EFiled: Apr 21 2025 02:45PM EDT
Filing ID 76080422
Case Number 40,2025

IN THE SUPREME COURT OF THE STATE OF DELAWARE

BENEFYTT TECHNOLOGIES, INC. (f/k/a Health Insurance Innovations, Inc.), Appellant, Plaintiff Below, v. CERTAIN UNDERWRITERS AT LLOYD'S OF LONDON, XL SPECIALTY INSURANCE COMPANY, EXECUTIVE RISK INDEMNITY, INC., and ENDURANCE ASSURANCE CORPORATION, Appellees, Defendants Below.	No. 40,2025 Court Below – Superior Court of the State of Delaware C.A. No. N21C-02-143 PRW [CCLD]

APPELLEE, DEFENDANT BELOW ENDURANCE ASSURANCE CORPORATION'S ANSWERING BRIEF

OF COUNSEL:
CARLTON FIELDS, P.A.
Michael D. Margulies, Esq. *(Pro Hac Vice)*
Charles W. Stotter, Esq. *(Pro Hac Vice)*
405 Lexington Avenue, 36th Floor
New York, NY 10174-3699
212.430.5511

MORRIS JAMES LLP
David J. Soldo, Esq. (#4309)
500 Delaware Avenue, Suite 1500
P.O. Box 2306
Wilmington, DE 19801-1494
302.888.6800

Attorneys for Appellee, Defendant Below Endurance Assurance Corporation

Dated: April 21, 2025

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Pages

Cases

Other Authorities

NATURE OF PROCEEDINGS

Appellee Endurance Assurance Corporation ("Endurance") agrees with Appellant, Benefytt Technologies Inc., now known as Benefytt Technologies, LLC ("Benefytt"), that this proceeding seeks review of the Superior Court's order granting summary judgment in favor of Endurance in an insurance coverage action, only with respect to the Superior Court's order determining that the *Belin* Amended Complaint fell outside coverage of the applicable Policy's 2018-2019 Policy Period. *See* Opening Br. 2.

SUMMARY OF ARGUMENT

1. Endurance denies that the Superior Court's holding that the *Belin* Amended Complaint was not first made in the 2018-2019 Policy Period should be reversed. Rather, the Superior Court's judgment should be affirmed for multiple, alternative reasons.

2. Endurance denies that Benefytt filed an adequate notice of circumstances in 2018 creating later coverage when the *Belin* Amended Complaint was filed after the 2018-2019 Policy Period ended. The 2018 notice failed to adequately inform Endurance of the specific facts, circumstances, or situations that might create later coverage, or the consequences that might result from those specific circumstances, as required by the Policy to amount to a notice of circumstances. Even if the 2018 notice had been adequate or clear, the *Spiewak* and *FTC* complaints attached to the notice did not give rise to the *Belin* Amended Complaint and could not support coverage of the *Belin* Amended Complaint.

a. The 2018 notice did not allow Endurance to anticipate later litigation insured by the Policy, but instead required Endurance to draw undisclosed inferences from generalized allegations that did not relate to the specific allegations in the later *Belin* Amended Complaint. Contrary to Benefytt's claims, the Superior Court did not apply "heightened" scrutiny or impose more restrictive conditions on

the notice of circumstances provision of the Policy. Instead, the Superior Court read the Policy's plain meaning, considering the Policy's provisions together as a whole.

b. Endurance denies that the Superior Court erred by determining that the *Belin* Amended Complaint did not arise from the *FTC* complaint. Rather, the Superior Court correctly determined that the two actions did not arise from each other because they involved different claims, different defendants, different requests for relief, were filed in different courts, required proof and pleading of different factual and legal elements, and shared, at most, only generalized allegations of misconduct.

3. Endurance denies that the Superior Court erred by holding that Benefytt could not relate the *Belin* Amended Complaint, filed after the 2018-2019 Policy expired, to the earlier original *Belin* Complaint, which was not reported, did not allege a **Wrongful Act** against an **Insured Person**, and merited no coverage under the Policy.[1]

a. Endurance denies that the Policy covered the *Belin* Amended Complaint because the original *Belin* Complaint was not reported and did not allege a **Wrongful Act** against an **Insured Person**. As such, the Superior Court correctly concluded that Benefytt could not use the original *Belin* Complaint as an anchor to bring the out-of-time *Belin* Amended Complaint into coverage.

[1] Bold capitalized terms refer to terms as they are defined in the Policies.

b. Endurance denies the Superior Court committed "clear error" by reading the Policy as a whole to give each provision meaning and effect.

c. Endurance denies that the Superior Court should have treated the original *Belin* Complaint, which was not reported and did not allege any **Wrongful Act** by an **Insured Person**, as a "**Claim**" that could serve as an anchor to create coverage for the later *Belin* Amended Complaint, filed after the 2018-2019 Policy Period ended.

4. Even if the Court reverses the Superior Court and places the *Belin* Amended Complaint in the 2018-2019 Policy, the Policy would still not cover the **Claim**.

a. Because the Policy only covers a **Loss** by an **Insured Person**, no coverage exists. The **Insured Person**, former Benefytt founder Michael Kosloske, suffered no **Loss** because the Settlement Agreement did not require that he contribute to any settlement payment or attribute any loss or part of the settlement payment to him.

b. The Professional Services Exclusion bars coverage of Kosloske and his alleged actions.

COUNTERSTATEMENT OF FACTS

Benefytt, formerly known as Health Insurance Innovations, Inc. operated a technology platform from which third parties sold to consumers "health insurance products" such as limited indemnity benefit policies and medical discount plans. It generated revenue from marketing and selling those products through external distributors and internal distribution channels. A126, ¶¶ 30-31.

A. Benefytt purchased Directors & Officers Policies for the 2017-2018 and 2018-2019 Policy Periods.

In 2017, Benefytt purchased a tower of primary and follow-form excess insurance policies to cover its directors and officers from certain claims and to cover the company for securities claims. Lloyd's provided the primary policy, which contained a $10 million policy limit. XL Specialty Insurance provided a $5 million policy limit above $10 million for the second level of coverage; Executive Risk Indemnity Co. provided another $5 million for the third level of coverage above $15 million; and Endurance, the Appellee here, provided an excess $5 million policy limit for claims above $20 million. The policy period ran from May 8, 2017, to May 8, 2018.

In 2018, Benefytt again purchased the same levels of primary and excess coverage for the June 8, 2018, to June 8, 2019 policy period. The insurers remain the same, except that Argonaut Insurance Company provided the third excess level of coverage. In both the 2017-2018 Policies and the 2018-2019 Policies, all of the

excess policies, including Endurance's, followed form to the terms and condition of Lloyd's Primary Policy. A1218-35.

i. The Policies only insure Claims against Insured Persons.

The Insuring Clauses of the Primary Policies promised to pay the **Insured Persons** under these circumstances, in relevant part:

> A. [Lloyd's] shall pay on behalf of the **Insured Persons**:
>
> 1. **Loss** resulting from any **Claim** first made *against the **Insured Persons*** during the **Policy Period** for a **Wrongful Act**;
>
> ***
>
> B. [Lloyd's] shall pay on behalf of the **Company:**
>
> 1. **Loss** which the **Company** is required or permitted or has agreed to pay as indemnification to *any of the **Insured Persons*** resulting from any **Claim** first made against the **Insured Persons** during the **Policy Period** for a **Wrongful Act**;

A1153 (emphasis added in italics).

Insured Persons meant, in relevant part, "all persons who were, now are, or shall be directors, officers or risk managers of the **Company** . . . ." A1157.

The Policies defined a **Wrongful Act** as "any actual or alleged act, error, omission, misstatement, misleading statement, neglect or breach of duty . . . *by any of the **Insured Persons*** . . . ." A1162 (emphasis added in italics).

Interrelated Wrongful Act meant different **Wrongful Acts**, committed by an **Insured Person**, that "have a common nexus any fact, circumstance, situation,

event, transaction or series of facts, circumstances, situations, events or transactions. A1158.

ii. The Policies only cover Wrongful Acts against Insured Persons made and noticed during the Policy Period or Wrongful Acts that interrelate to Wrongful Acts against Insured Persons during the Policy Period.

The Policies were claims made and reported policies. They applied "ONLY TO ANY **CLAIM** FIRST MADE . . . DURING THE POLICY PERIOD" provided the insurer reported the **Claim** and the Insurers received the **Claim** consistent with other policy terms. A1148.

The Policies required the **Insured**, "as a condition precedent to their rights to payment under this Policy," to provide written notice of any **Claim** "as soon as practicable after [specified corporate executives] first become[] aware of such **Claim** . . . but in no event later than . . . sixty (60) days after the end of the **Policy Period**[.]" A1168-69 (Sec. VI A). For the 2018-2019 Policies, that meant any **Claim** needed to be reported by August 7, 2019.

As the Superior Court explained, "The Policies recognize the possibility of multiple claims related to the same underlying conduct." Opening Br., Ex. A, p. 4. The Policies provided separate mechanisms to aggregate **Claims** or aggregate a "specific, fact, circumstance, or situation" that later gave rise to a **Claim**.

The Policies said that different **Claims** "having as a common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances,

situations, events or transactions shall be deemed a single **Claim**" considered made on "the date on which the **Claim** is first made." A1167 (Sec. IV F).

Similarly, the Policies treated multiple different **Claims**, made on different dates, about the same or interrelated **Wrongful Acts**, as one **Claim**, made on "the date on which the earliest **Claim**" is first made. A1167 (Sec. IV C).

iii. The Policies' Notices of Circumstances provision required Benefytt to notify Endurance about how the circumstances could later give rise to Wrongful Acts against an Insured Person.

Similarly, the Policies also treated multiple different **Claims**, made on different dates, about the same or interrelated **Wrongful Acts**, as one **Claim**, made on the date of a notice of circumstances. A1167, 1169 (Sec. IV C), (Sec. VI C(a)-(c)). A notice of circumstances occurred, as relevant here, when the Insured satisfied certain conditions. A1169. First, as relevant here, the **Insured** needed to "become aware of a specific fact, circumstance or situation which could reasonably give rise to a **Claim** or **Investigation**" in the future. A1169 (Sec. VI C 1-2). Second, the **Insured** during the **Policy Period** needed to "give written notice to Underwriters of: (a) the specific fact, circumstance, situation . . . ; (b) the consequences which have resulted or may result therefrom; and (c) the circumstances by which the **Insureds** first became aware thereof[.]" A1169 (Sec. VI C(a)-(c)). If those and other conditions are met, then any **Claim** "made subsequently arising out of such fact,

circumstance, [or] situation" is deemed "to have been made or commence at the time such notice [of circumstance] was first given." A1169 (Sec. VI C).

iv. The Policies excluded certain coverage.

The Policies also excluded coverage, in relevant part, for **Claims** "arising out of, directly or indirectly resulting from or in consequence of, or in any way involving" a **Wrongful Act** "or any fact, circumstance or situation" noticed before the Policy Period and accepted by certain other D&O policies. A1163 (III B 1).

The Policies also excluded **Claims** "arising out of, directly or indirectly resulting from or in consequence of, or in any way involving" any other **Wrongful Act** "whenever occurring, which, together with a **Wrongful Act** which has been the subject of such notice, would constitute **Interrelated Wrongful Acts**[.]" *Id.*

In addition, the Policies excluded coverage, except for **Securities Claims**, under a Professional Services Exclusion "[f]or any act, error or omission in connection with the performance of any professional services by or on behalf of the Company for the benefit of any other entity or person[.]". A1198.

B. In 2018, Benefytt purported to notice the circumstances of the *Spiewak* and *FTC* cases.

On December 13, 2018, Benefytt's outside counsel sent an e-mail to the agency that received notices under the Policies to tell them "about the FTC's recent lawsuit against HBO/Simple Health." A835-36. "There is no lawsuit against HII [Benefytt's predecessor] at this time, but we want to be proactive in case a claim

arises," the e-mail said. *Id.* Counsel then asked his colleague to e-mail the agency copies of the *FTC* and *Spiewak* lawsuits. The e-mail did not explain how these lawsuits might give rise to a **Claim** or **Loss** against any of the **Insured Person**s. *Id.* Neither Benefytt nor its counsel followed up (before this lawsuit) on the December 2018 e-mail to assert that a later **Claim** against an **Insured Person** arose from the *Spiewak* and *FTC* lawsuits referenced in the December 2018 e-mail.

i. The *Spiewak* case involved a "partnership dispute."

One of the two complaints that counsel referenced in his e-mail was a lawsuit filed by Matthew Spiewak. In October 2018, Spiewak, a health insurance general managing agent, sued Health Plan Intermediaries Holdings, LLC and Health Insurance Innovations, Inc. in Florida state court over commissions he was allegedly owed. A710. The lawsuit alleged that the defendants had breached a commission agreement with Spiewak and his company and sought a declaration about his rights to act as a general managing agent for the health insurance agency that Spiewak formed, Health Benefits One LLC.

In its December 2018 e-mail and notice of circumstances, Benefytt's counsel described the *Spiewak* case as "the partnership dispute inside the defendants of the FTC claim[.]" A835. Counsel did not assert that the *Spiewak* lawsuit would give rise to any **Claim** against any of the **Insured Persons** or the **Company**. *Id.* (The coverage afforded to the **Company** under the Policies was limited to **Securities**

Claims against the **Company**. A1153 (Sec. I C), A1161 (Sec. X).) Counsel did not explain how the *Spiewak* case could possibly give rise to a **Claim** against an **Insured Person** in the future. A835-36. Counsel did not disclose how the Insured had become aware of the case or detail the consequences that might result from the *Spiewak* case. *Id.* *See also* A1169 (Sec. VI C (a)-(c)).

ii. The *FTC* case alleged violations of the Telemarketing Sales Rule.

Counsel's December 2018 e-mail also referenced a lawsuit by the Federal Trade Commission (FTC) against several parties, including Health Benefits One, the agency that Spiewak founded, and Simple Health Plans, LLC. A835, A682. The FTC did not name Benefytt as a defendant or seek relief from it.

Also filed in October 2018, the *FTC* lawsuit alleged that the defendants had violated the Federal Trade Commission (FTC) Act and the Telemarketing Sales Rule, a regulation promulgated under the FTC Act, by engaging in deceptive telemarketing calls and practices. A704-07. The FTC sought an injunction and other relief. A708. The FTC did not name Benefytt, which had worked with Simple Health Plans, LLC, as a defendant. A682. The Complaint did not seek relief from Benefytt either. A708.

C. Benefytt failed to notify the Insurers of the original *Belin* Complaint.

On June 7, 2019, a putative class of consumers filed a putative class action lawsuit against Benefytt, successor to Health Insurance Innovations Inc., and a related entity in federal district court in Ft. Lauderdale, Florida. A891. The original *Belin* Complaint asserted claims under the Racketeer Influenced and Corrupt Organizations Act (RICO), breach of fiduciary duty, aiding and abetting fraud, and unjust enrichment. A934-39. The original *Belin* Complaint did not name any of Benefytt's directors or officers, or any individuals, as defendants. A891.

The original *Belin* Complaint alleged that the defendants participated in a criminal enterprise that defrauded consumers by leading them to believe that "limited benefit indemnity plans" and "medical discount plans" were insurance compliant with the ACA, when in fact they were not. A892, ¶ 3, A903-05, ¶¶ 43-49. The original *Belin* Complaint alleged that the defendants entered into agreements with Simple Health and its related entities to market and sell these products. *Id.*, ¶ 54. The original *Belin* Complaint also alleged that Benefytt funded, trained, monitored, and directed activities of the third-party distributors. A892, ¶ 3, A899-910. The original *Belin* Complaint alleged misstatements and omissions by defendants about ACA-compliance, customer service, and claimed defendants had deceived consumers. A892-93, ¶¶ 3, 5, A920-22, ¶¶ 122-28. It alleged the putative class members paid fees and premiums they would not have otherwise paid but for

the misrepresentations, incurred medical expenses that would have been covered if they had not been induced to buy the products, and incurred tax penalties due to non-ACA-compliant products they purchased. A926-27, ¶¶ 151-56.

The original *Belin* Complaint alleged two sub-classes of plaintiffs: (i) individuals who incurred uncovered medical expenses, and (ii) individuals who incurred a tax penalty under the ACA's individual mandate provisions. It sought from Benefytt (the entity) actual damages, treble damages under RICO, disgorgement of profits, and punitive damages.

At the time it first received the original *Belin* Complaint, Benefytt did not notify its Insurers, including Endurance, about the case. (The Policies, which only insured Benefytt from **Securities Claims**, would not have covered the case; it would not be a **Claim**. A1153 (Sec. I C), A1161 (Sec. II X)). Significantly, Benefytt did not send the Insurers a notice of circumstances suggesting the original *Belin* Complaint could later give rise to a **Claim** against an **Insured Person**. Benefytt did not inform the Insurers about the allegations, the underlying facts, the consequences that could flow from the case, or how they learned about the accusations in the original *Belin* Complaint.

The original *Belin* Complaint had been filed on June 7, 2019, within the 2018-2019 Policy Period, which ended on June 8, 2019. The Policies allowed the Insured

to either notice an actual **Claim** or submit a notice of circumstances for another 60 days, or until August 7, 2019. A1168-69 (Sec. VI A). They did not do so.

D. Benefytt notifies the Insurers of the *Belin* Amended Complaint, filed after the 2018-2019 Policy Period ended.

On July 17, 2019, after the 2018-2019 Policy Period expired, the *Belin* plaintiff amended the Complaint and for the first time named an individual defendant, Michael Kosloske, Benefytt's founder and former CEO. A946. The *Belin* Amended Complaint alleged, among other things, that Benefytt and Kosloske developed the limited benefit indemnity plans and the distribution channels, including Simple Health, through which consumers were defrauded. *Id.*, ¶¶ 3, 50-53. As a former Benefytt executive, Kosloske was likely an **Insured Person**, who may have been covered by the 2018-2019 Policies *if* the **Claim** had been made within the 2018-2019 Policy Period (although it wasn't). *See* A1157 (Sec. K 1). Even then, Benefytt did not immediately tell the Insurers about the out-of-time *Belin* Amended Complaint.

Three and a half months later, on October 31, 2019, a claims advocate for Benefytt simultaneously noticed the Insurers about the original *Belin* Complaint, filed within the 2018-2019 Policy Period, and the *Belin* Amended Complaint, filed after the expiration of that Policy Period. As Benefytt had not provided a notice of circumstance of the original *Belin* Complaint within the 2018-2019 Policy Period,

Benefytt's notice did not assert that the out-of-time **Claim** from the Amended *Belin* Complaint had arisen from (or related back to) the earlier original *Belin* Complaint.

Lloyd's and Endurance both issued letters denying coverage for the entire *Belin* case under the 2018-19 Primary and Excess Policies. A119-20, ¶¶ 10, 13. Endurance explained that it had denied the **Claim** because the Amended *Belin* Complaint fell outside the 2018-2019 Policy Period. A857.

Nearly two years later, on August 24, 2021, Benefytt informed the Insurers that the parties had reached an agreement in principle to settle *Belin*. A117-18, ¶ 6. The settlement ultimately provided for payment of $27.5 million by Benefytt alone; it specifically stated that Kosloske would not be responsible for paying any of the settlement funds. B114, ¶ I.(f). The Court approved the settlement on April 15, 2022.

E. The Superior Court grants Endurance summary judgment.

Benefytt later filed this lawsuit in Delaware Superior Court, seeking coverage for the $27.5 million settlement payment and more than $5 million in defense costs. A115. Both parties filed cross motions for summary judgment. After full briefing and oral argument, the Superior Court entered a detailed 40-page memorandum opinion and order granting Endurance, and denying Benefytt, summary judgment. (The Superior Court also disposed of other claims, not discussed in this brief, which Benefytt does not challenge on appeal.)

The Superior Court rejected Benefytt's argument that the *Belin* Amended Complaint related back to the original *Belin* Complaint. Although the *Belin* Amended Complaint, filed after the 2018-2019 Policy Period ended, made a **Claim** against former CEO Michael Kosloske, the original *Belin* Complaint did not. The Superior Court rejected a connection between the two complaints because "[t]he original claim is not covered because it doesn't make a claim against an insured person." Opening Br., Ex. A, p. 33. "The original *Belin* action only makes allegations about an insured person, Mr. Kosloske, and his activity; that's not enough here. Mr. Kosloske wasn't a named defendant in the original complaint, nor was any relief sought from him individually via that complaint. In fact, he wasn't even listed as a 'relevant nonparty.'" *Id.* at 33-34. As such, "there is nothing to relate back to that could gain coverage." *Id.* at 34.

The Superior Court also rejected Benefytt's attempt to link the *Belin* Amended Complaint, filed in 2019, to Benefytt's notice in 2018 about the *Spiewak* and *FTC* complaints. "The FTC action makes no allegations against Benefytt. And the *Spiewak* action alleges Benefytt breached a managing general agent commission agreement." *Id.* at 38. "Neither of these related to *Belin*—a consumer class action alleging Benefytt orchestrated a bait-and-switch regarding certain Benefytt products." *Id.* Because Benefytt did not write in the notice that it expected future

litigation, "it can't be interpreted as giving notice of the *Belin* action as a possible future consequence, as was required by the Policies." *Id.* at 38.

Finally, the Superior Court ruled that Benefytt could not rely on the Primary Policy's provision that the Insurer cannot deny coverage "based *solely* upon late notice" unless the Insurer can show the late notice materially prejudiced its interests. *Id.* at 39 & n.207 (emphasis added). The provision did not apply because Endurance's "denial certainly isn't 'based *solely* upon late notice.'" *Id.* at 39 (emphasis added). This appeal followed.

ARGUMENT

I. The Superior Court correctly held the *Spiewak* and *FTC* Complaints attached to Benefytt's 2018 notice did not properly notice or give rise to the Wrongful Acts against an Insured Person alleged in the *Belin* Amended Complaint after the Policy Period ended.

A. Question Presented

Did the Superior Court correctly decide that federal racketeering claims, focused on an alleged criminal enterprise in the *Belin* Amended Complaint, did not arise from earlier claims in different courts against different defendants about a "partnership dispute" over a commission agreement and regulatory claims about violations of telemarketing rules?

B. Standard of Review

The Court reviews the legal issues on summary judgment *de novo*, applying the same legal standard as the Superior Court. *See Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

Summary judgment should be granted where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Del. Super. Ct. Civ. R. 56(c). A dispute involving the meaning and application of insurance policy language is generally a question of law for the court. *See, e.g., Emmons v. Hartford Underwriters Ins. Co.*, 697 A.2d 742, 745 (Del. 1997).

C. Merits of Argument

Benefytt attempts to piece together from a patchwork of different allegations in different cases in different courts in different years against different defendants – none covered by the Policies – a link to the *Belin* Amended Complaint, filed against an **Insured Person** *after* the 2018-2019 Policy Period ended. The Superior Court correctly rejected Benefytt's effort to create insurance coverage by drawing multiple inferences to try to piece together different cases in different years against different defendants. Endurance's excess policy did not require it to engage in guesswork and link together a chain of inferences that Benefytt itself did not connect until this litigation began more than three years later. The Superior Court reached the correct legal conclusion by reading the Policy as a whole, not examining provisions in isolation. It correctly concluded that Benetytt's 2018 notice failed to properly notify Endurance of facts that gave rise to the *Belin* Amended Complaint – and could not have done so, as the *Belin* Amended Complaint did not arise from the earlier *Spiewak* and *FTC* cases. The Superior Court did not apply "heightened" scrutiny, as Benefytt claims – nor the lax, broad-brush review that Benefytt wants this Court to apply – to reach its correct conclusion. Instead, it applied the plain policy language, read as a whole, and New York law (the undisputed applicable law) to correctly conclude that the *Belin* Amended Complaint did not relate back to or arise from the 2018 notice.

1. The 2018 e-mail failed to provide notice under the Policy language and New York law.

Benfytt tries to prop up the straw man argument that the Superior Court required the 2018 notice to contain a "heightened level of specificity." The Superior Court did no such thing. It applied the Policy language, which required Benefytt to notify it of "specific" facts, circumstances, or situations within the notice of circumstances. Opening Br. 28; A1169 (Sec. VI C 2(a)). It did so "mindful to stay 'consistent with the rule that exclusion clauses should be construed narrowly and in favor of coverage.'" Opening Br., Ex. A., p. 38.

But even accepting *arguendo* Benefytt's argument that "'[n]otice requirements are to be liberally construed in favor of the insured, with substantial, rather than strict, compliance being adequate,'" Opening Br. 20, the 2018 notice falls far short.

The cases that Benefytt relies on demonstrate this. Benefytt cites the trial court opinion in *Liberty Insurance Underwriters, Inc. v. Perkins Eastman Architects, P.C.*, 929 N.Y.S.2d 200, 2011 WL 1744218, at *7 (N.Y. Sup. Ct. 2011), *aff'd in part as modified*, 958 N.Y.S.2d 90, 92 (N.Y. App. Div. 2012), where the court found the notice of circumstances adequate. But unlike the 2018 notice here, that notice consisted of multiple letters, including "a three-page, single-spaced letter" detailing specific construction problems, allegation of design errors, negotiations with sureties to honor a construction performance bond, and information that the contractor was

"attempting to deflect responsibility for the project's problems by blaming" the insured, among others. *Id.* at *2. The owner "will *undoubtedly* make claim for delays and damages that will be in the range of several million dollars," the letter said. *Id.* at *3 (emphasis added). Other letters explained that the sureties had entered into an agreement to take over the construction project, provided the Takeover Agreement, forwarded supporting documentation, and provided detailed responses to questions. A later letter warned: "It has also become clear that the Surety itself is trying to disingenuously back away from a firm completion date," and explained that only $7 million remained to complete more than $20 million in costs. *Id.* at *4. The insurer also provided coverage to respond to a subpoena from a subcontractor involved in a separate dispute over the same project. The notice "identified the owner, contractor, and contractor's surety as potential claimants for millions of dollars. It noted that the owner was litigious, that the contractor was looking to deflect blame, and that negotiations with the surety over honoring its performance bond were proceeding slowly." *Perkins Eastman Architects, P.C.*, 958 N.Y.S.2d at 92. By contrast, the 2018 notice here lacks anything close to this level of detail and fails to make the specific connection between the circumstances in the *Spiewak* and *FTC* Complaints and a later lawsuit. The 2018 notice is woefully inadequate, even applying the "liberal" construction in *Perkins Eastman Architects*.

Greenburgh Eleven Union Free Sch. Dist. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 758 N.Y.S.2d 291, 294 (N.Y. App. Div. 2003), which Benefytt also relies on, does not help it either. *See* Opening Br. 20. There, the insurer "was intimately involved in seeking a global settlement of all disputes," and its claims director testified he knew about the disciplinary proceedings that later formed the basis of two lawsuits. *Id.* at 294. In that case, there was "no dispute" that teacher disturbances led to disciplinary proceedings that led to litigation. *Id.* Such an undisputed logical or causal connection between the circumstances and the claim does not exist here.

Benefytt invokes other canons of construction to try to shore up its argument, but to no avail. It claims that if policy language "is doubtful or uncertain in its meaning, any ambiguity must be resolved in favor of the insured[.]" Opening Br. 21. But the Policy language is not ambiguous, and the Superior Court did not hold that it was. Moreover, simply because other policies may require "full particulars" or even more specificity than the "specific" facts required here, *see* Opening Br. 19, that does not mean the 2018 notice provided sufficient specific facts for notice under this Policy.

While leaning on general canons of construction of insurance contracts, Benefytt ignores other canons, discussed below, that support the Superior Court's ruling. *See infra* sec. II.C.i. Benefytt touts how notices of circumstances provisions

in claims-made policies benefit the insured, *see* Opening Br. 19-20, but ignores how the same policies also carry "the distinct advantage for the insurer of providing certainty that, when the policy period ends without a claim having been made, the insurer will be exposed to no further liability." *Perkins Eastman Architects, P.A.*, 2011 WL 1744218, at *8. This allows insurers to "better set reserves' for potential losses." *Id.*

2. The 2018 e-mail did not provide adequate notice of circumstances that would lead to a Claim.

The Superior Court concluded correctly that the 2018 notice e-mail did not notify Endurance of specific facts or circumstances that would later give rise to the claims in the *Belin* Amended Complaint. It held that the 2018 notice failed to "discuss[] facts that later gave rise to the *Belin* claim." Opening Br., Ex. A, p. 37. In fact, the 2018 notice identified no specific facts within the *Spiewak* and *FTC* complaints but simply dumped the complaints on Endurance and expected Endurance to figure out – without any assistance – some conceivable connection between the two disparate cases and a future claim.

Benefytt's opening brief argues that it sent the 2018 notice because "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[.]" Opening Br. 22. But the short, six-sentence e-mail notice says nothing of the sort. A835. At most, it says it is providing notice "to be proactive *in case* a

claim arises." A835 (emphasis added). The possibility a **Claim** might arise does not mean Benefytt anticipated a **Claim**. If it had, it would have described the likely **Claim** it foresaw.

The 2018 notice also does not explain the nature or volume of business between Benefytt and any of the *FTC* defendants. And it does not state how that business relationship would lead to a claim against Benefytt or, more relevantly, an **Insured Person** such as Benefytt's former founder, Michael Kosloske. For these reasons, the Superior Court correctly found "the 2018 Notice of Circumstances didn't state that Benefytt expected some future litigation." Opening Br., Ex. A, p. 38.

Benefytt also criticizes the Superior Court for writing that the 2018 notice did not "discuss[] facts that later gave rise to the *Belin* claim." Opening Br. 29-30, Opening Br., Ex. A, p. 37. It argues that "Clause VI.C does not require a 'discussion' – only 'written notice.'" Opening Br. 30. But the Superior Court's choice of a synonymous verb did not impose a new "heightened" standard on the Policy. Benefytt focuses on a distinction without a difference because it cannot undermine the Superior Court's cogent substantive analysis.

Benefytt also harps on the Superior Court's reasoning that neither the *FTC* nor the *Spiewack* complaints gave notice of facts "relevant to or incorporated in the *Belin* action." Opening Br., Ex. A, p. 38, Opening Br. 30. Instead, Benefytt claims

the Superior Court should have assessed whether the *FTC* or *Spiewak* complaints "*could reasonably give rise to a future claim*." Opening Br. 30 (emphasis in original). Benefytt again raises a distinction without a substantive difference. If the *FTC* or *Spiewak* complaints contained no facts either relevant to, or included in, the *Belin* Amended Complaint, it is unlikely those complaints could have been reasonably read to give rise to a future **Claim**.

3. The *Belin* Amended Complaint did not arise from the *FTC* or *Spiewak* Complaints or allege Interrelated Wrongful Acts

Under New York law, courts "engage[] in a 'side-by-side review of the underlying claims'" to determine whether actions are related. Opening Br., Ex. A, p. 25 (quoting *Lonstein Law Office, P.C. v. Evanston Ins. Co.*, 2022 WL 311391, at *8 (S.D.N.Y 2022)). Interrelated claims must share "a sufficient factual nexus," meaning the claims "arise from common facts" where the "logically connected facts and circumstances demonstrate a factual nexus" and the Claims "are neither factually nor legally distinct." Opening Br., Ex. A, p. 24 (internal citations and quotations omitted).

New York law disfavors an expansive review of relatedness "based solely upon similar categories of misrepresentations." *Nomura Holding Am., Inc. v. Fed. Ins. Co.,* 45 F. Supp. 3d 354, 372 (S.D.N.Y. 2014), *aff'd* 629 F. App'x 38 (2d Cir. 2015). As the Superior Court explained, "Making mere allegations about a company's general misconduct that may be related to another action isn't enough."

Opening Br., Ex. A, p. 3 (internal citation omitted). For this reason, courts applying New York law have held that allegations claiming that "temporally separate" and "factually and legally distinct" transactions are part of a larger scheme cannot "enmesh otherwise distinct claims." *Alvarez v. XL Specialty Ins. Co.*, 202 A.D.3d 566, 567 (N.Y. App. Div. 2022), *leave to appeal denied*, 192 N.E.3d 341 (N.Y. 2022). Similarly, claims about two architectural design failures involving different design teams, contractors, timeframes, damages, and solutions were insufficiently related even though "both may have resulted from the generalized negligence of the [a]rchitects." *Dormitory Auth. of N.Y. v. Cont'l Cas. Co.*, 756 F.3d 166, 170 (2d Cir. 2014). And claims about alleged misstatements about a licensing agreement alleged distinct, not interrelated, wrongdoing about alleged misstatements about earning, insider trading and the failure to disclose an SEC inquiry. *Home Ins. Co. of Ill. (N.H.) v. Spectrum Info. Tech., Inc.*, 930 F. Supp. 825, 848 (E.D.N.Y. 1996). Even where different claims both concerned financial statements by directors and officers, courts have held the claims unrelated where the claims involved distinct legal claims, and different wrongs to different parties. *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Ambassador Grp., Inc.*, 691 F. Supp. 618, 623-24 (E.D.N.Y. 1988).

In *Glascoff v. OneBeacon Midwest Insurance Co.*, No. 13 Civ. 1013(DAB), 2014 WL 1876984 (S.D.N.Y. May 8, 2014), the court rejected a "broad stroke" reading of an unambiguous interrelated claims provision *identical* to the one here.

The court found the claims were not irrelated because the "common facts" did not serve the purposes of the underlying lawsuits. *Id.* at *6, *7 n.5. In *Glascoff,* the FDIC as bank receiver brought claims against the insured bank president alleging deficient policies and practices leading to the bank's failure. After a D&O policy expired, a bank investor brought claims against the bank president and other directors based on control person liability, alleging that the president made false statements and misrepresentations to induce him to invest in the bank. The court concluded that the claims were not interrelated, holding the FDIC claim merely referenced the bank president's general misconduct while the investor's claim made specific allegations of fraud impacting the investor. The different actions "do not share parties, legal theories, or requests for relief . . . yet they want this Court to find the two Interrelated Wrongful Acts because both Claims ostensibly relate to [the directors'] oversight of [the bank president]. Without more, there simply is not a sufficient factual nexus between the" claims. *Id.* at *7.

Applying these principles of New York law, the Superior Court properly held that neither the *Spiewak* or *FTC* complaints, both attached to the 2018 notice, "related to *Belin* – a consumer class action alleging Benefytt orchestrated a bait-and-switch regarding certain Benefytt products." Opening Br., Ex. A, p. 38. The *FTC* complaint, alleging violations of telemarketing rules, did not name Benefytt as a defendant or make any allegation against it. *Id.* The *Spiewak* complaint named

Benefytt, but the allegations concerned "a managing general agent commission agreement," what Benefytt's own counsel described as a "partnership dispute." Opening Br., Ex. A, p. 38, A835.

The different cases made accusations against different parties. The *FTC* complaint made allegations against Simple Health and its principal, Dorfman, neither of whom were **Insured Persons** under the 2018-2019 Policies. It made no allegation against Benefytt or its former founder Kosloske, both named as defendants in the *Belin* Amended Complaint filed after the 2018-2019 Policy Period expired. A682, A1144.

The different cases also plead different causes of action and sought different claims for relief. The *FTC* complaint alleged violations of the FTC Act, the Telemarketing Act, and the Telemarketing Sales Rule. *Belin* alleged violations of RICO, based on an alleged criminal enterprise, and common law claims such as aiding and abetting breach of fiduciary duty, fraud, and unjust enrichment. The *Belin* plaintiffs needed to plead and prove entirely different elements to establish their claims, compared to the *FTC* plaintiffs. Similarly, the *FTC* complaint sought injunctive relief, rescission, reformation of contracts, restitution, and refund of monies paid, from the named Simple Health defendants (not from Benefytt or Kosloske). The *Belin* Amended Complaint sought actual damages, treble damages under RICO, disgorgement of profits, and punitive damages from the named

Benefytt and Kosloske defendants (not from Simple Health and its related entities and principal). Thus, there is no "common nexus" between the wrongful acts alleged against Simple Health and its principal in the *FTC* complaint, and those wrongful acts alleged against Benefytt and Kosloske in *Belin*.

Spiewak is even further removed from Belin. *Spiewak* alleged a dispute over distribution of brokerage commissions. It is a breach of contract action alleging Benefytt and others forced Spiewak out of a joint venture. There is no common fact between the alleged wrongful acts in *Belin* and *Spiewak*, and therefore no "common nexus" between the two.

Benefytt tries to connect the disparate actions against different defendants in different courts, raising different claims in different years by "painting in broad strokes," contrary to New York law. *See Glascoff*, 2014 WL 1876984, at *6. Courts have consistently held that claims are not interrelated based on similar "broad and generalized allegations" of the type Benefytt tries to make by, for example, comparing the prefatory, overview clauses of the *FTC* and *Belin* Amended complaints. *See* Opening Br. 34-35. Because a common nexus between the actions does not exist, Benefytt must depend on vague links, such as claiming that the "two lawsuits cast public light on Benefytt's deep involvement with the defendants targeted by the FTC[.]" Opening Br. 27. But as the Superior Court held in rejecting a similar link to another lawsuit, the *Keippel* action (a link Benefytt abandoned on

appeal): "'[A]ny specific common fact, event or circumstance' shared by the various actions' claim were used only to bolster the broad, generalized allegations of wrongdoing." Opening Br., Ex. A, p. 31 (quoting *Weaver v. Axis Surplus Ins. Co.*, 2014 WL 5500667, at *8 (E.D.N.Y. Oct. 30, 2014), *aff'd,* 639 F. App'x. 764 (2d Cir. 2016)).

Claims related "solely upon similar categories of misrepresentations," *Nomura Holding Am., Inc.,* 45 F. Supp. 3d at 372, or "temporally separate" and "factually and legally distinct" transactions considered part of a larger scheme cannot "enmesh otherwise distinct claims" into interrelated claims. *Alvarez*, 202 A.D.3d at 567. *See also Penn Traffic Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 79 A.D.3d 1729, 1731 (N.Y. App. Div. 2010) (where "two investigations involved different employees, different accounting irregularities, and different time periods," it "cannot be said that notice of the [first] investigation constitutes notice of [the second] investigation as well").

4. Benefytt waived arguments about its inadequate 2018 notice, but those arguments would not have created coverage even if properly raised.

Benefytt argues for the first time in its opening brief that Endurance had to tell Benefytt about the inadequacies in its 2018 notice. Benefytt, however, waived those arguments by failing to raise them in the Superior Court. It is axiomatic that a party waives an argument on appeal that it failed to raise in the record below. *In*

re Mindbody, Inc., *S'holder Litig.*, 2024 WL 4926910, at *48, ---A.3d--- (Del. Dec. 2, 2024). Allowing Benefytt to raise the argument now violates "fundamental fairness" and the "common sense notion that, to defend a claim or oppose a defense, the adverse party deserves sufficient notice of the claim or defense in the first instance." *Id.*

But the defense, even if timely raised, would not have changed the outcome of the case. The Superior Court did not grant Endurance summary judgment solely due to the inadequacies in the 2018 notice. Even if the notice had been crystal clear, the notice would not have created coverage because the *FTC* and *Spiewak* complaints were simply not related, as discussed above.

Benefytt cannot also disguise the inadequacies of its 2018 notice and the lack of relatedness between different cases as a "late notice" argument. Endurance did not deny coverage because Benefytt's notice was "late." It denied coverage because the only possible insured claim, the *Belin* Amended Complaint, was made *after* the 2018-2019 Policy Period ended. Even if Benefytt had provided notice on the same day the *Belin* Amended Complaint was filed, the Policy would not have covered the **Claim**. *See infra*, § II. Moreover, as discussed above, the *Belin* Amended Complaint did not relate back to any **Claim** or circumstance made during the Policy Periods. The Superior Court recognized this distinction when it turned away Benefytt's "last breath effort on notice[.]" Opening Br., Ex. A, pp. 38-39. The Policy only required

the insurer to establish "material prejudice[]" by late notice where it denied cover "based *solely* upon late notice." A1200 (emphasis added). "That doesn't save Benefytt's *Belin* claim here because the denial certainly isn't 'based *solely* upon late notice.'" Opening Br., Ex. A, p. 39 (emphasis added).

II. The *Belin* Amended Complaint, made and reported after the 2018-2019 Policy Period expired, does not relate back to an unreported claim that the Policy does not cover.

A. Question Presented

Did the Superior Court correctly determine that the *Belin* Amended Complaint, made against an **Insured Person** and reported after the 2018-2019 Policy Period expired, did not relate back to the earlier-filed, but unreported, original *Belin* Complaint, which did not allege any **Wrongful Act** by any **Insured Persons**?

B. Standard of Review

The Court reviews the Superior Court's decision on a motion for summary judgment *de novo,* applying the same standard as the trial court. *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

C. Merits of Argument

Benefytt recites selective canons of policy construction to argue that the *Belin* Amended Complaint, made after the 2018-2019 Policy ended, against an **Insured Person** (Benefytt's founder Kosloske), can relate back to a complaint filed during the 2018-2019 Policy, even though the complaint did not allege a **Wrongful Act** against an **Insured Person** and was not reported within the 2018-2019 Policy Period.

Benefytt's interpretation, applying some canons but not others, distorts the Policy's plain meaning. Benefytt tries to re-write the Policy to expand coverage

only by ignoring two well-settled canons of policy construction that hold that "[a]n insurance contract should be read as a whole, and should not be read so that some provisions are rendered meaningless." *Esurance Ins. Co. v. Burdeynyy*, 226 N.Y.S.3d 303, 308 (N.Y. App. Div. 2025). When reading the entire Policy as a whole, as the law requires, and giving each of its provisions effect, Benefytt's interpretation of the Policy falls apart.

Benefytt reads the term "**Claim**" in isolation to refer to any allegation against either Benefytt or one of its **Insured Persons** (Kosloske), whether reported or not, and whether covered by Policy's Insuring Clauses or not. The Superior Court correctly read the term "**Claim**" in the D&O Policy together with its other provisions, requiring that a "**Claim**" must allege an actual or alleged **Wrongful Act** either by an **Insured Person** (Kosloske) or the **Company** (Benefytt) involving a **Securities Claim**. A1162 (Sec. BB). The original *Belin* Complaint did neither. It did not name Kosloske as a defendant, and it did not raise a **Securities Claim** against Benefytt. A891.

The Superior Court also read the term "**Claim**" in connection with the Insuring Clauses, which limited coverage to a **Securities Claim** against Benefytt or a broader category of losses for a **Wrongful Act** by an **Insured Person** (Kosloske). A1153 (Sec. I A-B). The original *Belin* Complaint did not require coverage under

either Insuring Clause. It did not name Kosloske as a defendant, and it did not raise a **Securities Claim** against Benefytt. A891.

Finally, the Superior Court read the term "**Claim**" in connection with the Policy's claims-made reporting requirements, which stated that the Policy "applies *only* to any **Claim** first made . . . during the Policy Period provided: (1) such **Claim** or **Investigation** is reported to Underwriters in according with the terms of Clause VI.A," which in turn required that the **Insured** report the **Claim** "as soon as practicable" and no later than 60 days after the Policy Period ended. A1147 (Declarations) (emphasis added), A1168-69 (VI A 1-2). If, in fact, as Benefytt claims, the original *Belin* Complaint could be treated as a **Claim** under the Policy, then under Benefytt's interpretation of the Policy, Benefytt needed to report it within the 2018-2019 Policy Period. It did not. Having failed to report the "**Claim**," because the complaint did not require coverage, Benefytt cannot now use the unreported, uninsurable "**Claim**" in the original *Belin* Complaint as an anchor to relate back the *Belin* Amended Complaint.

Benefytt relies on two circuit court cases, but those cases support the Superior Court's ruling. Both cases required an out-of-time Claim to relate back to a covered and insurable Claim, reported within the Policy Period. *See* Opening Br. 44-46. In the first case, *Hanover Insurance Co. v. R.W. Dunteman Co.*, 51 F.4th 779 (7th Cir. 2022), the Seventh Circuit affirmed judgment *for the insurer*, which denied

coverage. It held that a later Claim could *not* relate back to an earlier Claim that the insured failed to report within the Policy Period. Although the original and second amended complaints in *Hanover* were logically connected and (unlike here) both covered by the policy, the Seventh Circuit affirmed the district court's denial of coverage because the insured failed to report the original complaint within the policy period. "The reporting requirement would be meaningless if this routine occurrence in litigation could excuse the insured's failure to report the original complaint to the insurer during the policy period in which it was filed." *Hanover Ins. Co.*, 51 F.4th at 787. Because Benefytt also failed to report the *Belin* original complaint as a "Claim," it too cannot relate back a later complaint to an unreported earlier one.

Similarly, the Fourth Circuit in *W.C. & A.N. Miller Development Co. v. Continental Casualty Co.*, 814 F.3d 171, 173 (4th Cir. 2016), affirmed denial of coverage under a "interrelated wrongful acts" provision. *See* Opening Br. 45-46. The court found the allegations in a separate 2010 lawsuit were interrelated to allegations in an earlier 2006 lawsuit. But since the policy did not cover the 2006 lawsuit, which was filed *before* the Policy Period began, relating back the 2010 lawsuit to the 2006 lawsuit could not create coverage. Instead, relating the 2010 lawsuit back to the 2006 lawsuit defeated coverage because the 2006 lawsuit did not trigger coverage because it fell outside the Policy Period. *Id.* at 178. Both cases

support the Superior Court's ruling that a later Claim must relate back to a covered and reported Claim insured by the Policy.

Benfytt's construction of the Policy also cannot stand because it would render the Policy's notice of circumstance provision toothless. The Policy provided two separate mechanisms to anchor a later, covered **Claim** to an earlier, covered **Claim** reported within an earlier Policy Period. Section IV provides that "[m]ore than one **Claim** involving the same **Wrongful Act** or **Interrelated Wrongful Acts** shall be deemed to constitute a single **Claim**" made on "the date of the earliest **Claim**." A1167 (Sec. IV C 1-2). Benefytt relies on Section IV, which governs how two separate **Claims** can be treated as a single **Claim**.[2] It argues that the *Belin* Amended Complaint should be deemed as one complaint, made on the date of the original *Belin* Complaint, because both are "**Claims**" within the Policy – even though the original *Belin* Complaint makes no allegations of **Wrongful Acts** against an **Insured Person**, triggers no coverage, and was not reported within the earlier Policy Period.

If Benefytt's interpretation of the Policy is right (it isn't), then the Policy's notice of circumstances provision would be duplicative and serve no meaningful

---

[2] Benefytt cites to Clause IV.F, rather than Clause IV.C, for its argument. *See* Opening Br. 43, A1167. But Clause IV.F. deals with a single Claim that contains common facts, circumstances or situations. It applies, for example, to a single Complaint with multiple counts based on common facts. That is not the issue here. The issue here concerns *different* complaints, an original complaint and an amended complaint filed months apart, and implicates only Clause IV.C. Benefytt also cites Clause IV.G, but that clause deals with retentions.

purpose here. The notice of circumstances provision allows an insured to notify an insurer of a "specific fact, circumstance, or situation" that does not itself constitute a **Claim** but might later give rise to a **Claim**. *See* A1169 (Sec. VI C). The provision would be superfluous and serve no purpose if the Superior Court had accepted Benefytt's interpretation of the Policy. Rather than report a notice of circumstance, an insured could rely on its expansive reading of the term "**Claim**" to capture any allegation against Benefytt, whether covered or reported.[3] The Superior Court correctly decided to read the entire Policy as a whole, giving each part meaning, rather than accept Benefytt's cramped reading viewing each term in isolation.

[3] Benefytt would have a different argument if it had filed a notice of circumstance when it received the original *Belin* Complaint within the 2018-2019 Policy Period. But it did not file any such notice of circumstance. It cannot now alter the Policy language to treat an unreported, uninsurable "**Claim**" in the same fashion as a notice of circumstance that it could have, but failed to, provide.

III. Even if the *Belin* Amended Complaint was placed in the 2018-2019 Policy Period, the Lack of a Covered Loss and the Professional Services Exclusion Would Bar Coverage.

A. Question Presented

Even if the *Belin* Amended Complaint fell within the 2018-2019 Policy Period (which it does not), does the Policy's Professional Services Exclusion and the Policy's requirement of a covered Loss still preclude coverage?

B. Standard of Review

The Court reviews the Superior Court's decision on a motion for summary judgment *de novo,* applying the same standard as the trial court." *Deloitte & Touche, LLP*, 974 A.2d at 145.

C. Merits of Argument

This Court should affirm for the reasons discussed above, but if it disagrees that the *Belin* Amended Complaint cannot be pulled back into the 2018-2019 Policy Period, it should still affirm the judgment below.

It is black-letter law in Delaware that this Court "may affirm a grant of summary judgment on grounds other than those on which the trial judge relied." *Riverbend Cmty., LLC v. Green Stone Eng'g, LLC*, 55 A.3d 330, 334 (Del. 2012). *See also Windom v. William C. Ungerer, W.C.*, 903 A.2d 276, 281 (Del. 2006) ("While the judge articulated a different rationale for her ruling in this case, we may affirm on grounds other than those relied on by her."). The record provides two

separate grounds upon which this Court can affirm the judgment, even if it disagrees with the Superior Court's reasoning about the Policy Period placement.

1. The *Belin* settlement and defense costs are not a covered Loss.

The insured bears "the burden of proving that a loss occurred and also that the loss was a covered event within the terms of the policy." *Consol. Rest. Operations, Inc. v. Westport Ins. Corp.*, 205 A.D.3d 76, 80 (N.Y. App. Div. 2022). Benefytt cannot satisfy its burden based on the undisputed facts.

As an initial point, Benefytt does not – and cannot – claim that *Belin* alleges any **Wrongful Acts** against Benefytt that would trigger coverage. The Insuring Clause only covers Benefytt itself from **Securities Claims**, and the *Belin* Amended Complaint made no **Securities Claim** against Benefytt. A946. Thus, Benefytt can only establish coverage from the D&O Policy based on alleged **Wrongful Acts** of its directors or officers. As a result, Benefytt relies on the **Wrongful Acts** in the *Belin* Amended Complaint allegedly committed by Benefytt's founder, Michael Kosloske. It claims those allegations against Kosloske trigger an insurable obligation for Benefytt to indemnify Kosloske under the Policies.

But having checked off this first Policy condition Benefytt fails to satisfy the next condition that Kosloske suffered a covered **Loss**. He did not – because it is undisputed that Kosloske paid nothing toward the *Belin* Settlement. **Loss** is defined in the Policies as "damages, judgments . . . and settlements . . . *incurred by* any of

the **Insureds** . . . ." A1158-59 (Sec. O 1) (emphasis added). The *Belin* Settlement Agreement expressly defines Consideration and Class Payment as a cash sum made by the HII Defendants, who are corporate entities. It explicitly states: "For the avoidance of doubt, *Mr. Kosloske shall not be responsible for any portion of the Consideration or Class Payment*. Other than the Consideration or Class Payment, Defendants shall owe no additional monies of any kind under this Settlement Agreement." B114, ¶ I.(f) (emphasis added). The *Belin* Settlement Agreement reiterates this fact again in the section on Settlement Consideration: "For the avoidance of doubt, *Defendant Kosloske shall not be responsible for paying any portion of the Consideration*." B122, ¶ III.(b) (emphasis added). No provision of the Settlement Agreement attributes any liability to Kosloske either.

The Settlement Agreement expressly carves out responsibility for any payment from or liability attributable to Kosloske. As no portion of the *Belin* Settlement has been "incurred" by Kosloske, there is no covered **Loss**. The settlement consideration is entirely attributable to the defendant entities for RICO claims that are not covered by the Policies. As a result, there is no covered **Loss** for the Policies to ensure.

2. The Professional Services Exclusion bars any Loss.

Coverage would fail for a second, independent reason, as well. The Policies contain a Professional Services Exclusion, precluding coverage "[f]or any act, error

or omission in connection with the performance of any professional services by or on behalf of the **Company** for the benefit of any other entity or person." A1198. The phrase "professional services" is not defined in either policy.

In New York, when "professional services" is undefined in an insurance policy, the "policy should be read in light of common speech and the reasonable expectations of a businessperson." *David Lerner Assocs., Inc. v. Phila. Indem. Ins. Co.*, 934 F. Supp. 2d 533, 541 (E.D.N.Y. 2013). In determining whether certain conduct qualifies as professional services, New York courts "[look] to the nature of the conduct under scrutiny rather than the title or position of those involved, as well as to the underlying complaint." *Id. (*quoting *Reliance Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.,* 262 A.D.2d 64 (N.Y. App. Div. 1999)). Courts hold that the "question of whether one is engaged in a professional service depends on whether those individuals 'acted with the special acumen and training of professionals when they engaged in the acts.'" *David Lerner,* 934 F. Supp. 2d at 541 (internal quotation omitted); s*ee also Mirman v. Exec. Risk Indem., Inc.*, 474 F. Supp. 3d 609, 615-16 (S.D.N.Y. 2019) (same). When the conduct at issue involves "go[ing] beyond a lay person's knowledge and skill," the conduct constitutes professional services. *See Mirman*, 474 F. Supp. 3d at 616. It is of no consequence that the profession at issue is not a "traditional" profession as courts have found professional services for, among other services, the sale of life insurance policies,

claims-handling, and records keeping at a nursing home. *See David Lerner*, 934 F. Supp. 2d at 542 (collecting cases); *Westchester Fire Ins. Co. v. Metro. Life Ins. Co.*, 280 A.D.2d 331 (N.Y. App. Div. 2001) (applying professional services exclusion to conduct by life insurance company employees). Moreover, if the underlying action "alleges the existence of facts clearly falling within [the] exclusion, and none of the causes of action . . . could exist but for the existence of the excluded activity or state of affairs, the insurer is under no obligation to defend the actions." *Beazley Ins. Co., Inc. v. ACE Am. Ins. Co.*, 880 F.3d 64, 71 (2d Cir. 2018) (affirming application of exclusion to claims against NASDAQ directors and officers for technology and other failures in trading platforms).

In *David Lerner*, the insured, an underwriter for real estate investment trusts, sought coverage for underlying actions alleging that it misrepresented the value of multiple shares in the trusts. 934 F. Supp. 2d at 537. The insurer denied coverage based on a professional services exclusion. *Id*. at 538. The court found it "clear that the only reasonable interpretation of 'professional services' is that individuals engaged in the due diligence and sale of financial products are engaged in professional services," that the insured's actions and inactions fell "squarely within a common-sense understanding of 'professional services,'" and that "[i]f the sale of life insurance is considered a professional service, then surely . . . the sale of investment products must also be classified in the same manner." *Id*. at 541-42.

So too here. The *Belin* Amended Complaint alleged Benefytt developed limited benefit indemnity plans and medical discount plans, and the distribution channels to sell these plans to consumers, leading consumers to believe the products were compliant with the ACA when they were not. A946, ¶¶ 1, 3. Benefytt and Kosloske are alleged to have developed the products to be sold and the distribution channels, trained sales agents, and monitored compliance, training and administrative functions, including sales calls. A993, ¶ 210(a) – (m). The *Belin* Amended Complaint alleged that Kosloske specifically "approved the products to be sold; recruited agents . . . ; developed distribution channels . . . ; approved the [Defendants'] financing of those [channels]; and participated in the operation and management of the Enterprise's compliance, training and administrative functions." *Id.*, ¶ 211. As in *David Lerner*, sales of the limited benefit indemnity products, like the sale of investment products, falls squarely within a common-sense understanding of "professional services." The allegations in *Belin* could not exist "but for" those professional services provided by Benefytt and Kosloske. Accordingly, the Professional Service Exclusion applies and bars coverage.

If the Court finds the **Claim** falls within the 2018-2019 Policy Period, it should nevertheless affirm the Superior Court's judgment on either of these alternative grounds.

CONCLUSION

"The purpose of a claims-made policy is to allow the insurance company to easily identify risks, allowing it to know in advance the extent of its claims exposure and compute its premiums with greater certainty. Because the insurer has a clearer picture of its risk exposure, it in turn may offer insureds more-available and less-expensive policies." *Hanover Ins. Co.*, 51 F.4th at 785 (internal citations and quotations omitted). Benefytt bargained for such a "claims made" Policy covering specific **Claims** made during the Policy Period and earlier interrelated claims noticed within the earlier Policy Period. It now wants to rewrite the Policy to expand its coverage for **Claims** made outside the Policy Period and revamp the risks Endurance agreed to accept and the benefits Endurance agreed to provide.

The Superior Court correctly rejected Benefytt's attempt to re-write the Policy. It held that Benefytt could not create coverage by connecting together, through inferences, three different cases in different courts alleging different claims and seeking different relief from different defendants. It also held that the Policy, read as a whole, did not support Benefytt's attempt to relate the *Belin* Amended Complaint, filed after the 2018-2019 Policy Period ended, to the earlier, unreported, and uninsurable *Belin* original complaint. The Superior Court properly entered judgment for Endurance. For the reasons set forth in this brief, the Court should affirm the judgment.

OF COUNSEL:

Admitted *Pro Hac Vice:*

Michael D. Margulies, Esq.
Charles W. Stotter, Esq.
CARLTON FIELDS, P.A.
405 Lexington Avenue, 36th Floor
New York, NY 10174-3699
212.430.5511
mmargulies@carltonfields.com
cstotter@carltonfields.com

MORRIS JAMES LLP

/s/ *David J. Soldo*
David J. Soldo, Esq. (Bar No. 4309)
500 Delaware Avenue, Suite 1500
P.O. Box 2306
Wilmington, DE 19801-1494
302.888.6800
dsoldo@morrisjames.com

Attorneys for Appellee/Defendant Below
Endurance Assurance Corporation

Dated: April 21, 2025