Your Coverage Advisor

Don't Lose on a Technicality:
The Policyholder's Playbook on Policy Conditions

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IN THIS ISSUE

Don't Lose on a Technicality: The Policyholder's Playbook on Policy Conditions ...... page 1

Insurance Cases to Watch in 2019 .... page 6

General Contractors Beware: Using Endorsements to Cover Your "Own Work" in the Wake of the Ohio Northern Univ. Decision .... page 7

Wisconsin Follows "Cause Theory" in Determining Number of Occurrences .... page 9

Attorney Highlights...... page 12

The conditions can be a particularly dangerous part of an insurance policy: they are often overlooked until it's too late and an otherwise covered claim is rejected because of a condition violation. When a claim arises, the policyholder has a troublesome or even devastating loss on its hands. A building has been lost in a fire, a bodily injury suit has been filed, or the policyholder discovered that a trusted employee has been stealing company funds for years. Navigating the fine print of an insurance policy is the last thing on the policyholder's mind.

The good news is that, while condition violations *can* have a preclusive effect on an insurance claim, in most circumstances they do not. Below, we discuss five conditions that policyholders should be familiar with, including tips on best practices to avoid issues with conditions.

1. Notice

As policyholder lawyers, we cannot stress enough the importance of getting notice out to all potentially-applicable insurers as soon as possible. Policyholders may not recover amounts incurred

(Continued on page 2)

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prior to giving notice. And, depending on the applicable state law, late notice can bar coverage entirely.

Almost all policies require that the policyholder send notice "promptly," "as soon as practicable" or "immediately." Generally, these terms mean within a reasonable time after a policyholder discovers facts resulting in a potential occurrence. Whether notice is "reasonable" is a question of fact – there are no bright-line rules.[1] Depending on the specific facts, a court may find notice years after the occurrence reasonable or notice very shortly after the occurrence unreasonable. The only universal guideposts are that a policyholder should provide notice (i) as early as possible, (ii) to all known, potentially applicable insurers, including primary, umbrella, and excess insurers, and (iii) to include policies under which the policyholder may be an additional insured.

If a court determines that notice is "late," – that is, not given within a reasonable time, – the consequences vary. In most jurisdictions, including Ohio, unless the insurer was actually prejudiced by late notice, the claim will not be barred.[2] What is actual prejudice is a question of fact. Most often, the policyholder has defended itself, and nothing would have changed had the insurer been notified sooner.

While late notice may not bar coverage, however, the policyholder may have a difficult time recovering costs incurred prior to notice, also called "pre-tender costs." Notably, in some jurisdictions if earlier notice would have been futile or if notice was late because, despite diligently searching, the policyholder was not aware of the existence of the coverage sooner, pre-tender costs may be recovered.[3]

On the other hand, some jurisdictions do not apply a prejudice standard to late notice issues – rather, coverage is barred if a court determines that notice was unreasonably late. New York is a notable example.[4]

The best practice to avoid notice issues is to notify all applicable insurers as early as possible – preferably prior to incurring any costs. Even if notice is late, all is not lost; in most jurisdictions the claim will not be barred and should not serve as a basis for a claim denial. Seek guidance from a coverage attorney to help navigate late notice issues.

While this condition can be concerning and is frequently asserted by insurers as a bar to coverage, it rarely is.

2. Cooperation

Another condition that often causes trouble for policyholders is the duty to cooperate. A typical provision might provide:

- **You must cooperate with us in the investigation or settlement of the claim or defense against the suit.**
- **The insured must cooperate with the insurer in all matters pertaining to this Coverage Section as stated in its terms and conditions.**
- **The insured shall cooperate with the company and, upon the company's request, shall attend hearings and trials, and shall assist in effecting settlements, securing and giving evidence, obtaining the attendance of witnesses and in the conduct of suits.**

While this condition seems straightforward, and often is, insurers frequently raise violation of this duty as a coverage defense. This condition often arises under liability policies where the insurer is not actively defending a

(Continued on page 3)

third-party claim against a policyholder, but rather is conducting a particularly lengthy investigation or where the policy is subject to a large retention or deductible. Insurers who raise this condition as a defense may assert that the policyholder failed to provide sufficient responses to its requests for information or failed to advise it of settlement discussions, mediations or other important case developments.

Policyholders do have a duty to cooperate and absolutely should cooperate with an insurer's reasonable, good faith requests. The insurer needs to have copies of the underlying claim file and invoices for payment, for example. Requests that are unreasonable are another matter. For example, the policyholder should not have to repeatedly provide multiple versions of voluminous claim information to the insurer each time a new adjuster appears on the file. Policyholders should not have to turn over proprietary business information that is wholly unrelated to the claim. Indeed, such facts can lead to allegations of bad faith claims handling conduct.[5]

Like notice, while this condition certainly can be an issue, it is only detrimental if the insurer can establish that it was actually prejudiced by the policyholder's alleged failure to cooperate. Further, it is important to remember that an insurer cannot rely on a violation of a policy condition to deny coverage if it has breached the duty to defend or has otherwise denied coverage. In other words, if an insurer has refused to defend you or has denied your claim, it waives its right to rely on policy conditions, including the cooperation condition.

3. Consent and Voluntary Payments

The next commonly-raised condition is consent. The consent condition comes in various forms, but generally states that insurers do not have to pay what the policy refers to as "voluntary payments" (i.e., payments for which the policyholder has not obtained the insurer's consent). This condition is raised in various contexts, such as when a policyholder pays certain costs prior to notice or settlements when the insurer was not involved. Consent issues also arise in the context of environmental cleanup administrative actions when a policyholder enters into consent agreements without the insurer's input. While this condition can be concerning and is frequently asserted by insurers as a bar to coverage, it rarely is.

First, such payments are often not truly "voluntary." For example, insurers argue that amounts paid by policyholders to investigate and cleanup a superfund site in an EPA CERCLA action are "voluntary" because they are incurred pursuant to a "consent" agreement to investigate and study the issue. Any policyholder who has been through this experience, however, will tell you their actions were anything but "voluntary" – they really have no choice in the matter. Non-compliance with "consent" decrees subjects policyholders to onerous penalties and fines. This is why nearly all courts that have addressed this matter have rejected the insurers' argument in this regard.[6]

Second, like the cooperation condition, an insurer can only defeat coverage if it can show prejudice.[7] And prejudice is rare.

Further, an insurer that has failed to defend or has denied coverage waives its right to rely on conditions (particularly true as it relates to the consent condition): an insurer that has abandoned its policyholder cannot then complain that the policyholder failed to seek its consent prior to paying a settlement.[8] Instead, the insurer is obliged to indemnify the policyholder for any reasonable settlement, which is defined to include any settlement that is not fraudulent.

(Continued on page 4)

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As it relates to the consent condition, the best defense is a good offense: a policyholder that keeps its insurer up to date regarding the status and key developments of its claim, even if the insurer is not defending, can generally avoid running afoul of this condition.

4. Loss Payable/Attachment

Umbrella and excess coverage is critically important where the claim at issue may exceed the primary policy's limit, particularly where the underlying claims are mass tort liabilities. Policyholders may think that because the primary insurer is defending and/or paid its portion of indemnity, the transition to excess coverage will be smooth. More often than not, however, policyholders are surprised to find themselves battling with their umbrella and excess insurers. A common dispute arises from the loss payable/attachment provision that can be found as a condition set forth in most umbrella and excess policies:

- **Liability under this policy with respect to any occurrence shall not attach unless and until the insured, or the insured's underlying insurers, shall have paid the amount of underlying limits on account of such occurrence.**
- **Liability of the company with respect to any one occurrence shall not attach unless and until the insured, the company on behalf of the insured, or the insured's underlying insurer, has paid the amount of retained limit.**

This condition gives rise to several questions: Does the policy attach only after the primary limits are actually paid, or when the liability is simply incurred? Does it matter who pays – the insured or the primary insurer? What if the primary insurer is insolvent? What if there's a gap between the settlement amount paid by the primary insurer and primary limit? An entire paper could be devoted to these issues, which is beyond the scope of this article. However, three things bear mentioning here.

First, the seminal case regarding whether a settlement for less than policy limits may properly exhaust a policy is *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665 (2nd Cir. 1928). There, the excess insurer contended the below-limits settlement with the primary insurer prevented the underlying policy from exhausting as defined in the excess policy, effectively eliminating coverage. The court rejected this argument, holding that the insurer "had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies." Many jurisdictions follow the rationale set forth in *Zeig* and hold that it does not matter who, how, or how much is paid to exhaust the primary policy: the excess insurer is still obliged to cover the loss exceeding the underlying limit.[9] But some jurisdictions have reached a different result.[10]

> Umbrella and excess coverage is critically important where the claim at issue may exceed the primary policy's limit, particularly where the underlying claims are mass tort liabilities.

Second, generally speaking, the fact that a primary insurer is insolvent is insufficient to require an umbrella or excess insurer to "drop down" and defend an insured.[11]

(Continued on page 5)

Don't Lose on a Technicality: The Policyholder's Playbook... **(Continued from page 4)**

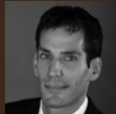
However, courts have required this of excess and umbrella insurers where the specific policy language at issue expressly requires it, or if the court finds the language to be ambiguous and construes it against the insurer. The outcome of these decisions depends on the policy language describing the attachment points and requirements for proper exhaustion.[12] Nonetheless, many courts refuse to require excess insurers to "drop down," even where primary insurers are insolvent, frequently noting the low premiums charged for the higher layers of coverage.

Finally, even once triggered, excess/umbrella insurers may challenge the reasonableness and proper application of a primary insurer's payments. The court in *Matter of Viking Pump, Inc.*, 52 N.E.3d 1144 (N.Y. 2016) addressed this argument, for example. The court found that testimony regarding the defense strategy and the reasonableness of the underlying asbestos claims' settlements, and compliance with the governing trigger of coverage, was sufficient to meet the burden. On the other hand, courts will not deem an underlying policy exhausted when the underlying insurer has merely "burned" its limits. Excess/umbrella insurers also may argue that the primary policy limits are not properly exhausted if the claim payments were allocated unreasonably or contrary to the governing law. However, if the primary insurers' allocation is objectively reasonable, an excess/umbrella insurer should not be permitted to retroactively re-allocate claims and dictate what allocation method the primary insurers should have used.

Coverage issues involving umbrella and excess policies are among the most complex in insurance law and often require guidance from experienced coverage counsel. A practical takeaway, however, is to ensure that any excess and umbrella insurers whose policies may be triggered by the underlying claims are involved early and notified of key developments in the case. If all players are involved early, future transition issues may be easier.

(Continued on page 11)

Insurance Cases to Watch in 2019



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2019 looks to bring substantive and compelling new developments in insurance law around the country. Take the following, for example:

- **The California Supreme Court is poised to decide whether a policyholder must horizontally exhaust all lower-level insurance policies at each coverage level and for each year before it can access its higher-level policies. The trial court held that such complete horizontal exhaustion was necessary to access the higher-level coverage, but the court of appeals disagreed and reversed the trial court in part, holding that it depended on the language of each higher-level insurance policy. The opinion from which the appeal to the Supreme Court was taken is *Montrose Chem. Corp. v. Superior Court*, 14 Cal.App.5th 1306, 222 Cal.Rptr.3d 748 (2017), *as modified* (Sept. 8, 2017), *review granted*, 225 Cal.Rptr.3d 796, 406 P.3d 327 (2017). To date, briefing appears to be complete, but oral argument remains to be scheduled.**
- **The Connecticut Supreme Court will decide whether the "unavailability of insurance rule" applies under Connecticut law. The rule provides that defense and indemnity costs cannot be prorated to an insured for periods where insurance was unavailable to the insured. The trial court held that the rule applied, and the court of appeals agreed. The opinion from which the appeal to the Supreme Court was taken is *R.T. Vanderbilt Co., Inc. v. Hartford Accident & Indem. Co.*, 171 Conn.App. 61, 156 A.3d 539 (2017), *review granted in part*, 327 Conn. 923, 171 A.3d 63 (2017). To date, briefing continues, and oral argument remains to be scheduled.**
- **The Georgia Supreme Court is considering whether correspondence from an insured to its insurer put the insurer on sufficient notice of an opportunity to settle a claim within policy limits. The insurer did not settle the claim before the insured obtained a civil judgment for over five million dollars in excess of the policy limits; and the insured pursued the insurer for that full amount under the theory of negligent or bad faith refusal to settle. The trial court held that the correspondence was too vague to constitute sufficient notice of an opportunity to settle and, therefore, granted the insurer summary judgment. The court of appeals reversed the trial court in part, holding that the correspondence created a genuine issue of material fact for trial. The opinion from which the appeal to the Supreme Court was taken is *Hughes v. First Acceptance Ins. Co. of Georgia, Inc.*, 343 Ga.App. 693, 808 S.E.2d 103 (2017), *cert. granted* (June 4, 2018). Briefing appears to have concluded in October 2018, but oral argument remains to be scheduled.**

Although these are matters of law specific to each state, the decisions will no doubt serve as guideposts in the development of the law in other jurisdictions. Stay tuned . . . ■

General Contractors Beware: Using Endorsements to Cover Your "Own Work" in the Wake of the *Ohio Northern Univ.* Decision

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While general contractors oversee entire construction projects, specialized subcontractors, such as masons, roofers, electricians and other trades, often perform those portions of the projects falling within their scope of work. Despite its use of skilled subcontractors, the general contractor remains responsible for the project as a whole. This responsibility has important implications regarding the general contractors' insurance coverage in states like Ohio, where the Ohio Supreme Court has ruled that, even where a general contractor utilizes subcontractors, the entire construction project is the general contractor's work. *Ohio N. Univ. v. Charles Construction Servs., Inc.*, 2018-Ohio-4057. Accordingly, Ohio law may prevent general contractors from obtaining coverage under their own standard CGL policies for damage to any portion of a project, even if a subcontractor performed the defective work. This article provides a brief overview of the *Ohio Northern* decision and its predecessor, *Westfield Ins. Co. v. Custom Agri Sys., Inc.*, 133 Ohio St.3d 476, 2012-Ohio-4712 and identifies potentially-available endorsements that cover gaps in coverage related to the *Ohio Northern* and *Custom Agri* decisions.

A. Claims for Faulty Construction Under Ohio Law.[1]

In 2012, the Ohio Supreme Court held that an insured's claims for defective construction or faulty workmanship arising from its own work are not covered under a commercial general liability policy: they are "not claims for 'property damage' caused by an 'occurrence'…" *Westfield Ins. Co. v. Custom Agri Sys. Ins.*,133 Ohio St.2d 476, 2012-Ohio-4712 at Syl. The *Custom Agri* Court, however, cited with approval previous Ohio cases that found coverage for consequential damages arising from the defective work, subject to the conditions and exclusions in the policy. For example, under *Custom Agri*, if a policyholder defectively installed a roof on a building and the defective roof allowed water to leak in the building and damage the top floor, the cost to repair the roof (the defective work itself) would not be covered, but the water damage to the top floor (the consequential damages) would be covered.

Custom Agri left open the question of whether defective construction performed by a subcontractor (as opposed to the general contractor itself) could be a covered "occurrence" under the general contractor's liability policy. In *Ohio Northern*, the Ohio Supreme Court answered this question. At issue in *Ohio Northern* was property damage arising from a subcontractors' faulty work. The general contractor sought coverage under its commercial general liability policy, its insurer denied the claim, and litigation ensued. The question ultimately decided by the Ohio Supreme Court was whether the general contractor's liability policy covered the costs to repair or replace its subcontractor's defective work. Or, in other words, whether *Custom Agri*—which held that repair of a policyholder's **own work** was not covered—applied to bar coverage of a **general contractor's** claim for a subcontractor's faulty work. The Court found that *Custom Agri* applied and that the general contractor could not recover under its policy for damages arising from the subcontractor's faulty work.

B. General Contractors Should Consider Additional Coverage in Light of *Ohio Northern*

Coverage is available to general contractors for

(Continued on page 8)

General Contractors Beware... **(Continued from page 7)**

the gaps in coverage that the Ohio Supreme Court's decisions in *Ohio Northern* and *Custom Agri* identified. Most insurance companies have the ability to offer coverage for property damage caused by a subcontractor through an endorsement (i.e., an extension of coverage) to the general contractor's policy; however, the coverage that insurers offer is not standard across the industry. Some examples of insurers' individual endorsements are:

Cincinnati Insurance - GA 4315 03 12 Injury or Damage To Or Resulting From Your Work And Injury Or Damage Resulting From Your Product. This coverage form states that damage from completed work performed by higher-tiered subcontractor is property damage caused by an occurrence.

Westfield Insurance - CG7121 Damage to Your Work. This form provides coverage for property damage that is the result of work performed by a subcontractor as long as the subcontractor is not a Named Insured and the property damage is unexpected or unintended.

CNA - CNA 74906 1 15 Damage to Subcontractors' Work Endorsement. This policy form provides coverages for the Named Insured due to unintended or unexpected property damage that is the result of work performed on the Named Insured's behalf by a subcontractor, consists of your work performed by the subcontractor, or for other property damaged by the subcontractor's work.

If you utilize subcontractors, it is imperative that you review the language of your current insurance policy or consult with your current insurance broker about the *Ohio Northern* decision to confirm that you have the proper coverage. ■

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[1]For a more complete analysis of the *Ohio N. Univ.* decision, please refer to Ohio Supreme Court Narrows Coverage for Construction Defect Claims, Amanda Leffler and Anastasia Wade, Ins. Cov. Newsletter Fall 2018, Vol. XXI.

Wisconsin Follows "Cause Theory" in Determining Number of Occurrences

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In *Secura Insurance v. Lyme St. Croix Forest Company, LLC*, No. 2016AP299 (Oct. 30, 2018), the Wisconsin Supreme Court determined the number of occurrences arising from a large forest fire that took place in May of 2013. The fire in question allegedly began in a piece of logging equipment and quickly spread to an adjacent grass pile and eventually the surrounding forest. In total, the fire consumed 7,442 acres over three days, damaging the real and personal property of many individuals and businesses.

Ray Duerr Logging, Inc., the owner of the piece of equipment that ignited and caused the fire, sought coverage for damage to third-party property under a commercial liability policy issued by Secura. That policy contained a general aggregate limit of $2,000,000, but a sub-limit of $500,000 per occurrence "due to fire, arising from logging operations…" The policyholder took the position that the fire constituted several occurrences; specifically each time the fire spread to a new property represented a new occurrence. Secura, in turn, argued that the entire fire constituted a single occurrence.

In finding that the fire was a single occurrence, the court noted that Wisconsin followed the "cause theory" as opposed to the "effect theory" when determining whether an event is a single occurrence or

(Continued on page 10)

Wisconsin Follows "Cause Theory" in Determining Number of Occurrences... **(Continued from page 9)**

multiple occurrences. Under the cause theory, "'where a single, uninterrupted cause results in all of the injuries and damage, there is but on accident or occurrence.'"[1] Alternatively, "the effect theory suggests that the wording 'each accident' 'must be construed from the point of view of the person whose property was injured.'"[2]

The policyholder's position – that each time the fire spread to a new property represented a new occurrence – fit with the effect theory of causation, as from the standpoint of each property owner, the damage to their own property was a new, separate accident. However, the court could not square this view with the cause theory. Here, the cause of the fire in question all traced back to the fire in the logging equipment. Further, the court noted that while the fire spread over a large area, it was all within the same geographic area. And the fire was continuous – there was no temporal break over the three days that the fire spread. In sum, there was no way that the fire could be considered anything other than a single cause, meaning that coverage under Secura's policy was limited to a single, $500,000 occurrence limit.

This case highlights the importance of purchasing adequate occurrence limits. Here, while the policyholder purchased $2,000,000 in coverage, $1,500,000 of the limits was unavailable due to the triggering of the applicable per-occurrence limit in the policy. ■

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[1] *Secura* Insurance at P21 (quoting *Welter v. Singer*, 376 N.W.2d 84 (Ct. App. 1985)).

[2] *Id.* At P22 (quoting *Anchor Cas. Co. v. McCaleb*, 178 F.2d 322, 324 (5th Cir. 1949)).

5. Contractual Limitations

Last but not least, one condition that tends to creep up on policyholders limits the time period for filing a coverage lawsuit condition – Legal Action Against Us:

- **The insured may not bring any legal action against the insurer involving loss unless the insured has complied with all terms of this Coverage Section and unless brought within two (2) years from the date of the loss.**
- **If any limitation in this Condition is prohibited by law, such limitation is amended so as to equal the minimum period of limitation provided by such law.**

This condition can be problematic under certain circumstances.

First, despite challenges by policyholders, contractual limitations periods are generally enforceable, even if the period is one or two years.[13] However, there may be a waiver of a contractual time limitation provision by the insurance company in certain cases. Second, this condition can catch policyholders off guard based on what event triggers the limitations period: the date of loss or the date the claim was denied.[14]

The key take away is to review your policy shortly after your loss to determine if it contains a limitations period and, if so, what event starts the clock. Further, if the deadline is approaching and the insurer hasn't provided a coverage determination or if the claim is in dispute, the policyholder should obtain a written extension of the policy's limitations period for filing suit. Extensions are commonly provided in these cases.

In sum, while conditions can be technical and should be treated with care from the start, condition violations should not always result in denied claims. When it comes to conditions, most often the best defense is a good offense. ■

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[1] *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 95 Ohio St.3d 512, 2002-Ohio-2842, 769 N.E.2d 835.

[2] *Ferrando v. Auto–Owners Mut. Ins. Co.*, 98 Ohio St.3d 186, 2002-Ohio-7217, 781 N.E.2d 927; *Ormet Primary Aluminum Corp. v. Employers Ins. of Wausau*, 88 Ohio St.3d 292 (2000).

[3] *See, e.g., Fiorito v. The Superior Court of San Diego Co.*, 226 Cal.App.3d 433, 438 (1990); *Shell Oil Co. v. National Union Fire Ins. Co. of Pittsburgh*, 44 Cal.App.4th 1633 (1996).

[4] *Argo Corp. v. Greater N. Y. Mut. Ins. Co.*, 827 N.E.2d 762 (N.Y. 2005); *Security Mut. Ins. Co. of N.Y. v. Acker-Fitzsimons Corp.*, 293 N.E.2d 76 (N.Y. 1972); *Utica First Ins. Co. v Vazquez*, 92 A.D.3d 866 (N.Y. App. Div. 2012); In re *Nationwide Mut. Ins. Co. (Mackey),* 808 N.Y.S.2d 797 (N.Y. App. Div. 2006); *Atlantic Gen. Contracting, Inc. v. U.S. Liab. Ins. Group,* 806 N.Y.S.2d 225 (N.Y. App. Div. 2005).

[5] *Zaycheck v. Nationwide Mut. Ins. Co.* (Ohio Ct. App., Summit County June 29, 2007), No. 23441, 2007 Ohio App. LEXIS 3065, *14 (question of fact as to whether insurer's repetitive requests for documentation that the insured had already provided were made in bad faith).

[6] *SnyderGeneral Corp. v. Century Indem. Co.*, 113 F.3d 536, 539 (5th Cir. 1997) (Texas law); *Hazen Paper Co. v. U.S. Fid. & Guar.,* 555 N.E.2d 576 (Mass. 1990); *Farmland Indus., Inc. v. Republic Ins. Co.,* 941 S.W.2d 505 (Mo. 1997).

[7] *Ferrando v. Auto-Owners Mut. Ins. Co.*, 98 Ohio St. 3d 186, 781 N.E.2d 927, Syll. (2002) (defenses based on violation of consent-to-settle provisions may be rebutted by proof that the insurer was not prejudiced); *Abercrombie & Fitch Co. v. Federal Ins. Co.*, No. 09-3096, 2010 U.S. App. LEXIS 5282 (6th Cir. March 11, 2010).

[8] *Sanderson v. Ohio Edison Co.*, 69 Ohio St.3d 582, 587 (1994) ("Neither the insured nor the injured party is required to perform conditions in a policy made vain and useless by reason of the insurer's prior breach.").

[9] *The Continental Ins. Co. v. Northern Ind. Public Service Co.*, No. 2:05-CV-156, 2011 WL 1322530 (N.D. Ind. April 5, 2011)("it appears the recent trend in Indiana law is to accommodate claims against the excess insurer after the claim has been settled with the primary insurer. To the extent that [the insured] settled with the primary insurers for less than the applicable limits, [the insured] is considered self-insured up to the policy limits").

[10] *Qualcomm, Inc. v. Certain Underwriters At Lloyd's, London*, 161 Cal. App. 4th 184 (4th Dist. 2008) (CGL policy exhausted only after "the insurers under each of the Underlying Policies have paid or have been held liable to pay the full amount of the Underlying Limit"); *Comerica Inc. v. Zurich American Ins. Co., et al.*, 498 F. Supp. 2d 1019, 1032 (E.D. Mich. 2007) (requiring actual payment of limits by primary insurer to trigger coverage under excess policy).

[11] *Revco D.S., Inc. v. Government Employees Ins. Co.*, 791 F. Supp. 1254 (6th Cir. 1991).

[12] *See Zurich Ins. Co. v. Heil Co.,* 815 F.2d 1122, 1125 (7th Cir.1987) (listing cases).

[13] *Hounshell v. Am. States Ins. Co.* (Aug. 5, 1981), 67 Ohio St.2d 427, 429-430, 21 O.O.3d 267, 424 N.E.2d 311.

[14] *Bethel Village Condominium Assn. v. Republic-Franklin Ins. Co.*, No. 06AP-691 2007 WL 416693 (Ohio Ct. App. 10th Dist. Feb. 8, 2007).

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Attorney Highlights

Jodi Spencer Johnson was appointed as co-chair of the Insurance Recovery Practice Group.

On December 3-7, 2018, **Paul A. Rose** taught a course titled "How the US Constitution Shapes Individual Rights" at the Lifelong Learning program in San Miguel de Allende, Guanajuato, Mexico.

Amanda M. Leffler, Paul A. Rose, Stacy RC Berliner, and **Joseph P. Thacker** were selected as 2019 Ohio Super Lawyers for Insurance Coverage.

Lucas M. Blower, Andrew W. Miller, Gabrielle T. Kelly and **Nicholas J. Kopcho** were selected as 2019 Ohio Super Lawyers Rising Stars for Insurance Coverage.

Amanda M. Leffler was selected as a Top 50 Ohio Female Attorney and a Top 25 Cleveland Female Attorney for 2019 by Super Lawyers, a service of Thomson Reuters Legal Division.

Andrew W. Miller will speak at a roundtable titled "The Data Driven Lawyer - Causation, Genomics, and the Impact on Insurance Coverage" at the ICLC Conference on March 1, 2019.

Lucas M. Blower spoke on "Cyber Insurance" and **Anastasia J. Wade** spoke on "Insurance Coverage for When Your Company Goes Viral" at the Akron Bar Association on January 29, 2019.

Save the Date

7th Annual Insurance Coverage Conference
Thursday, October 10, 2019

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