when it lead policyholder to believe notice was adequate and failed to request further information regarding director liability).

Endurance not only refused to identify any deficiencies in the December 2018 Notice upon receipt, but also delayed raising the alleged deficiencies as a defense for almost four years. Endurance received the December 2018 Notice during the 2018-2019 policy period. A1281. Yet, Endurance did not ask questions of, or seek additional information from, agent RPS, Benefytt, or Benefytt's outside counsel. Nor did it advise that the notice was insufficient. Endurance never contacted Benefytt about the December 2018 NOC during the underwriting of the 2019-2020 Endurance policy. Endurance first acknowledged the December 2018 NOC on March 17, 2021, in a letter denying the Belin Claim, then asserting only that it was improper because it was not sent to the claims unit email address designated in the Endurance Excess Policy. A860. Endurance later withdrew its affirmative defense on that issue. Endurance proceeded through almost the entire coverage litigation without challenging the sufficiency of the notice until *the last day to complete fact discovery*. A667-68. No legitimate reason exists for

Endurance to wait out the policy period and then take almost four years to inform its policyholder that a notice of circumstance is purportedly deficient. The Superior Court should have rejected Endurance's attempt to lie in wait for years.

### 5. Lloyds', the Primary Insurance Company, Accepted the December 2018 NOC as an Adequate Notice under Clause VI.C of Its Policy.

The Superior Court also erred in adopting Endurance's untimely argument by ignoring that Lloyds', the primary D&O insurer, accepted the December 2018 NOC for the 2018-2019 policy period. In a May 2019 reservation of rights letter, Lloyds' referenced "the FTC Action, the Insureds' previous notification of which Underwriters accepted as a notice of circumstances under the Policy." A845. Lloyds' corporate representative in the insurance coverage action conceded that another D&O claim against Benefytt, the Keippel Claim, related back to the December 2018 NOC and that Lloyds' treated the Belin Claim similarly. A1261. No other excess insurer in the 2018-2019 D&O tower asserted that the December 2018 NOC did not comply with Clause VI.C, except Endurance.

The Superior Court's decision to void Benefytt's coverage for the Belin Claim on the basis that the December 2018 Notice was insufficient contravenes the broad protection notice of circumstance clauses are intended to provide

policyholders.[5] The Superior Court should have found that the December 2018 NOC provided sufficient notice to Endurance to allow Endurance to understand that the Belin Claim arose from the "situation" or "circumstances" detailed therein.

[5] The December 2018 NOC enabled Endurance to protect itself in the future. The 2019-2010 D&O policies inserted a new endorsement broadly excluding any loss "alleging, arising out of, based upon or attributable to: Claims arising from or related to any Wrongful Acts errors or omissions committed by: [] any distributor … [Managing General Agent] or other seller of insurance or benefits products[.]" A304. That is precisely the type of claim that could arise out of the December 2018 NOC. Endurance specifically inserted this "laser exclusion" to cabin the FTC and Spiewak Complaints.

## II. THE SUPERIOR COURT ERRED BY RULING THAT THE BELIN CLAIM WAS NOT A "CLAIM" FIRST MADE IN THE 2018-2019 D&O POLICY PERIOD BECAUSE THE ORIGINAL BELIN COMPLAINT DID NOT NAME FORMER CEO, KOSLOSKE.

### A. Question Presented.

Did the Superior Court err by ruling that the Belin Claim was not "first made" during the 2018-2019 D&O policy period because the Initial Belin Complaint did not name former CEO Koleske as a co-defendant? Ex. A at 31-34.

### B. Standard of Review.

A court's summary judgment decision interpreting a contract, including insurance policy clauses, is reviewed de novo. *City of Newark*, 305 A.3d at 679.

### C. Merits of Argument.

The Superior Court erred in holding that the original Belin complaint was not a "Claim" first made during the 2018-2019 policy period. The Superior Court improperly wrote conditions into the Primary Policy's definition of "Claim" for the original Belin complaint to qualify as a "Claim". But the Policies' reporting and claims placement clauses do not contain the qualifying language the Superior Court imposed here.

The Superior Court ruled that: "the original [Belin] complaint didn't contain a triggering claim, so there is nothing to relate back to that could gain coverage." Ex. A at 34 (emphasis added). The Superior Court reasoned that because the amended Belin complaint, filed after the 2018-2019 policy period, was the

"triggering claim", and not the original complaint, there was nothing to relate the amended Belin complaint back to that could gain coverage in the 2018-2019 policy period.

The Superior Court's interpretation of when a "Claim" is first made is premised on adding qualifying conditions that do not exist in the Policies. Clauses IV.F. and VI.A. address the reporting of claims and the placement of multiple claims. A1167-68. Importantly, these sections do not require that a first or subsequently filed "Claim" be a covered "Claim". *Id.* Nor is the concept of a "triggering claim" referenced in the Policies for these purposes. *Id.* To the contrary, these provisions simply refer to a "Claim". *Id.*

The Primary Policy unambiguously defines "Claim" to mean, in part, "**any … civil…proceeding**…initiated against **any of the Insureds**[.]" A1154 (Clause II.B). (emphasis added). The original Belin complaint constitutes a civil proceeding. It was against an "Insured".[6] It constitutes a "Claim" first made the date it was filed, June 7, 2019 (within the 2018-2019 policy period).[7]

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[6] The Primary Policy defined "Insureds" as "the Company and the Insured Persons". A1158 (Clause II.L). In turn, "Company" means, in part, the "Parent Company" and "any Subsidiary". A1155 (Clause II.C).

[7] Although Benefytt did not provide notice of the initial Belin complaint until October 2019, an endorsement prohibits the insurers from denying coverage for a claim unless they demonstrate "material prejudice" as a result of "such late notice". A1200. Here, no insurer argued that it was materially prejudiced by receiving the Belin Claim in October 2019.

Under the plain language of the Policies, whether it was a "covered" Claim is immaterial for ultimate claim placement of subsequent claims.[8] The Declarations in the Primary Policy state, in relevant part:

> "THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE…DURING THE PERIOD PROVIDED: (1) SUCH CLAIM … IS REPORTED TO UNDERWRITERS IN ACCORDANCE WITH THE TERMS OF CLAUSE VI.A…."

A1148 (emphasis added). Clause VI.A, in turn, only refers to "Claim", not "covered Claim". A1168. Clauses IV.F and IV.G (as amended), which place related Claims in the same policy period, also do not reference "covered Claim". A1167. Thus, the Policies' provisions "apply" to any "Claim" reported during the policy period. They do not require that a "Claim" be covered or "trigger" coverage to determine "Claim" reporting or placement. Holding otherwise blurs the distinction between the reporting and claim placement provisions with the payment obligations under Section I. Indeed, Clause VI.A expressly states that "notice in writing of any Claim" is a "condition precedent to [the Insureds] right to payment under the Polic[ies]." A1168. The Superior Court's construction contravenes New York (and Delaware) law requiring that the plain and ordinary meaning of the

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[8] The Superior Court's suggestion that under New York law, amended complaints may constitute separate claims (Ex. A at 34 n.184) still does not negate coverage for the Belin Claim, as Clauses VI.F. and as amended VI.G. deem the amended complaint and the original complaint a "single claim" due to the common nexus of facts, circumstances, situations, events or transactions. A1167-68.

policy language be applied to interpret the parties' rights and obligations. *Jin Ming Chen*, 163 N.E.3d at 450 ("[t]he language of a policy, when clear and unambiguous, must be given its plain and ordinary meaning"); *Fieldston Prop. Owners Ass'n, Inc. v. Hermitage Ins. Co.*, 16 N.Y.3d 257, 264 (2011) (courts look first to plain language of applicable policy to resolve insurance disputes).

Contrary to the Superior Court' ruling, the original Belin complaint and the amended Belin Complaint adding Kosloske must be treated as a "single Claim". Under Clauses IV.F and IV.G (as amended) of the Primary Policy, where the subsequent Claim (the Belin amended complaint) has as a "common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events or transactions," the two complaints are treated as a "single Claim" and deemed to have been made on "the date on which the Claim is first made" – June 7, 2019, within the 2018-2019 policy period. A1167 (Clause IV.F.3), and Books and Records Endorsement A1209-A1210.

Simply comparing the allegations of the original complaint and amended complaints demonstrate a "common nexus" "of facts, circumstances, situations, events or transactions". A common nexus exists when two claims "are neither factually nor legally distinct, but instead arise from common facts and where the logically connected facts and circumstances demonstrate a factual nexus between the claims." *Quanta Lines Ins. Co. v. Investors Capital Corp.*, 2009 WL 4884096,

at *14 (S.D.N.Y. Dec. 17, 2009). The Belin amended complaint not only arises from common facts, it is almost virtually identical to the original Belin complaint in most respects. Most amendments to the allegations add Kosloske's name in various paragraphs and state that he managed and directed Benefytt's business operations in establishing the distribution channels for the health plans sold through Simple Health. A946-47; A952; A958; A992-96. Thus, under the Primary Policy's express terms, the two complaints are deemed a "single Claim" made on "the date on which the Claim is first made" – June 7, 2019, within the 2018 – 2019 policy period.

The importance and rationale for such language is to avoid a whipsaw to policyholders where the original claim is not covered but amendments to the claim bring it within the scope of coverage. In *Hanover Insurance Co. v. R.W. Dunteman Co.*, 51 F.4th 779 (7th Cir. 2022), for example, the Seventh Circuit found that an original complaint was a reportable "claim," even though it would not have been covered under the 2017 policy, and rejected the claim for an otherwise covered amended claim made in 2018 because of the failure to provide notice of the original complaint during the 2017 policy period).[9] The Seventh Circuit reasoned:

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[9] *See also Apro Mgmt., Inc. v. Royal Surplus Lines Ins. Co.*, 2007 WL 1238574 (N.J. Super. Ct. App. Div. Apr. 30, 2007). There, potentially "uncovered"

*footnote continued*

> [the] reporting obligation does not depend on the specific remedies that the plaintiff requests in the underlying litigation. Nor is it relevant whether the suit could have led to a compensable loss. The policy's reporting requirement kicks in when an insured receives notice of a claim against it, including the filing of a civil action alleging any wrongful act. The estate's original complaint clearly fits the bill under the policy's broad definitions of the terms "claim" and "wrongful act," and that complaint triggered a reporting duty under the 2017 policy.

*R.W. Dunteman Co*., 51 F.4th at 786. The Seventh Circuit then found the amended complaint was not first filed in the subsequent policy period, but instead related back to the original complaint that the panel ruled should have been noticed under the 2017 policy period. *Id*. (finding that "the estate's original complaint was a reportable claim first made during the 2017 policy period. Under the policy's aggregation provisions, the broadened allegations in the [2018] amended pleading are related to and thus are treated as part of that claim.").

Similarly, in *W.C. and A.N. Miller Development Co. v. Continental Casualty Co*., 2014 WL 5812316, at *4 (D. Md. Nov. 7, 2014), *aff'd* 814 F.3d 171(4th Cir. 2016), the Fourth Circuit held that a D&O policy "does not require a 'Claim' to be

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claims in the original underlying complaint were not noticed. During the next policy period, the complaint against the policyholder was amended to include covered claims. The Appellate Division in reversing the trial court's finding in favor of the policyholder, reasoned that the original complaint was a "claim" (i.e., "a written or verbal demand for money or services received by the Insured, including service of suit, or the institution of arbitration proceedings against the Insured") and, in any event, the original lawsuit should have been reported because it was, at the very least, "an incident, occurrence or offense that may reasonably be expected to result in claims covered by the policy."

covered for it to form the basis of an 'Interrelated Wrongful Act' and, thus, to be treated as a single 'Claim'". There, an insurer denied a 2010 lawsuit where the policyholder failed to report a 2006 lawsuit, which the carrier argued was related to the subsequent lawsuit. The court held that for purposes of establishing when "Claims" are first made, the question of whether they were actually *covered* claims is irrelevant:

> Based on this [insurance policy] language, Miller argues that "[b]y excluding coverage for breach-of-contract claims, Continental cannot claim that there was a 'wrongful act' in 2006 which can be brought forward into the 2010 Lawsuit analysis." Id. at 8**. This argument incorrectly assumes that "Claims" must be covered under the Policy in order for them to be treated as a single "Claim." To the contrary, however, the Policy does not require a "Claim" to be covered for it to form the basis of an "Interrelated Wrongful Act" and, thus, to be treated as a single "Claim"**; rather, to be treated as a single "Claim" all that is required is for the triggering events to be "Claims" and "Interrelated Wrongful Acts," as those terms are defined in the Policy. See ECF No. 2-1 at 9 (the Policy's single "Claim" provision: "More than one Claim involving . . . Interrelated Wrongful Acts shall be considered as one Claim"). Here, the Policy broadly defines a "Claim" as, among other things, "a civil . . . adjudicatory proceeding . . . against [Miller or its subsidiaries]" or "a written demand for monetary damages. . . against [Miller or its subsidiaries]." ECF No. 2-1at 15. Under either of these broad definitions, the 2006 Adversary Proceeding constitutes a "Claim."

*Id.* at *4 (emphasis added).

Accordingly, the Superior Court erred in ruling that the Belin Claim was not first made during the 2018-2019 D&O policy period.

## CONCLUSION

Benefytt respectfully requests that the Court reverse the Superior Court decision regarding coverage for the Belin Claim under the 2018-2019 Policy Year and remand for further proceedings.

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Dated: March 20, 2025