No. 25539 -- Paul Mitchell, as executor of the Estate of Mary Mitchell v. Anthony George Broadnax, AND Naomi S. Mitchell and Geraldine O'Dell v. Anthony Broadnax

Starcher, J., concurring:

FILED
April 21, 2000
DEBORAH L. McHENRY, CLERK
SUPREME COURT OF APPEALS
OF WEST VIRGINIA

RELEASED
April 21, 2000
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I concur with the majority's analysis of our uninsured motorist insurance statute. I agree that the statute requires an insurance carrier to demonstrate that it has "appropriately adjusted" the premiums for an automobile insurance policy (which ostensibly provides comprehensive coverage) to reflect that the coverage has in fact been reduced or eliminated through an exclusion buried in the policy. Our insurance laws plainly require insurance companies to ensure that any exclusion written into an automobile insurance policy be "consistent with the premium charged," and to also tell the consumer in plain language when an "exception or condition" in any type of insurance policy limits the general coverage which the consumer assumes they are purchasing.

This case is another example of the axiom that "what the big print giveth, the small print taketh away." As former Justice Neely eloquently stated, "In most insurance cases, the plaintiffs pay for and believe they have insurance, to discover only after disaster strikes, no insurance. The insurer has the plaintiffs' money and after the disaster -- fire, death or accident -- informs the plaintiffs that no insurance covers the fire, death or accident." *Keller v. First National Bank*, 184 W.Va. 681, 684, 403 S.E.2d 424, 427 (1991).

The problem in most insurance cases lies in the fact that, unlike most consumer purchases, what consumers believe they are buying is not the product that the insurance company actually sells and delivers. The insurance company markets its product through brochures and advertisements that assure

the consumer they will be in "good hands." The insurance consumer buys the product believing they are buying peace of mind, and the assurance that if bad things happen to their house, car or themselves, they will be taken care of. However, what the insurance company is really selling is the promise to pay only a limited amount of dollars if specific bad things happen. The consumer never discovers how limited the insurance company's promises are until after they have paid the premiums and a loss has occurred.

I firmly believe that insurance companies can define the risks they are insuring against by using exclusions and conditions in insurance policies. However, I also believe, as the majority opinion recognizes, that insurance companies have an affirmative duty to advise consumers of the existence of such limiting exclusions and conditions in a policy, and to advise consumers -- before litigation occurs -- that the company has adjusted the premiums so that the policy reflects the reduction or elimination of coverage caused by an exclusion.

The majority's focus in this case was on the fundamental unfairness of the Anthem "owned but not insured" exclusion. The record from the circuit court contains little evidence of the circumstances surrounding Mary Mitchell's purchase of insurance from Anthem, and little evidence of how Anthem communicated the exclusion to Mary Mitchell. There is absolutely no evidence in the appellate record regarding whether Anthem reduced its premiums to reflect the exclusion, and if so, whether that reduction was communicated to Mary Mitchell.

As best I can tell from the record, Mary Mitchell never asked for the exclusion, never bargained for the exclusion, and never knew it existed until after she (and later her estate) sought coverage. Mary Mitchell bought $300,000 in coverage. Anthem refused to pay anything at all. Only after months of litigation did Anthem even agree to pay a mere $20,000 in coverage.

The briefs of the attorneys for the parties inadequately discussed the statutes, case law, and public policy surrounding how we should interpret *W.Va. Code*, 33-6-31(b), our lengthy uninsured motorist statute. This occurred even though we specifically ordered the parties to brief these issues. Hence, the majority's opinion focused solely on correcting the unfair situation created by Anthem's "owned-but-not-insured" exclusion. There was no attempt to explain how the rules adopted in the majority opinion are to apply to future cases.

I write separately to emphasize the impact that the majority's opinion will have on the future handling of insurance claims in West Virginia. Surprising a policyholder, after a fire, death or accident, with an exclusion that no rational, honest person would expect to find in a comprehensive insurance policy is fundamentally unfair. The majority's opinion crafts a framework for how an insurance company bears the burden of eliminating that policyholder surprise by (1) telling the policyholder, up front, before they make a claim, that their policy contains exclusions and that "there is no coverage for this, this, and that;" and (2) telling the policyholder how much it has reduced their premiums because of the exclusions.[1]

I write to fill in the framework built in the majority's opinion.

In simple terms, the Court's decision is based on the premise that consumers do not read (and even if they do read, cannot understand) the terms that insurance companies use in insurance policies. Insurance companies give consumers the impression that they have full coverage under a comprehensive

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[1]As the majority opinion makes clear, an insurance company has a statutory duty to advise the holder of a *motor vehicle* insurance policy that their premiums have been adjusted to reflect an exclusion, condition or other limitation in the policy. *See* footnote 24 of the majority's opinion.

However, I find no limitation in the *West Virginia Code* or our jurisprudence that prohibits the application of this principle to all other types of insurance policies.

policy, and routinely fail to tell the consumer in plain English of the existence and the meaning of the legalistic exclusions that the insurance company has buried in a policy. So, when an insurance company seeks to avoid liability on an automobile insurance policy through the use of an exclusion, courts should first determine whether the insurance company created a reasonable expectation of coverage in the consumer, and whether the insurance company eliminated that expectation by telling the policyholder (1) that their coverage has been reduced or eliminated by the exclusion, and (2) that their premiums have been reduced to reflect the exclusion.

A.

Consumers neither Read nor Understand Insurance Policies

A fundamental precept of our insurance statutes and our case law is the recognized fact that insurance consumers do not, repeat, DO NOT, read insurance policies.

In the average, non-insurance contract case, courts will not excuse a party's failure to read the contract. Nevertheless, insurance contracts are treated differently by courts, in part because they are not freely negotiated agreements between the insurance carrier and the policyholder. Also, the policyholder's decision to purchase insurance is often not entirely voluntary. For example, West Virginia law requires vehicle owners to purchase liability and uninsured motorist coverage, and banks require people who borrow money to buy property insurance to insure their new home or comprehensive and collision coverage to insure their new car.

Furthermore, a policyholder buys a policy as a completed "product," a standardized "fill-in-the-blanks" contract form that is essential to our system of mass production and distribution. By using these

standardized forms, an insurance company simplifies the insurance purchasing process, and thereby reduces the overall costs of insurance. Consumers who buy a standard form insurance policy know that they cannot have the product changed or customized, and must take what they are given.[2] Hence, both the insurance agent and the policyholder know that it would be pointless for the policyholder to scrutinize the specific language and terms of the policy. The drafters of the *Restatement of Contracts (Second)*, in their discussions regarding contracts of adhesion like an insurance policy, recognized that:

> A party who makes regular use of a standardized form of agreement does not ordinarily expect his customers to understand or even to read the standard terms. One of the purposes of standardization is to eliminate bargaining over details of individual transactions, and that purpose would not be served if a substantial number of customers retained counsel and reviewed the standard terms. Employees regularly using a form often have only a limited understanding of its terms and limited authority to vary them. Customers do not in fact ordinarily understand or even read the standard terms. They trust to the good faith of the party using the form and to the tacit representation that like terms are being accepted regularly by others similarly situated. *But they understand that they are assenting to the terms not read or not understood, subject to such limitations as the law may impose.*

Restatement of Contracts (Second), § 211, comment b [1981] (emphasis added).

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[2]One commentator aptly noted:

> [I]n the current era of mass marketing, a party may reasonably believe that he is not expected to read a standardized document and would be met with impatience if he did. In such circumstances an imputation that he assents to all of the terms in the document is dubious law. An assertion that he is bound by them would place a premium upon an artful draftsman who is able to put asunder what the salesman and the customer have joined together.

J. Calamari, "Duty to Read: A Changing Concept," 43 *Fordham L.Rev.* 341 (1974).

In sum, how insurance companies sell insurance policies dictates how those policies will be interpreted by the courts.

> "[O]nly by acknowledging that the conditions of an insurance contract are for the most part dictated by the insurance companies and that the insured cannot 'bargain' over anything more than the monetary amount of coverage purchased, does our analysis approach the realities of an insurance transaction."

Collister v. Nationwide Life Ins. Co., 479 Pa. 579, 593, 388 A.2d 1346, 1353 (1978).[3] Because of the way insurance policies are sold, courts interpreting those policies *will and do* excuse a policyholder's failure to read the policy.

Another corollary problem with interpreting insurance contracts is the knowledge of the parties to the contract. An insurance company drafts insurance policy language in light of the statutes of dozens of different states, and in light of the varying interpretations by courts of the statutes and policy language. Policy language is also drafted to reflect the types of claims that are filed by policyholders. The

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[3]Another court similarly stated:

> Insurance policies are unipartite in nature. They are prepared by the company's experts, men learned in the law of insurance who serve its interests in exercising their art of draftsmanship. The resulting document with its many clauses is given to the insured upon the payment of the premium. There is no arm's length bargaining such as characterizes negotiations between equals in the marketplace. Consequently courts in their quest for justice for the insured, universally give him the benefit of any construction of the language which can be said fairly to represent the protection extended to him.

Bowler v. Fidelity Casualty Co. of New York, 53 N.J. 313, 326, 250 A.2d 580, 587 (1969).

Professor Keeton, in his seminal law review article discussing the doctrine of reasonable expectations, also discussed the need for judicial protection of policyholders that is caused by the one-sided nature of insurance policies:

> Insurance contracts continue to be contracts of adhesion, under which the insured is left little choice beyond electing among standardized provisions offered to him, even when the standard forms are prescribed by public officials rather than insurers. Moreover, although statutory and administrative regulations have made increasing inroads on the insurer's autonomy by prescribing some kinds of provisions and proscribing others, most insurance policy provisions are still drafted by insurers. Regulation is relatively weak in most instances, and even the provisions prescribed or approved by legislative or administrative action ordinarily are in essence adoptions, outright or slightly modified, of proposals made by insurers' draftsman.

R. Keeton, "Insurance Law Rights at Variance with Policy Provisions," 83 *Harv.L.Rev.* 961 (1970).

policyholder lacks such knowledge, and therefore lacks an understanding of the factual and legal context into which the insurance company designs a policy provision to fit.[4]

Another important consideration is that most insurance consumers do not even see -- repeat, DO NOT EVEN SEE -- the policy that they purchased until after they have paid the premiums.[5]

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[4]For example, Mary Mitchell could not have understood that West Virginia's insurance code mandated she receive $20,000 in uninsured motorist coverage -- coverage that would protect her wherever she might be -- but that the remaining $280,000 in coverage could be argued to be limited to only specific circumstances in light of this Court's interpretation of a different portion of the insurance code in *Deel v. Sweeney*, 181 W.Va. 460, 383 S.E.2d 92 (1989). Mary Mitchell's confusion would be further compounded if she knew that in *Bell v. State Farm Mutual Automobile Ins. Co.*, 157 W.Va. 623, 207 S.E.2d 147 (1974), this Court totally invalidated "owned but not insured" exclusions like that employed by Anthem, and yet over 20 years later Anthem was using language in its policy that totally voided *any* coverage, without regard to *Bell* or the statutes mandating $20,000 in coverage.

This is all hypothetical, of course. The point is, insurance companies have teams of lawyers who read statutes and cases, and deal with sticky legal questions created by insurance policies day after day. Insurance companies apply insurance policy provisions to numerous legal and factual situations every day. Policyholders, on the other hand, make claims against their policy on, at most, only a handful of occasions in a lifetime.

[5]Imagine buying a new car. We know we can dicker with the salesman over the color of the car, whether it has two or four doors, the kind of radio -- we are given a list of choices, and pick from the list. However, no one would think to demand that the car manufacturer build the car 6 inches longer and add reinforcing steel to the sides for greater safety -- its just not an option. In the age of mass production, we take the choices we are given. Insurance consumers, however, have few choices beyond the level of coverage and the premium they are willing to pay.

Now, imagine going to a car dealership to buy a new car. The car salesman gives you three options of colors, and says "pick." The price you pay for the car will depend on the color you pick. And you don't get to actually see the car until several weeks *after* you buy the car. You pay the dealer some money, and 4 weeks later the dealer delivers it to your house. And when you discover after you put the key in the ignition that the car doesn't have an engine, the dealer pulls the owner's manual out of the glove box, points to the phrase "engine not included," and insists that you knew all along the car came without an engine because the phrase "engine not included" is in the owner's manual. The dealer will also insist that your failure to read the owner's manual, and therefore your ignorance of this contractual provision, is your own fault.

The analogy sounds absurd, but it is exactly what insurance companies do in the transaction of insurance.

It is therefore unfair to bind a consumer by the terms of an exclusion that the insurance carrier never showed to the consumer at the time the consumer purchased the policy.[6]

B.
Reasonable Expectations of the Policyholder

Professor Keeton, in his seminal article on the interpretation of insurance contracts, says that courts routinely, implicitly acknowledge that insurance policies are contracts of adhesion, and that insurance consumers do not read, and if they did would not understand, insurance policies. In response to this acknowledged problem, courts often act to prohibit insurance companies from having any unfair or unconscionable advantage in insurance transactions. Additionally, courts interpret insurance contracts in a way that will honor the reasonable expectations of policyholders and beneficiaries, regardless of the details of the policy language. R. Keeton, "Insurance Law Rights at Variance with Policy Provisions," 83 *Harv.L.Rev.* 961 [1970]. Professor Keeton suggests that courts have used a number of strategies to achieve these goals, including finding policy language to be ambiguous, or invoking contractual theories of detrimental reliance or unconscionability.

When a policy is read by a court against an insurance company in a manner that is at variance with the technical language of the insurance policy, observers often shrug, explaining the court's decision with "the ambivalent, suggestive, and wholly unsatisfactory aphorism: 'It's an insurance case.'" *Id*.

[6]For a list of cases discussing the fact that "most consumers never even see the policy until after the premiums are paid," *see Kelly v. Painter*, 202 W.Va. 344, 350 n. 2, 504 S.E.2d 171, 177 n. 2 (1998) (Starcher, J., concurring).

To give meaning to decades of conflicting court decisions, Professor Keeton distilled a fundamental principle that underlies most insurance cases, and "that insurance law ought to [openly] embrace." 83 *Harv.L.Rev.* at 967. The principle he distilled is this:

> The objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations.

Id.

Seventeen years later, this Court followed Professor Keeton's suggestion and embraced this legal principle. In Syllabus Point 8 of *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987), we held that:

> With respect to insurance contracts, the doctrine of reasonable expectations is that the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations.

Our Legislature has established by law a similar rule as the public policy of this State. Our insurance laws state that an insurance carrier may not issue an insurance policy which contains "exceptions or conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract." *W.Va. Code*, 33-6-9(b) [1957].[7] In sum, before an insurance carrier may rely on an exclusion

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[7]The majority opinion exhorts the Insurance Commissioner to enforce this statute and be "ever vigilant in safeguarding the rights of insurance consumers in this State[.]" While I agree with this statement, I recognize that the Commissioner and his staff may give short shrift to this statutory duty due to budgetary and other constraints.

Here is how it happens: *W.Va. Code*, 33-6-8 [1994] requires an insurance carrier to file copies of any insurance policy, endorsement, rider or other type of form that is part of a policy with the Insurance

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to avoid liability on an insurance contract, it must demonstrate that the "exceptions or conditions" were not deceptive, and were communicated to the insured in a manner calculated to advise the insured of the adverse effect that the exclusionary language would have on the general insurance coverage provided by the policy.

An insurance company's statutory responsibility to fully convey to a policyholder the effect that an exception or condition will have upon the risk purported to be assumed by the general coverage of the policy is parallel to its obligation of fulfilling the reasonable expectations it has created in its policyholders.

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Commissioner at least 60 days before delivering such a document to an insurance consumer. The Insurance Commissioner, in theory, must then examine and either approve or reject the document.

The catch to this process is found in *W.Va. Code*, 33-6-8(b), which states in pertinent part:

> At the expiration of such sixty days, the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by the commissioner.

In other words, if the Insurance Commissioner does nothing and lets the insurance documents collect dust on a corner of his or her desk for 60 days, the documents are automatically deemed to be "approved" as valid under West Virginia law.

Because of this administrative loophole, courts allow citizens to fill this regulatory void through actions to enforce the reasonable expectations of coverage created by insurance carriers. *W.Va. Code*, 55-7-9 [1923] authorizes such an action and states:

> Any person injured by the violation of any statute may recover from the offender such damages as he may sustain by reason of the violation, although a penalty or forfeiture for such violation be thereby imposed, unless the same be expressly mentioned to be in lieu of such damages.

As discussed in the text, a policyholder may therefore seek to have a policy declared as void when the insurance policy contains "inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract." *W.Va. Code*, 33-6-9(b) [1957].

"The rule of reasonable expectations applies if there is a dispute as to the existence of insurance coverage." *Tynan's Nissan, Inc. v. American Hardware Mut. Ins. Co.*, 917 P.2d 321 (Colo.Ct.App. 1995). The doctrine exists to insure that the insurance consumer's reasonable expectations are fulfilled -- every consumer has a right to expect they will receive something of comparable value in return for the premiums they have paid.

A contract to provide insurance should be interpreted and applied as a layman would understand the contract, based upon the entire insurance purchasing transaction, and not according to an after-the-fact interpretation given by sophisticated underwriters and lawyers. The expectations of the average consumer should be enforced *regardless of any ambiguity in the policy language*.[8]

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[8]As the majority opinion implies, the doctrine of reasonable expectations as applied in *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, *supra* does *not* require that the specific language of an insurance policy be ambiguous. Rather, the focus is whether ambiguity exists in the entire insurance transaction -- could a reasonable policyholder under similar circumstances believe coverage exists when the insurance company asserts that it does not?

The concept of construing the specific language of an insurance policy which is ambiguous in accord with the reasonable expectations of a policyholder and against the insurance company is a principle of contract law, not insurance law. The drafter of a contract, particularly an adhesion contract, has a duty of choosing language carefully. Any ambiguous language is strictly construed against the preparer of a contract so long as the construction chosen by the non-drafter is reasonable. *See, e.g., Nisbet v. Watson*, 162 W.Va. 552, 530, 251 S.E.2d 774, 780 (1979).

However, the insurance doctrine of reasonable expectations operates independently of any ambiguity in the language of the insurance policy. This Court has incorrectly suggested that language ambiguity is a requirement. *See National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. at 742, 356 S.E.2d at 496 (1987) ("In West Virginia, the doctrine of reasonable expectations is limited to those instances . . . in which the policy language is ambiguous." (*Citing Soliva v. Shand, Morahan & Co.*, 176 W.Va. 430, 433, 345 S.E.2d 33, 36 (1986)); Syllabus Point 2, *Robertson v. Fowler*, 197 W.Va. 116, 475 S.E.2d 116 (1996). ("Before the doctrine of reasonable expectations is applicable to an insurance contract, there must be an ambiguity regarding the terms of that contract.")

The "terms" of an insurance policy are the mutual undertakings of the parties to the agreement, while the "language" of a policy are the specific words and grammar chosen to express those terms. An

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insurance policy is construed when the language is ambiguous, and applied when the language is not ambiguous. The doctrine of reasonable expectations applies when the terms of the insurance transaction are ambiguous -- namely, when the policyholder and insurance company disagree about who was going to do what. When the insurance company makes broad representations of coverage to the policyholder, and at the same time in the un-read fine print the coverage is limited, there is an ambiguity in the terms of the contract, regardless of the clarity of the specific fine-print exclusion language. If a disagreement exists as to the terms of the agreement, then the reasonable expectations of the policyholder should be enforced, regardless of what a painstaking reading of the policy language might reveal.

Professor Keeton makes clear why language ambiguity is not necessary to the operation of the doctrine of reasonable expectations:

> [I]nsurers ought not to be allowed to use qualifications and exceptions from coverage that are inconsistent with the reasonable expectations of a policyholder having an ordinary degree of familiarity with the type of coverage involved. This ought not to be allowed even though the insurer's form is very explicit and unambiguous, because insurers know that ordinarily policyholders will not in fact read their policies. . . . Moreover, the normal processes for marketing most kinds of insurance do not ordinarily place the detailed policy terms in the hands of the policyholder until the contract has already been made. . . . Thus, not only should a policyholder's reasonable expectations be honored in the face of difficult and technical language, but those expectations should prevail as well when the language of an unusual provision is clearly understandable, unless the insurer can show that the policyholder's failure to read such language was unreasonable.
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> Moreover, the principle of resolving ambiguities against the draftsman is simply an inadequate explanation of the results of some cases. The conclusion is inescapable that courts have sometimes invented ambiguity where none existed, then resolved the invented ambiguity contrary to the plainly expressed terms of the contract document. To extend the principle of resolving ambiguities against the draftsman in this fictional way not only causes confusion and uncertainty about the effective scope of judicial regulation of contract terms but also creates an impression of unprincipled judicial prejudice against insurers.

83 *Harv.L.Rev.* at 968, 972.

Any reading of *McMahon & Sons* or *Robertson v. Fowler* as suggesting a requirement of specific language ambiguity before the reasonable expectations of a policyholder may be enforced is,

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When the actions of the insurance company and its agents (through their advertisements, brochures, statements, applications, policies, conditional receipts, or whatever) give a consumer a reasonable expectation that insurance coverage for an event has been purchased, then courts should enforce that reasonable expectation, regardless of the policy language.

> Courts should also keep alert to the fact that the expectations of the insured are in large measure created by the insurance industry itself. Through the use of lengthy, complex, and cumbersomely written applications, conditional receipts, riders, and policies, to name just a few, the insurance industry forces the insurance consumer to rely upon the oral representations of the insurance agent. Such representations may or may not accurately reflect the contents of the written document and therefore the insurer is often in a position to reap the benefit of the insured's lack of understanding of the transaction. . . . . Courts must examine the dynamics of the insurance transaction to ascertain what are the reasonable expectations of the consumer.

Collister v. Nationwide Life Ins. Co., 479 Pa. 579, 594-95, 388 A.2d 1346, 1353-54 (1978)

Thus, in a situation in which the public may reasonably expect coverage, an exclusion must be conspicuous, plain and clear. Ninety years ago one court recognized that insurance consumers do not read policies and exclusions, and usually could not understand their implications if they did. That court suggested that as a solution, before a policy exclusion would be enforced, the insurance company would be required to bring the provision to the attention of the insurance consumer. The court stated, when discussing whether to enforce an exclusion:

> It is a matter almost of common knowledge that a very small percentage of policy holders are actually cognizant of the provisions of their policies and many of them are ignorant of the names of the companies issuing the

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therefore, simply wrong.

> said policies. The policies are prepared by the experts of the companies, they are highly technical in their phraseology, they are complicated and voluminous -- the one before us covering thirteen pages of the transcript -- and in their numerous conditions and stipulations furnishing what sometimes may be veritable traps for the unwary. The insured usually confides implicitly in the agent securing the insurance, and it is only just and equitable that the company should be required to call specifically to the attention of the policy holder such provisions as the one before us.

Raulet v. Northwestern National Ins. Co. of Milwaukee, 157 Cal. 213, 230, 107 P. 292, 298 (1910).

When an exclusion is not brought to the attention of a policyholder, it would be unjust to apply the unknown provision to void the coverage which the policyholder fully and justifiably expects to be provided by the policy. As another California appeals court stated, nearly 30 years ago:

> It is now firmly settled that insurance contracts are contracts of adhesion between parties not equally situated. Consequently, the insurer, as the dominant and expert party in the field, must not only draft such contracts in unambiguous terms but must bring to the attention of the insured all provisions and conditions which create exceptions or limitations on the coverage.

Young v. Metropolitan Life Ins. Co., 272 Cal.App.2d 453, 460-61, 77 Cal.Rptr. 382, 387 (1969). Another court suggested that "verbal vacuity" could not "serve as clear and plain notice to the insured of noncoverage." *Steven v. Fidelity and Casualty Co. of New York*, 58 Cal.2d 862, 872, 27 Cal.Rptr. 172, 178, 377 P.2d 284, 290 (1962). From these precedents, a later court gleaned a general principle of public policy:

> In the case of standardized insurance contracts, exceptions and limitations on coverage that the insured could reasonably expect, must be called to his attention, clearly and plainly, before the exclusions will be interpreted to relieve the insurer of liability or performance.

Logan v. John Hancock Mut. Life Ins. Co., 41 Cal.App.3d 988, 995, 116 Cal.Rptr. 528, 532 (1974).

As the majority opinion states, an insurance carrier bears the burden of dispelling a policyholder's reasonable expectations. The insurance company must prove that a policyholder has been affirmatively apprised of all exclusions in a policy that limit any "general coverage" that a policyholder has purchased and reasonably expects will exist to indemnify against a particular loss. We discussed this duty of an insurance carrier in *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, *supra*, where we stated at Syllabus Point 10 that "An insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage . . . must bring such [exclusionary] provisions to the attention of the insured."

The doctrine of reasonable expectations thus limits an insurance carrier's use of exclusions in one portion of a policy to eliminate a broad grant of coverage in another portion of the policy. In other words, an insurance company may not give with the big print and take away with the small print, when the big print reasonably gave the purchaser of the policy an expectation of coverage. An insurance company has an affirmative duty to inform an insurance consumer what they are purchasing; it is not the duty of the consumer to seek out exclusions, limitations and conditions which are not plainly revealed to him or he

If an insurance company wishes to avoid liability on an insurance policy through the operation of an exclusion or other policy condition, it must do so in clear and unequivocal language. Furthermore, the insurance company must call such limiting conditions to the attention of the insured, and

explain the effect of the condition. Absent such a disclosure, the policy coverage will be deemed to be that which could be expected by the ordinary lay person.[9]

C.
Conclusion

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[9]Many courts have, as part of the doctrine of reasonable expectations, placed a duty on insurance carriers to explicitly inform policyholders of the existence of exclusions. The courts of Colorado have applied the following rule:

> [A]n insurer who wishes to avoid liability must do so in clear and unequivocal language and must call such limiting conditions to the attention of the insured. Absent such disclosure, coverage will be deemed to be that which could be expected by the ordinary lay person.

Tynan's Nissan, Inc. v. American Hardware Mut. Ins. Co., 917 P.2d 321, 324 (Colo.App. 1995). *See also, Peters v. Boulder Insurance Agency, Inc.*, 829 P.2d 429 (Colo.App. 1991); *Leland v. Travelers Indemnity Co.*, 712 P.2d 1060 (Colo.App. 1985).

Louisiana has a very simple rule: "Insurance policy exclusions are not valid unless clearly communicated to the insured." *Sims v. Insurance Unlimited of West Monroe*, 669 So.2d 709, 711 (La.App. 1996). "Notice of any exclusionary provisions is essential because the insured will otherwise assume the desired coverage exists." *Louisiana Maintenance Services, Inc. v. Certain Underwriters at Lloyd's of London*, 616 So.2d 1250, 1252 (1993).

Idaho has also stated its rule in simple terms: "It is the duty of the insurer to inform the insured of what he is obtaining; it is not the duty of the insured to seek out exclusions and limitations not revealed to him." *Featherston v. Allstate Ins. Co.*, 125 Idaho 840, 843, 875 P.2d 937, 940 (1994).

See also, Barrette v. Casualty Co. of America, 79 N.H. 59, ___, 104 A. 126, 127 (1918) ("[T]he company did absolutely nothing to notify [policyholder] Dubray [of the exclusion] . . . [W]hen the company's local agent delivered the policy, he gave Dubray to understand that it protected him from all liability . . . It cannot be said that Dubray was in fault for relying on the agent's representation, or that the ordinary man in his situation would have read the policy to ascertain whether it evidenced the contract he made with the company[.]"); *General Motors Acceptance Corp. v. Martinez*, 668 P.2d 498, 501 (Utah 1983) ("Utah appellate courts have consistently held that exclusions from coverage under an insurance policy, even if clear, are ineffective unless they are communicated to the insured in writing."); *Moore v. Energy Mutual Ins. Co.*, 814 P.2d 1141, 1143 (Utah Ct. App. 1991) ("[E]xclusions from coverage must use 'language which clearly and unmistakably communicates to the insured the specific circumstances under which the expected coverage will not be provided.'")

On remand, the circuit court should consider whether Mary Mitchell had a reasonable expectation of uninsured motorist coverage. Additionally, the circuit court should determine whether Anthem brought the "owned but not insured" exclusion to Mrs. Mitchell's attention, and told her the premiums for the policy had been reduced along with her coverage.

I see nothing in the existing record to suggest that Anthem directed Mary Mitchell's attention to the exclusion they assert is controlling in her insurance policy. "The law expects an insurance salesman to tell an insurance consumer that an insurance product does not do what the consumer would expect it to do." *Kelly v. Painter*, 202 W.Va. 344, 349, 504 S.E.2d 171, 176 (1998) (Starcher, J., concurring).

Mary Mitchell bought $300,000 of insurance to protect her against uninsured motorists like Anthony Broadnax. Anthem should not be permitted to surprise Mary Mitchell with an exclusion of which she was not aware and for which she did not bargain. If Anthem never told her of the exclusion, and never explained its effect, and never told her it cut her premiums by a few dollars to account for the exclusion, then Anthem should not be allowed, after-the-fact, to try to rely on the exclusion to avoid its responsibilities under the policy.[10]

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[10]The only evidence I can find in the record regarding Mary Mitchell's interaction with an insurance agent consists of the policy and the application. The application completed by Mary Mitchell in 1992 states that she was, at that time, a 74-year-old housewife seeking coverage on her 1981 Buick. She purchased liability coverage of $300,000 per person, per occurrence; $300,000 in property damage coverage; and $300,000 in bodily injury coverage per person, per occurrence, and for property damage caused by an uninsured and underinsured motorist. She also bought towing and rental insurance.

The application shows that Mary Mitchell had been insured through the same insurance agency for 21 years (since May 1971) and that the agent recommended she be approved for the Anthem policy because she was an "excellent insurance client."

The result reached by the circuit court, in enforcing the exclusion, was patently unfair. I therefore concur.