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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION FIVE

JOHN M. HAGAN,

Plaintiff and Appellant,

v.

CALIFORNIA PHYSICIANS' SERVICE, et al.,

Defendants and Respondents.

A130809

(Lake County Super. Ct. No. CV405315)

In 2005, appellant John M. Hagan (Hagan) applied for a family health insurance policy from respondent Blue Shield of California Life and Health Insurance Company (Blue Shield).[1] Hagan sought a policy to cover himself, his wife Lori, and their two daughters. Blue Shield's application asked a number of questions about the applicants' medical histories. The Hagans responded to the questions, and after reviewing the application, Blue Shield approved it and issued an insurance policy.

In 2006, after Lori was admitted to a medical facility for treatment, Blue Shield commenced a routine investigation of the Hagans' application. Based upon information discovered during the investigation, Blue Shield concluded the Hagans had misrepresented or omitted material information about Lori's medical history on their application. It therefore rescinded the policy.

[1] Respondents in this case are California Physicians Service, doing business as Blue Shield of California Life and Health Insurance Company. We will refer to the entity as Blue Shield.

Hagan then brought an action against Blue Shield seeking damages for breach of contract, breach of the implied covenant of good faith and fair dealing, and negligent and intentional infliction of emotional distress, as well as violations of Business and Professions Code section 17200. Blue Shield answered, asserting an affirmative defense of rescission, and later moved for summary judgment. The court below found there were no triable issues of fact as to the rescission defense, and it granted summary judgment to Blue Shield on that ground. It further ruled that because Blue Shield had properly rescinded the policy, the remainder of Hagan's causes of action failed as a matter of law.

Hagan now appeals. He contends there were triable issues of fact that precluded summary judgment. We disagree and accordingly affirm.

FACTUAL AND PROCEDURAL BACKGROUND

"Because [Hagan] has appealed from the trial court's grant of summary judgment against him, we must 'independently examine the record in order to determine whether triable issues of fact exist to reinstate the action.' [Citations.] 'In performing our de novo review, we view the evidence in the light most favorable to [Hagan]' [citation], and we 'liberally construe' plaintiff's evidence and 'strictly scrutinize' that of defendant 'in order to resolve any evidentiary doubts or ambiguities in [Hagan's] favor' [citation]." (*O'Riordan v. Federal Kemper Life Assurance Co.* (2005) 36 Cal.4th 281, 284 (*O'Riordan*).) Viewing the record in this light, the relevant facts are these:[2]

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[2] Our review of the facts has been complicated by Hagan's failure to provide citations to the record that comply with California Rules of Court, rule 8.204(a)(1)(C). Hagan's opening brief cites to the separate statement of disputed facts he filed in opposition to Blue Shield's motion for summary judgment, but he does not tell us where in the record we can find the evidence supporting the facts asserted in his separate statement. "The separate statement is not itself evidence of anything. It is mere assertion. The evidence of the asserted facts appears elsewhere—in affidavits, depositions, etc. [Hagan's] brief should have cited to those pages in addition to the separate statement of disputed facts. [Citation.]" (*Stockinger v. Feather River Community College* (2003) 111 Cal.App.4th 1014, 1024-1025.) Here, in part because Hagan has supplied appropriate record citations in his reply brief, "we shall disregard the failure to comply with the appellate rules, though we note for the benefit of appellate

Lori's Medical History

Between 2001 and 2007, Lori's gynecologist was Dr. Laurence Hartley. On her first visit with Dr. Hartley, Lori complained of discomfort and painful periods. An ultrasound performed prior to her visit with Dr. Hartley showed Lori had some uterine fibroids.[3] Dr. Hartley's examination revealed that Lori's uterus was enlarged to about eight weeks size and was somewhat tender with manipulation. Dr. Hartley talked with Lori about possible treatment options, including a hysterectomy. A subsequent ultrasound examination revealed Lori had at least three fibroids. Dr. Hartley prescribed antibiotics for Lori to determine whether any of her discomfort was caused by infection.

On June 4, 2001, because of Lori's complaints of pain during her menstrual cycle, Dr. Hartley performed an exploratory laparoscopy.[4] According to Dr. Hartley's medical records, Lori was admitted to the Ukiah Surgery Center where the procedure was performed on an outpatient basis. The laparoscopy showed fibroids, extensive omental adhesions to the uterus, tube, and abdominal wall, and a small area of endometriosis. Because of her severe cramping, in late 2001, Lori was given injections of Depo Lupron, a hormone that may shrink fibroids and relieve menstrual pain. After receiving the injections, Lori's pain and cramping subsided for a time. Despite the initial improvement, Lori again experienced pain and discomfort, and she discontinued the Depo Lupron therapy in early 2002.

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counsel that this court has discretion to disregard contentions unsupported by proper page cites to the record. [Citations.]" (*Id.* at p. 1025.)

[3] Dr. Hartley testified that "fibroid" is a term commonly used to describe a leiomyoma, which is a type of benign, noncancerous tumor. Fibroids are common and are present in at least half of women.

[4] In his deposition, Dr. Hartley explained that an exploratory or diagnostic laparoscopy is "a surgical procedure" or "operation" that is usually performed under general anesthesia, as it was in Lori's case. Incisions are made in the patient's abdomen, and the laparoscope is passed through one of the incisions so that the abdominopelvic cavity may be viewed. (See Stedman's Medical Dictionary (27th ed. 2000) p. 966, col. 1.)

Dr. Hartley next saw Lori in March 2004, at which time she reported that her periods were still painful and were getting heavier. Dr. Hartley's notes indicated that he diagnosed her with menorrhagia, which is heavier than average menstrual bleeding, and dysmenorrhea, or pain with menses. He discussed the possibility of treatment by endometrial ablation, a procedure in which heat or laser is used to destroy the endometrium to control bleeding and which may help relieve cramps. He also noted that Lori's recent pap smear had showed atypical cells. Dr. Hartley therefore performed an endometrial biopsy, the results of which were negative and showed no evidence of atypia inside Lori's uterus.

Lori saw Dr. Hartley again on April 25, 2005, for an annual exam. His notes of that examination reflect that Lori continued to have menstrual discomfort and felt "like she is kind of PMS almost all the time." He recorded his impression that she was suffering from dyspareunia (painful intercourse), "pretty intense dysmenorrhea," and that she had "a lot of adhesive disease as well." Dr. Hartley discussed various treatment options with Lori, including endometrial ablation and hysterectomy. Lori appears to have told Dr. Hartley that she would give these options further thought and would let him know if she wanted something done.

The Hagans Apply to Blue Shield for Insurance

On May 18, 2005, Hagan signed an application for Blue Shield health insurance coverage for himself, his wife Lori, and their two daughters. Hagan, Lori, and their older daughter all signed the application. The following language is printed on the application immediately above the Hagans' signatures: "I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. I understand and agree to each of them. I alone am responsible for the accuracy and completeness of the information provided on this application. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if coverage is issued, it may be cancelled or rescinded upon such a finding."

On its third page, the application asked, "Have you or any applying family member in the past 20 years received any professional advice or treatment, including prescription medications, from a licensed health practitioner or had any symptoms pertaining to any of the following?" There followed a list of questions regarding specific conditions. The Hagans answered "no" to the following medical history questions:

"8.A. *Female reproductive system* – such as: . . . adhesions, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal Pap test, problems of the ovaries, uterus, and associated female organs . . . . ?"

"21. Abnormal laboratory results – such as: blood work, x-rays, EKG, nerve condition, blood flow studies, MRI, CT, PET or other scan(s) . . . ?"[5]

"23. Diagnoses, symptoms and/or health problems not mentioned elsewhere on this application, or that have not been evaluated by a physician, or have any complications or residuals remaining following any treatment, or been advised to have a physician exam, further testing, treatment, or surgery which has not yet been performed by a physician, dentist, or other health care provider?"

The Hagans answered "yes" to Question 20, which asked whether any applying member had "[b]een an inpatient or outpatient in a hospital, surgical center, sanitarium, or other medical facility, including an emergency room, or had surgery . . . ?" In the box requesting details about all "yes" answers to questions on the medical history portion of the application, the Hagans disclosed "tonsils/adenoids" treatment for their daughter in 1990 and herniated disk treatment for Lori in 1996.

Part 7 of the application asked the Hagans to "provide details regarding the last physician visit you and/or any applying family member has had, regardless of the date (includes check-ups)." The response to this question listed Lori's last physician visit as a "check up" with Dr. Elyse Donald on June 6, 2004. The "findings" were described as "all good," and Lori listed her present status as "healthy."

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[5] The Hagans initially left this question unanswered, but later provided a negative answer by addendum.

Blue Shield Underwrites the Hagans' Application

Blue Shield is an insurance company offering individual and family health insurance products. As an insurance company, Blue Shield is subject to regulation under the Insurance Code.[6] (§ 740, subd. (a).) Coverage under Blue Shield's individual and family policies is not guaranteed, and applicants for insurance must qualify for coverage based on their medical history and health status. The process of determining whether an applicant qualifies for coverage, and if so, at what premium rate, is called "underwriting."

Blue Shield's underwriting process requires applicants to complete an application containing questions about their medical history and conditions. If an applicant provides a positive response to any of the medical history questions, the application requires the applicant to provide underlying details. Blue Shield's application lists a toll-free number applicants may call "for help filling out the application."

Blue Shield's Installation and Membership (I&M) Department reviews every application when first received to confirm the applicant has signed it, answered all medical questions, and provided all other requested information. If the application is incomplete, the I&M reviewer suspends the process and requests missing information from the applicant.

Blue Shield also follows up with applicants or medical providers in certain instances. For example, Blue Shield will obtain additional information from the applicant if the applicant discloses a condition that requires further information to assess its significance. Blue Shield will also order medical records in certain circumstances, such as when an applying family member indicates he or she has had a physician visit within 30 days of the date of the application.

Underwriters also review Blue Shield's computer systems to determine if the applicant or applicant's family members had a prior application or membership history

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[6] All undesignated statutory references are to the Insurance Code.

We note that Blue Shield is not a health care service plan, and therefore it is not subject to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). (See Health & Saf. Code, § 1340 et seq.; *id.* §§ 1343, subd. (a), 1345, subd. (f).)

with Blue Shield. If such a history is found, the underwriter reviews Blue Shields claims and pharmacy databases for information regarding prior claims or medical conditions, compares that information to the information provided on the application, and if the systems contain information not reflected in the application, the underwriter will request additional information from the applicant.

Blue Shield then evaluates the information provided by the applicant, together with any other information gathered during the underwriting process, in accordance with Blue Shield's proprietary medical underwriting guidelines to determine whether to extend coverage. In doing so, the underwriter uses a numerical debit point guideline based on actuarial data provided by a third party. Each individual and family policy has a threshold point level, which varies by the applicant's age, for determining whether the applicant should be approved or declined and, if approved, the appropriate rate category to be assigned. The combined underwriting points for a given applicant, based on known medical conditions, represent Blue Shield's assessment of projected future risk and form the basis of the decision on whether to extend coverage and, if so, at what rate.

Blue Shield processed the Hagans' application in accordance with the above-described procedures. When initially submitted, the application lacked a response to Question 21 on the "Medical History" part, and the "Producer Information" section contained unanswered questions. The I&M Department suspended underwriting and followed up to obtain addenda concerning Question 21 and the "Producer Information." Upon receiving the addenda, the application contained answers to all medical questions and appeared to provide all information requested. Under Blue Shield's underwriting guidelines, nothing on the Hagans' application raised any underwriting concern or required further follow-up. Blue Shield approved the application and issued the Hagans a "Shield Spectrum PPO Savings Plan 8000 (Family)" policy, effective July 1, 2005, at the best, "premier" premium rate.

Blue Shield Rescinds the Policy

In May 2006, Blue Shield's Medical Management Department referred the Hagans' policy to the Eligibility Review Unit (ERU) for a potential review of whether the

application contained any material misrepresentations or omissions. The referral was made pursuant to standard procedures because Lori was admitted to a medical facility within two years of obtaining coverage. After concluding that the initial underwriting of the policy had been completed, Blue Shield's ERU investigator requested records from Lori's health care providers, including Stanford Hospital, the facility to which she was admitted in March 2006 for cervical cancer treatment.

The records revealed the exploratory laparoscopy Lori had undergone in 2001, the resulting diagnoses of fibroid uterus, omentum adherent to the uterine fundus, and a small area of endometriosis, as well as Lori's treatment with Depo Lupron injections. Blue Shield wrote to Lori on July 13, 2006, advising her that it had reviewed her underwriting file and that the records obtained from Stanford Hospital revealed information not disclosed on the Hagans' application. The letter asked Lori to provide details concerning the diagnoses and treatment referred to in the medical records, and it specifically requested the names and addresses of all health care providers and health care facilities she had visited, together with the names and dosages of all medications prescribed within the previous 36 months.

Lori responded by letter on July 18, 2006. She informed Blue Shield that in June 2001 she had begun to experience discomfort and pelvic pain during her menstrual cycle. She further stated that Dr. Hartley had "performed exploratory surgery" and had noted scar tissue and fibroid cysts. Lori informed Blue Shield that Dr. Hartley had "prescribed Lupron" and told her that she might want to consider a hysterectomy if the pain did not go away. Her letter also revealed that she had had an abnormal pap test in 2004, after which Dr. Hartley had performed an endometrial biopsy with normal results. Lori provided Blue Shield with Dr. Hartley's name and address.

Blue Shield then obtained Dr. Hartley's medical records, which revealed the facts of Lori's medical history we have described above. After reviewing this information, Blue Shield's ERU underwriter determined that the Hagans' "no" responses to Questions 8.A., 21, and 23 were false, as was information provided concerning Question 20 and Part 7. Lori had not disclosed her April 2005 visit with Dr. Hartley,

which had occurred within 30 days of submission of the Hagans' application, and the information she did provide in response to the "last physician visit" question was inaccurate. Lori's last visit with Dr. Donald had not taken place on June 6, 2004, as stated in the application, but rather on September 13, 2004, at which time Dr. Donald had prescribed the antibiotic Cipro for Lori.

Blue Shield concluded that if it had known the information it obtained during the investigation prior to issuing the policy, it would have declined coverage. Among other things, Lori's diagnosis of menorrhagia alone would have caused the numerical debit points assigned to Lori to exceed the maximum total points allowable for issuance of coverage to her. Under Blue Shield's underwriting guidelines, Lori's diagnosis of endometriosis within five years of the application would have caused Blue Shield to request records of the diagnosis, and those records would have revealed Lori's laparoscopic surgery, fibroid uterus diagnosis, and Depo Lupron injections. This would have led Blue Shield to deny coverage to the Hagans. In addition, if Lori had disclosed her April 25, 2005 visit with Dr. Hartley as her last physician visit, Blue Shield would have obtained his records, which would have revealed material information leading to a denial of coverage. Furthermore, the mere advisement by Dr. Hartley of *potential* treatment in the form of ablation or hysterectomy would have caused Blue Shield to postpone the determination of whether to issue coverage (and if so, at what rate) pending any further decisions with respect to the treatment.

Accordingly, on August 23, 2006, Blue Shield rescinded the Hagans' policy prospectively and informed Lori of the rescission by letter.

The Action Below

On July 7, 2008, Hagan filed a first amended complaint against Blue Shield in Lake County Superior Court.[7] It alleged causes of action for breach of the duty of good faith and fair dealing, breach of contract, violation of Business and Professions Code section 17200, and negligent and intentional infliction of emotional distress. The causes

[7] The complaint states that Lori died on May 9, 2007. Hagan filed his complaint both in his individual capacity and as successor-in-interest of his late wife's estate.

of action for breach of the duty of good faith and fair dealing and negligent and intentional infliction of emotional distress included claims for punitive damages. Blue Shield's answer to the complaint asserted, as its second affirmative defense, rescission of the policy based on material misrepresentation and/or concealment of material facts in connection with the application for the policy.

On April 22, 2009, Blue Shield filed a motion for summary judgment and/or summary adjudication on each cause of action and on Blue Shield's rescission defense. It attached a compendium of documentary evidence in support of its motion, as well as declarations by Blue Shield underwriters Susan Burke and Susan Hill. Hagan opposed the motion, but he did not object to any of Blue Shield's evidence. In support of his opposition, Hagan filed his own declaration and a declaration by Terry Van Noy, whom he offered as an expert in insurance coverage and underwriting. Blue Shield replied to Hagan's opposition and filed objections to Hagan's evidence, most of which concerned what it viewed as speculative statements in Hagan's declaration and improper opinion testimony in Van Noy's.

On September 16, 2010, the trial court issued an order sustaining 58 of Blue Shield's 107 evidentiary objections. The trial court heard argument on Blue Shield's motion for summary judgment on September 20, 2010. It announced from the bench that it would grant Blue Shield's motion for summary judgment as to the rescission defense, and it further concluded that Hagan's other causes of action failed based upon the court's ruling on rescission. The trial court filed a written order granting the motion on November 8, 2010.

In its order, the trial court ruled Blue Shield had properly rescinded the Hagans' policy based upon the standards set forth in the recent case of *Nieto v. Blue Shield of California Life & Health Ins. Co.* (2010) 181 Cal.App.4th 60 (*Nieto*). The court explained that the law permits an insurer to rescind a policy when the insured has misrepresented or concealed material information, whether intentionally or negligently, in connection with obtaining insurance. It found the Hagans had clearly misrepresented and concealed material facts known to them when they submitted their application.

Specifically, it noted that the Hagans' answers to Questions 8.A., 20, 21, 23, and the "last physician visit" question were false. It found the misrepresented or omitted information material in that Blue Shield would not have issued the policy if the questions had been answered accurately. It further held that even if Blue Shield were required to demonstrate that the Hagans had *willfully* misrepresented the information on the application, Blue Shield would still be entitled to judgment as a matter of law, because there was no reasonable factual dispute that the misrepresentations and omissions in the application were willful. The trial court also found Blue Shield had properly completed medical underwriting prior to issuing the policy, and thus there was no evidence Blue Shield had violated section 10384's prohibition on postclaims underwriting.

The trial court found that Blue Shield's rescission of the policy was proper as a matter of law and granted summary adjudication on the rescission affirmative defense. Because rescission was proper, the court ruled that all of Hagans' other causes of action failed as a matter of law. Accordingly, it granted summary judgment to Blue Shield.

The court entered judgment on November 8, 2010. Blue Shield then filed a memorandum of costs seeking a total of $39,380.17. Hagan filed a motion to tax costs challenging some of Blue Shield's claimed expenses. Blue Shield opposed the motion and provided an itemized list of its costs, together with receipts and a declaration of counsel. The trial court's ruling on the motion to tax costs disallowed certain meal expenses but granted Blue Shield its other costs, leaving a total cost award of $38,542.15.

Hagan filed a timely appeal.

DISCUSSION

Hagan argues Blue Shield was not entitled to summary judgment based on its rescission defense. He contends triable issues of fact exist as to whether there were misrepresentations on the application and as to whether the misrepresentations would have caused Blue Shield either to refuse to issue the policy or to charge a higher premium. In addition, Hagan contends there were triable issues of fact on the issue of whether Blue Shield violated section 10384's prohibition on postclaims underwriting. Hagan asserts that if Blue Shield did engage in postclaims underwriting, it would be

foreclosed from rescinding the policy. He also claims the trial court abused its discretion in awarding costs to Blue Shield.

As we explain below, we find none of Hagan's arguments persuasive. We will therefore affirm both the grant of summary judgment to Blue Shield and the trial court's order on costs.

I. *Standard of Review – Summary Judgment*

We review the trial court's grant of summary judgment de novo. (*Nieto, supra,* 181 Cal.App.4th at p. 71.) The court may grant summary judgment where "all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law . . . ." (Code Civ. Proc., § 437c, subd. (c).) The defendant may meet this burden if it shows that one or more elements of the plaintiff's cause of action cannot be established or that there is a complete defense to the action. (Code Civ. Proc., § 437c, subd. (p)(2).) If a defendant makes this showing, the burden then shifts to the plaintiff to show that there exists a triable issue of material fact as to that cause of action or defense. (Code Civ. Proc., § 437c, subd. (p)(2); *Nieto,* at p. 71.) "A plaintiff opposing summary judgment cannot rely upon the mere allegations or denials of its pleadings, but 'shall set forth the specific facts' based on admissible evidence showing a triable issue exists. [Citations.]" (*Nieto,* at p. 71.)

II. *Objections to Evidence*

In reviewing the trial court's grant of summary judgment, we consider "all the evidence set forth in the moving and opposition papers except that to which objections were made and sustained." (*Johnson v. City of Loma Linda* (2000) 24 Cal.4th 61, 65-66.) If an evidentiary objection was improperly sustained, however, the evidence erroneously excluded is considered part of the record on appeal. (See *Nazir v. United Airlines, Inc.* (2009) 178 Cal.App.4th 243, 255, 257 (*Nazir*).) Hagan challenges a number of the trial court's rulings sustaining Blue Shield's objections to the evidence he submitted in opposition to the motion for summary judgment. We must first address these arguments to determine what evidence we may properly consider.

A. *Standard of Review – Objections to Evidence on Summary Judgment*

Hagan asks us to review the trial court's rulings on these objections de novo. Blue Shield appears to disagree, for it argues the trial court's evidentiary rulings were not an abuse of its discretion. The California Supreme Court has not decided "whether a trial court's rulings on evidentiary objections based on papers alone in summary judgment proceedings are reviewed for abuse of discretion or reviewed de novo." (*Reid v. Google, Inc.* (2010) 50 Cal.4th 512, 535.) This is a question "that is by no means settled" (*Nazir, supra,* 178 Cal.App.4th at p. 255, fn. 4), but the weight of authority holds that such rulings are subject to an abuse of discretion standard. (E.g., *Miranda v. Bomel Construction Co., Inc.* (2010) 187 Cal.App.4th 1326, 1335.) Neither party has presented us with argument or authority on this question, and we conclude we need not resolve it. As we explain, the trial court's rulings pass muster under either standard.

B. *Declaration of Terry Van Noy*

Hagan claims the trial court erred in sustaining a number of Blue Shield's objections to the declaration of Terry Van Noy, whom Hagan presented as an expert in insurance underwriting and claims handling.[8] Most of Blue Shield's objections are to portions of the declaration in which Van Noy opined that particular questions or terms found in Blue Shield's application were overbroad or ambiguous. Blue Shield also objected to Van Noy's opinion that the Hagan's understanding of, or answers to, certain questions were "reasonable."

We find no error in the trial court's rulings on these objections. The interpretation of questions on an application for insurance is a matter of law upon which courts make an independent determination. (*Williamson & Vollmer Engineering, Inc. v. Sequoia Ins. Co.* (1976) 64 Cal.App.3d 261, 268-269.) Van Noy's proffered testimony "was an opinion which interpreted the terms of a written instrument — purely a legal conclusion." (*Devin v. United Services Auto. Assn.* (1992) 6 Cal.App.4th 1149, 1157-1158, fn. 5; see also

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[8] Hagan identifies the specific objections in his reply brief. At issue are the objections numbered 62 through 74 in Blue Shield's objections to plaintiff's declarations and evidence.

Cooper Companies v. Transcontinental Ins. Co. (1995) 31 Cal.App.4th 1094, 1100 ["the meaning of the policy is a question of law about which expert opinion testimony is inappropriate"].) California case law is clear that an expert's opinion as to the meaning of an insurance policy "is irrelevant to the court's task of interpreting the policy as read and understood by a reasonable lay person." (*National Auto. & Casualty Ins. Co. v. Stewart* (1990) 223 Cal.App.3d 452, 459; accord, *Suarez v. Life Ins. Co. of North America* (1988) 206 Cal.App.3d 1396, 1407 ["The meaning the average reader would give the advertisement and the policy was not a question for the opinion of an expert witness . . . ."].) Blue Shield's objections to this testimony were therefore properly sustained. Similarly, the trial court correctly excluded other portions of Van Noy's declaration which depended upon his opinion that certain questions were ambiguous, including his conclusion that the ambiguity of questions 8.A., 20, 21, 23, and the "last physician visit" question were the cause of Blue Shield's alleged failure to complete medical underwriting, as well as his conclusion that Blue Shield rescinded the policy based on information not called for on its application.

Nor did the trial court err in excluding Exhibit D to Van Noy's declaration, a document that purported to be a page from a health history questionnaire drafted by another insurer. Blue Shield objected that the document violated the secondary evidence rule, lacked authentication, and was irrelevant. To authenticate the document, Hagan was required to introduce "evidence sufficient to sustain a finding that it is the writing [Hagan] claims it is[.]" (Evid. Code, § 1400.) But the document's contents do not indicate what the document is, and Van Noy claimed only that he had received it from Hagan's counsel. As there was no evidence that the document was what Hagan claimed it was, the trial court could properly exclude it. In addition, the document was offered in an effort to prove that a term in Blue Shield's application was ambiguous, and as we have already noted, whether the application was ambiguous was a purely legal question for the court. (*Devin v. United Services Auto. Assn., supra,* 6 Cal.App.4th at pp. 1157-1158, fn. 5.) The document was therefore also irrelevant.

C. *Declaration of John Hagan*

Hagan also challenges the trial court's decision to sustain two of Blue Shield's objections to the declaration he submitted in opposition to Blue Shield's motion for summary judgment. In his declaration, Hagan stated: "At the time Lori and I filled out and signed the Blue Shield application, we did not understand Part 7 to request information regarding Lori's gynecologist, Dr. Hartley."[9] Blue Shield objected to this statement on a number of grounds. It asserted Hagan lacked personal knowledge of what Lori may have understood, and it claimed the statement contradicted prior deposition testimony in which Hagan had testified he had no recollection of filling out Part 7 or of reading the instruction for that part. We agree that Hagan could not testify to his wife's understanding of Part 7, because he lacked personal knowledge. (Evid. Code, § 702, subd. (a).) In addition, Hagan testified at his deposition that he had no recollection of filling out the application, and he could not remember even reading the instructions to Part 7 of the application. In light of Hagan's prior deposition testimony, the trial court did not err in excluding his statement regarding how he understood the instructions, particularly since Hagan offered no explanation for the inconsistency between his declaration and his deposition testimony. (*Whitmire v. Ingersoll-Rand Co.* (2010) 184 Cal.App.4th 1078, 1087-1088.)

The trial court also properly sustained Blue Shield's objection to the portion of Hagan's declaration in which he stated he and Lori would have provided the name of Lori's gynecologist if the application had asked for that information. What the Hagans would have done in a hypothetical situation is simply not relevant to the issues in this case. (Evid. Code, § 210.)

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[9] We note that, in his briefs to this court, Hagan does not appear to contest the trial court's decision to sustain another of Blue Shield's objections which challenged a similar statement. Blue Shield successfully objected to the following portion of Hagan's declaration: "We understood [Part 7 of the application] to mean each of our last visits with our family physician, Dr. Elyse Donald. Consequently, we identified Dr. Donald in the space asking for the physician's contact information and wrote in the date we had last seen Dr. Donald."

Having resolved the evidentiary issues, we turn now to the merits of the parties' arguments. In so doing, we consider only the evidence that we have determined was properly admissible. (See *Johnson v. City of Loma Linda, supra,* 24 Cal.4th at pp. 65-66.)

III. *General Principles Governing an Insurer's Right to Rescind*

" 'Governing law permits an insurer to rescind a policy when the insured has misrepresented or concealed material information in connection with obtaining insurance.' [Citation.]"[10] (*Nieto, supra,* 181 Cal.App.4th at p. 75.) When an applicant seeks to procure insurance, "an insurer has a right to know all that the applicant . . . knows regarding the state of his health and medical history." (*Thompson v. Occidental Life Ins. Co.* (1973) 9 Cal.3d 904, 915 (*Thompson*); see § 332 [each party to insurance contract "shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract . . . ."].) Under the Insurance Code, "heavy burdens of disclosure are placed upon both parties to a contract of insurance and any material misrepresentation or the failure, whether intentional or unintentional, to provide requested information permits rescission of the policy by the injured party." (*Imperial Casualty & Indemnity Co. v. Sogomonian* (1988) 198 Cal.App.3d 169, 179-180, fn. omitted (opn. per Croskey, J.) (*Sogomonian*).) These disclosure requirements and the statutory right to rescind based on concealment or material misrepresentation safeguard the parties' freedom to contract. (*Mitchell v. United National Ins. Co.* (2005) 127 Cal.App.4th 457, 468-469 (*Mitchell*).)

The insurer is generally entitled to rely on the information the insured provides in the application for insurance. (See *Robinson v. Occidental Life Ins. Co.* (1955) 131 Cal.App.2d 581, 585 (*Robinson*) [insurer could rely on statements insured made to medical examiner].) The law does not require the insurer to verify the accuracy of that

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[10] (See § 331 ["Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance"], § 359 ["If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false"].)

information. (*Mitchell, supra,* 127 Cal.App.4th at p. 477.) Nor is the insurer required "to take all possible measures to reveal undisclosed conditions." (*Lunardi v. Great-West Life Assurance Co.* (1995) 37 Cal.App.4th 807, 826 (*Lunardi*).) Instead, it is the duty of the insured to "divulge fully" all he or she knows. (*Robinson,* at p. 585.)

We judge the materiality of a misrepresentation or omission "solely by the probable and reasonable influence" the undisclosed information would have upon Blue Shield's decision to issue the policy. (§ 334; *Sogomonian, supra,* 198 Cal.App.3d at p. 181.) As Justice Croskey explained in *Sogomonian,* "[t]his is a *subjective* test; the critical question is the effect truthful answers would have had on [Blue Shield], not on some 'average reasonable' insurer." (*Sogomonian,* at p. 181.) Blue Shield need not show that knowledge of the actual facts would have led it to deny coverage; it is sufficient if disclosure of the facts would have caused it either to charge a higher premium or to investigate further before issuing the policy. (*Old Line Life Ins. Co. v. Superior Court* (1991) 229 Cal.App.3d 1600, 1604-1605 [misrepresentation material if it affects fixing of premium]; *Torbensen v. Family Life Ins. Co.* (1958) 163 Cal.App.2d 401, 405 ["The question is whether the misrepresentation is such that if the insurer had known the true facts it would have made further inquiries or would have been influenced materially in its decision in accepting the risk"].)

"The fact that the insurer has demanded answers to specific questions in an application for insurance is in itself usually sufficient to establish materiality as a matter of law." (*Thompson, supra,* 9 Cal.3d at p. 916.) The materiality of particular information may also be established by testimony that the misrepresented or omitted information would have affected the insurer's underwriting decision. (See, e.g., *Old Line Life Ins. Co. v. Superior Court, supra,* 229 Cal.App.3d at p. 1604 [insurer's underwriter testified company would not have issued nonsmoking policy to smoker].)

Finally, an applicant's incorrect or incomplete responses do not constitute grounds for rescission if the applicant has "no present knowledge of the facts sought" or if the applicant "fail[s] to appreciate the significance of information related to him" or her. (*Thompson, supra,* 9 Cal.3d at p. 916.) But the applicant's duty to disclose is not excused

merely because the applicant does not completely understand all the effects of a health condition. (*Casey by & through Casey v. Old Line Life Ins. Co.* (N.D. Cal. 1998) 996 F.Supp. 939, 949.) The applicant's personal belief about the gravity of his or her health condition does not matter. (See *Cohen v. Penn Mut. Life Ins. Co.* (1957) 48 Cal.2d 720, 727 (*Cohen*).) "Where an insured is aware of her condition, symptoms, or treatment, she is obliged to disclose them upon request." (*Freeman v. Allstate Life Ins. Co.* (9th Cir. 2001) 253 F.3d 533, 537 (*Freeman*).)

IV. *The Policy Does Not Require Blue Shield to Prove the Hagans's Misrepresentations or Omissions Were Intentional.*

Hagan argues that while section 331 generally entitles an insurer to rescind a policy based upon unintentional concealment, Blue Shield's "Evidence of Coverage" (EOC) form provides that the policy's coverage may be cancelled only for "false representations," a term which, in Hagan's view, "clearly means intentional conduct."[11] Hagan therefore claims Blue Shield could only rescind the policy if it could show the Hagans had made intentional misrepresentations or omissions on their insurance application. Hagan contends that "general statutes," such as sections 331 and 359, "cannot be read into insurance policies to limit coverage."

The trial court did not address this issue directly, as it found that there could be no reasonable dispute that the Hagan's misrepresentation and omissions were willful. Nevertheless, since the issue affects our determination of whether Hagan has raised a genuine issue of material fact precluding summary judgment, we will resolve it. (Cf. *Teselle v. McLoughlin* (2009) 173 Cal.App.4th 156, 172 [materiality of factual dispute depends on issues in the case, and what matters are at issue in case is determined in part

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[11] The portion of the policy on which Hagan relies states in relevant part: "This Policy may be cancelled by Blue Shield Life for false representations to, or concealment of material facts from, Blue Shield Life in any health statement, application, or any written instruction furnished to Blue Shield Life by the Insured at any time before or after issuance of this Policy, or fraud or deception in enrollment. . . . [¶] Blue Shield Life may terminate this Policy for cause immediately upon written notice for the following: [¶] a. Material information that is false or misrepresented information provided on the enrollment application or given to the Plan[.]"

by substantive law].) Our review of the record and applicable law compels us to reject Hagan's argument.

First, although the parties do not discuss the issue, we note that the policy language Hagan cites sets forth only the conditions under which the policy "may be *cancelled*." (Italics added.) It does not address rescission, which is entirely distinct from cancellation. (See *Sogomonian, supra,* 198 Cal.App.3d at p. 182.) Rescission is a *retroactive* termination of the policy, whereas cancellation is a *prospective* one. (*Ibid.*) Rescission extinguishes the policy *ab initio,* "as though it had never existed." (*Id*. at p. 184.) "A policy void *ab initio* . . . cannot be breached." (*LA Sound USA, Inc. v. St. Paul Fire & Marine Ins. Co.* (2007) 156 Cal.App.4th 1259, 1266 (*LA Sound*).) Hagan's entire argument necessarily assumes that a valid contract of insurance was formed between his family and Blue Shield. But if the policy was properly rescinded, then the Hagans "never were insureds under [Blue Shield's] policy of insurance." (*Sogomonian,* at p. 184.) Consequently, the language of the EOC logically cannot apply to limit Blue Shield's right to rescind, which is based upon provisions of the Insurance Code that "are directed specifically at the *formation* of the insurance contract."[12] (*Mitchell, supra,* 127 Cal.App.4th at p. 468, italics added; see also *LA Sound,* at p. 1270 [language appearing in policy applies only to statements made after policy is issued, not to statements made to obtain policy]; *Atmel Corp. v. St. Paul Fire & Marine* (N.D. Cal. 2005) 426 F.Supp.2d 1039, 1050 [language contained in policy issued after application has been approved does not apply to misrepresentation or concealment in application].)

Second, we are not at liberty to disregard the applicable provisions of the Insurance Code, because the Legislature has directed that they shall govern "[a]ll insurance in this State[.]" (§ 41.) As discussed above, sections 331 and 359 are part of a statutory framework imposing disclosure obligations upon both parties to an insurance

[12] We note also that Hagan's argument does not attempt to reconcile the allegedly limiting language of the EOC with the language of the application itself, which states that coverage may be cancelled or rescinded if any information provided on the application is "false or incomplete."

policy, and even an unintentional failure to provide requested information permits the injured party to rescind the policy. (*Mitchell, supra,* 127 Cal.App.4th at pp. 468-469.) Under this framework, "*an actual intent to deceive need not be shown*." (*Thompson, supra,* 9 Cal.3d. at p. 916, italics added; see also *O'Riordan, supra,* 36 Cal.4th at pp. 286-287 [insurer may rescind policy for concealment "even if the act of concealment was unintentional"].) Thus, under sections 331 and 359, an insurer may rescind an insurance policy "based on an insured's negligent or inadvertent failure to disclose a material fact in the application for insurance . . . ."[13] (*Mitchell,* at p. 469.) Indeed, an insurer may rescind the policy for a material misrepresentation "even though the insured's misstatements were . . . *the product of innocence*." (*Barrera v. State Farm Mut. Automobile Ins. Co.* (1969) 71 Cal.2d 659, 665-666, fn. 4, italics added.) Therefore, for purposes of summary judgment, Blue Shield was not required to demonstrate that the Hagans intentionally sought to deceive it. (1 Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2011) ¶ 5:169, p. 5-42.) Consequently, under California law, evidence that the Hagans lacked any intent to mislead or defraud Blue Shield would not create a triable issue of fact. (See *Nieto, supra,* 181 Cal.App.4th at p. 78.)

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[13] We also reject Hagan's claim that these statutes "cannot be read into insurance policies to limit coverage." The cases he cites are inapposite. (See *State Farm Fire & Casualty Co. v. Workers' Comp. Appeals Bd.* (1997) 16 Cal.4th 1187, 1199, fn. 7 ["an insured is not required to consult the California codes to discover any statutory limitations on coverage, but is ordinarily entitled to trust the language of the policy"]; *Utah Property & Casualty Ins. Etc. Assn. v. United Services Auto Assn.* (1991) 230 Cal.App.3d 1010, 1021 ["Laypersons cannot be expected to know of statutory limitations or exclusions on coverage not contained in their insurance policies"].) As explained above, sections 331 and 359 address the formation of the insurance contract. (*Mitchell, supra,* 127 Cal.App.4th at p. 468.) If no insurance contract is formed, then there is no coverage at all. (*Sogomonian, supra,* 198 Cal.App.3d at p. 184.) Thus, these statutes cannot be viewed as limitations or exclusions on *coverage*. To the extent that *Clarendon Nat. Ins. v. Insurance Co. of the West* (E.D. Cal. 2006) 442 F.Supp.2d 914 can be read to hold to the contrary, we disagree with its analysis and decline to follow it. (See *LA Sound, supra,* 156 Cal.App.4th at p. 1270, fn. 4 ["*Clarendon's* rescission analysis is unpersuasive and not binding on us"].)

Third, even if the language of the EOC could somehow be held to limit retroactively Blue Shield's right to rescind, the language is not as restrictive as Hagan suggests. The EOC states that the policy "may be cancelled by Blue Shield Life for . . . concealment of material facts from, Blue Shield Life in any . . . application . . . ." Under the Insurance Code, if a party neglects to communicate that which the party knows and ought to communicate, the party is guilty of "concealment."[14] (§ 330.) Thus, if the Hagans negligently failed to disclose material information on the application, then even under the terms of the EOC, Blue Shield was entitled to cancel the policy.[15]

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[14] Contrary to Hagan's argument, the term "concealment" does not clearly require intentional conduct, nor is the term ambiguous. A term in a standard form insurance policy is not ambiguous when it has been judicially construed. (*Lockheed Martin Corp. v. Continental Ins. Co.* (2005) 134 Cal.App.4th 187, 197-198, disapproved on another point in *State of California v. Allstate Ins. Co.* (2009) 45 Cal.4th 1008, 1036, fn. 11.) Here, the Legislature itself has both defined the term "concealment" and specified that concealment entitles a party to rescind an insurance contract. (§§ 330, 331.) If a term is unambiguous when it has been *judicially* construed, we think it can hardly be held ambiguous when it has been *legislatively defined*.

[15] In a motion filed September 2, 2011, Hagan requested that we take judicial notice of the Second District's unpublished opinion in *Bath v. Blue Shield of California* (Aug. 31, 2011, B219290) [nonpub. opn.]) (*Bath*). We deny his request. (Cal. Rules of Court, rule 8.1115(a) [opinions not certified for publication "must not be cited or relied on by a court or a party in any other action"].) Hagan contends *Bath* may be cited as a matter of collateral estoppel. (Cal. Rules of Court, rule 8.1115(b).) He argues that *Bath* estops Blue Shield from arguing it was entitled to rescind the Hagans' policy for unintentional misrepresentations or omissions, claiming this issue was decided adversely to Blue Shield in *Bath*.

Hagan has the burden of establishing the threshold requirements of collateral estoppel. (E.g., *Lucido v. Superior Court* (1990) 51 Cal.3d 335, 341.) Among those requirements are: (1) "the issue sought to be precluded from relitigation must be identical to that decided in [the] former proceeding," (2) "this issue must have been actually litigated in the former proceeding," and (3) "the party against whom preclusion is sought must be the same as, or in privity with, the party to the former proceeding." (*Ibid.*) Even assuming that all other requirements for application of collateral estoppel are met, we cannot say Hagan has established the existence of the foregoing elements. First, it is far from clear that the issue presented in *Bath* is identical to the one in our case. *Bath* construed the provisions of a different policy that did not contain some of the language we have discussed above. (See *Malek v. Blue Cross of California* (2004) 121

V. *The Hagans Omitted Material Information on Their Insurance Application.*

Hagan claims there were disputed issues of material fact as to whether he and his family misrepresented or concealed material information on their application for insurance. Much of the parties' briefing focuses on whether the application required disclosure of Lori's diagnosis of uterine fibroids or "abnormal bleeding." Whether or not the application was sufficiently clear to require the Hagans to disclose those conditions, we conclude there is no dispute of fact as to the Hagans' failure to disclose other conditions and history plainly listed on the application. In addition, it is undisputed the Hagans provided incorrect information in response to the "last physician visit" question. These misrepresentations or omissions were material and, on their own, justified Blue Shield's rescission of the policy.

Cal.App.4th 44, 65-66, fn. 10 [collateral estoppel not appropriate where "the issues decided [in the former proceeding] were based on a different Blue Cross enrollment form"].) *Bath* also involved an insurance agreement issued by a health services plan subject to the Knox-Keene Act, and for this reason, the court expressly declined to consider the effect of sections 330, 331, 358, and 359 on the interpretation of the agreement. Collateral estoppel does not apply when the proceeding in which estoppel is sought involves different substantive law than the former proceeding. (*California Hospital Assn. v. Maxwell-Jolly* (2010) 188 Cal.App.4th 559, 572.) Second, in determining whether an issue was actually litigated in the former proceeding, "courts look carefully at the *entire record* from the prior proceeding . . . ." (*Hernandez v. City of Pomona* (2009) 46 Cal.4th 501, 511, italics added.) Here, Hagan has given us the Second District's opinion in *Bath,* but we have no materials from the record in that case. Finally, Blue Shield, which issued the policy in this case, was not a party in *Bath.* Nor is it clear that Blue Shield was in privity with California Physicians' Service, the insurer in *Bath*. In this case, Hagan sued California Physicians' Service solely on an alter ego theory, and he argues that Blue Shield has conceded it is a wholly-owned subsidiary of California Physicians' Service, which provides Blue Shield with all of its employees, facilities, information systems, and operations support. But the alter ego doctrine is a limited one and presents a "peculiarly factual issue." (*Tomaselli v. Transamerica Ins. Co.* (1994) 25 Cal.App.4th 1269, 1284, 1285.) Hagan does not contend the alter ego theory was litigated or decided below, and he directs us to nothing in the record showing the existence of "such critical facts as inadequate capitalization, commingling of assets, [and] disregard of corporate formalities" that would make application of the alter ego doctrine appropriate in this case. (*Id.* at p. 1285.) Hagan has therefore failed to meet his burden of establishing the elements of collateral estoppel.

As discussed in our statement of facts, the health history portion of the application asked whether, in the past 20 years, any of the applicants had "received any professional advice or treatment, including prescription medications, from a licensed health care practitioner or had any symptoms pertaining to any of the following?" Question 8.A. inquired about the female reproductive system, and it specifically asked about "adhesions" and "endometriosis," as well as about "problems of the ovaries, uterus, and associated female organs." Question 20 asked whether any of the applicants had been "an inpatient or outpatient in a hospital, surgical center, sanitarium, or other medical facility, . . . or had surgery[.]" And Question 23 asked about "[d]iagnoses . . . not mentioned elsewhere in this application . . . ."

The Hagans responded "no" to Question 8.A. The record shows, however, that when Lori was first examined by Dr. Hartley, he found her uterus was enlarged to about eight weeks size and was tender with manipulation. He prescribed the antibiotic Cipro to see whether it would help with the pain Lori was experiencing. After Dr. Hartley performed an exploratory laparoscopy in June 2001, he informed Lori that she had extensive adhesive disease and endometriosis. As treatment for her menstrual cramping, Lori received injections of Depo Lupron, a prescription medication, for about four months. She was also given Premarin, which Dr. Hartley described as estrogen. When Dr. Hartley saw Lori in March 2004, she complained of painful periods and heavier blood flow. He recorded a diagnosis of menorrhagia (abnormally heavy menstrual bleeding) and dysmenorrhea (pain with menses) and discussed the possibility of treatment by endometrial ablation.

The record also demonstrates that while Lori was admitted to the Ukiah Surgery Center for the laparoscopy, the Hagans did not disclose either the admission or the procedure in response to Question 20. But Dr. Hartley testified that laparoscopy is a "surgical procedure" and that Lori was placed under general anesthesia for the "operation." Indeed, in her July 18, 2006 letter to Blue Shield, Lori herself described the procedure as "exploratory surgery."

Part 7 of the application asked the Hagans to "provide details regarding the last physician visit you and/or any applying family member has had, regardless of the date (*includes check-ups*). (Italics added.) Although Lori had seen Dr. Hartley just three weeks before she signed the application, her last physician visit was listed as a June 6, 2004 check up with her family physician, Dr. Elyse Donald, and the findings of that visit were described as "all good." In fact, however, the record shows that Lori's last visit with Dr. Donald took place on September 13, 2004, at which time Dr. Donald prescribed Cipro to treat Lori's urinary infection.

To summarize, the undisputed facts in the record show that the Hagans did not inform Blue Shield of at least two diagnoses about which Question 8.A. specifically inquired — adhesions and endometriosis. They also did not disclose that Lori had received "prescription medications" for treatment of cramping. Nor did they reveal the fact that Lori had been admitted at a surgery center where she had undergone a surgical procedure, two facts about which Question 20 specifically inquired. And despite Question 23, which asked about diagnoses, symptoms, or health problems not mentioned elsewhere on the application, Lori's diagnoses of menorrhagia and dysmenorrhea also went unmentioned. Thus, in this case, the undisputed evidence established that Lori misrepresented and/or omitted facts regarding her medical condition and treatment in filling out the application. (See *Nieto, supra,* 181 Cal.App.4th at p. 77 [insured failed to disclose chronic back problems, misrepresented date of her last doctor's visit, and did not reveal taking numerous prescription medications].)

VI. *The Application Was Sufficiently Specific to Require Disclosure of Lori's Medical History.*

Hagan argues the duty to disclose material facts about Lori's medical history was not triggered because the application did not request the information upon which Blue Shield relied in rescinding the policy. For example, he contends that since Question 8.A. did not ask about an "enlarged uterus" or "menorrhagia," there was no obligation to reveal that Lori had received those diagnoses. Thus, Hagan argues that the discrepancy between the language used in the application and the medical conditions and history Blue

Shield claims Lori should have disclosed was itself sufficient to raise a triable issue of fact as to whether Lori's negative answers were misrepresentations or omissions. Put another way, Hagan asserts that unless the application specifically asked about a particular condition or symptom, the Hagans were under no duty to disclose it.

California law is to the contrary, however. An applicant for insurance is under a statutory duty to disclose "all facts within his knowledge which are or which he believes to be material to the contract . . . ." (§ 332.) "Where an insured is aware of her condition, symptoms, or treatment, she is obliged to disclose them upon request." (*Freeman, supra,* 253 F.3d at p. 537.) Courts that have permitted rescission of insurance policies have never required that an application make detailed inquiries about specific conditions before an applicant's duty to disclose health information is triggered. For example, in *Freeman, supra,* 253 F.3d 533, the court held the insurer could properly rescind a life insurance policy when it discovered that the applicant, who had been asked whether she suffered from any disease of the nervous system, failed to reveal she suffered from epilepsy. (*Id.* at pp. 536-537.) Similarly, in *Robinson, supra,* 131 Cal.App.2d 581, at pages 585 to 586, the court held the insurer properly denied a claim under a life insurance policy where the applicant had failed to disclose he suffered from vascular hypertension and had seen a physician for that condition.[16] Thus, in *Freeman,* the insurer's question about whether the applicant had "sought or received treatment or advise [*sic*] . . . for a disease of . . . the nervous . . . system" required the applicant to disclose her epilepsy. (*Freeman,* at pp. 535, 537.) In *Robinson* the court held the applicant should have disclosed his vascular hypertension when the application inquired whether he was in "good health" or had "any other disease or injury." (*Robinson,* at pp. 582, 585-586; accord, *Life Ins. Co. of North America v. Capps* (9th Cir. 1981) 660

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[16] Among other things, the application at issue in *Robinson* asked, "Do you know of any impairments now existing in your health or physical condition?" and "Have you ever had any of the following: . . . Disease of [the] heart?" (*Robinson, supra,* 131 Cal.App.2d at p. 582.) The applicant answered "no" to those questions. (*Ibid.*) In addition, the applicant responded that he was in "good health" and did not have "any other disease or injury." (*Ibid.*)

F.2d 392, 393-394 [rescission proper where insured failed to disclose prolapsed mitral valve on application that asked whether she had "ever had heart trouble"].) In short, that Blue Shield's application did not specifically ask about each and every symptom, disease, or condition that might conceivably be relevant to its underwriting decision does not create a triable issue of fact as to whether the failure to disclose Lori's diagnoses constituted misrepresentation or concealment.[17]

Hagan seeks to excuse the failure to disclose Lori's diagnosis of endometriosis — a condition *specifically listed* in Question 8.A. — by arguing that it was a "small amount" and that Lori never received any "professional advice or treatment" concerning it. But whether the Hagans personally believed the area of endometriosis outside of Lori's uterus was too small to merit disclosure is irrelevant. Blue Shield "did not ask on the application for merely [Lori's] evaluation of [her] physical condition, but also for a truthful statement of [her] medical history." (*Cohen, supra,* 48 Cal.2d at p. 727; see also *LA Sound, supra,* 156 Cal.App.4th at p. 1267 [where corporate applicant participating in joint venture responded "no" to question on application asking whether it was involved in a joint venture, its answer was false and insurer was entitled to rescission under §§ 331 and 359].) Moreover, the record establishes that Lori was advised by Dr. Hartley of this diagnosis. Thus, contrary to Hagan's contention, his wife did, in fact, receive professional advice pertaining to this condition.

Hagan's attempted explanations for the failure to disclose Lori's laparoscopic surgery fare no better. He asserts the laparoscopy "was for exploratory purposes only."

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[17] Here, there is no dispute that Lori was informed by Dr. Hartley of the conditions with which she was diagnosed and that she had experienced symptoms. (See *Robinson, supra,* 131 Cal.App.2d at p. 585 [applicant "knew of his malady" because "[h]is doctor had told him and he had suffered"]; *Life Ins. Co. of North America v. Capps, supra,* 660 F.2d at p. 394 [applicant was aware of her conditions, symptoms, and treatment and recognized existence of her heart trouble].) This distinguishes the case before us from *Thompson, supra,* 9 Cal.3d 904, upon which Hagan relies. In that case, the California Supreme Court concluded that a jury could reasonably find the decedent had not concealed his arteriosclerosis and intermittent claudication from the insurer because none of the physicians with whom decedent had consulted had advised him he suffered from those conditions. (*Id*. at p. 917.)

Once again, Hagan's opinion about the purpose or significance of the laparoscopy does not matter to our analysis. (See *Cohen, supra,* 48 Cal.2d at p. 727 ["Nor does it matter what the deceased might personally have believed about his heart condition and its lack of substantial character"].) What matters is the undisputed fact that Lori was admitted to the Ukiah Surgery Center where she underwent a laparoscopy, a procedure that both Dr. Hartley and Lori herself described as surgery.[18] Moreover, Question 20 asked only whether any applicant had been "an inpatient or outpatient in a . . . surgical center . . . or had surgery . . . ." It did not inquire about the purpose of the surgery. Hagan also argues that a laparoscopy is "nothing like the 'angioplasty, bypass, transplant, etc.' surgeries mentioned in the question." But even if we assume this to be both true and relevant, Hagan cites no facts upon which we could base such a conclusion.

With regard to the "last physician visit" question, it is undisputed that Lori saw Dr. Hartley approximately three weeks before she signed the application. Despite this, on the application her last physician visit was listed as a June 6, 2004 check-up with Dr. Elyse Donald. Nevertheless, Hagan argues there is a disputed issue of fact as to whether the answer constituted misrepresentation or concealment because the question did not ask specifically for the name of Lori's gynecologist and could reasonably be interpreted as inquiring about an applicant's "general physician." We disagree. The application asked the Hagans to "provide details regarding the last physician visit you and/or any applying family member has had, regardless of the date (includes check-ups)." The quoted language plainly requested information about the applicants' last visit to a physician. The parenthetical phrase "includes check-ups" clearly indicates the request was not limited to check-ups but rather simply sought information regarding the last physician the applicants had seen. Hagan's interpretation of the question is "at best [a]

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[18] Hagan argues Blue Shield failed to present evidence as to how the laparoscopy would have been rated or what Blue Shield would have done differently had it known about it, and therefore the burden on this issue never shifted to the plaintiff. We disagree. Blue Shield presented evidence that it would not have issued the policy had it known of Lori's undisclosed medical history, including the laparoscopy.

hypertechnical dissection[] of the language."[19] (*Lundardi, supra,* 37 Cal.App.4th at p. 820.)

VII. *The Omissions Were Material.*

Although Hagan's opening brief does not make a separate argument challenging the materiality of the information that was not disclosed on the application, we agree with the trial court that the information was material. Burke and Hill both stated in their declarations that if Blue Shield had known of Lori's diagnosis of endometriosis, it would have requested medical records concerning the diagnosis, and those records would have revealed Lori's laparoscopy, diagnosis of fibroid uterus, Depo Lupron injection treatment, and Dr. Hartley's advice to Lori regarding treatment by hysterectomy or endometrial ablation. (See *Nieto, supra,* 181 Cal.App.4th at pp. 77-78 [declarations of Blue Shield underwriters demonstrated that omissions on insurance application were material under § 334]; see also *Torbensen v. Family Life Ins. Co., supra,* 163 Cal.App.2d at p. 405 [information material if it might have affected the extent of insurer's investigation and examination of the applicant].) Furthermore, both Burke and Hill declared that the information contained in the medical records would have led Blue Shield to deny coverage.

Moreover, if Lori had disclosed her April 2005 visit to Dr. Hartley, Blue Shield would have obtained the records of that visit, and the information contained in those records would have led to a denial of coverage. Clearly, information that would have led the insurer to deny the application qualifies as material. (*Nieto, supra,* 181 Cal.App.4th

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[19] Hagan also argues that he believed Blue Shield would request medical records from Dr. Donald and another insurer as part of the underwriting process. He claims this demonstrates the Hagans were not trying to hide anything from Blue Shield. As we have explained above, however, Blue Shield was entitled to rely on the information the Hagans provided on their application and was not required to investigate further. (*Mitchell, supra,* 127 Cal.App.4th at p. 469; see *Robinson, supra,* 131 Cal.App.2d at p. 585 [it was not incumbent upon insurer to investigate statements applicant made to examiner].) Moreover, because rescission may be predicated upon unintentional misrepresentation or concealment, the fact that the Hagans were not trying to hide anything from Blue Shield does not create a triable issue of fact. (See *Nieto, supra,* 181 Cal.App.4th at p. 78.)

at pp. 77-78.) In addition, since both Burke and Hill declared that the mere advisement by Dr. Hartley of Lori's potential treatment in the form of endometrial ablation or hysterectomy would have caused Blue Shield to postpone its determination of whether to issue coverage and, if so, at what rate, this further demonstrates that the omitted information was material. (*Old Line Ins. Co. v. Superior Court, supra,* 229 Cal.App.3d at pp. 1604-1605 [information material if it would affect fixing of premium].)

VIII. *There Is No Factual Dispute on the Issue of Causation.*

Hagan next argues there are factual disputes about whether Blue Shield would have refused to issue the policy if Lori's medical history had been fully disclosed. He notes the trial court ruled that Burke's testimony established that Blue Shield would not have issued the policy but for the misrepresentations and/or omissions on the application. He contends, however, that the trial court ignored portions of Burke's deposition that created a dispute of fact on this issue. Not so.

In moving for summary judgment, Blue Shield asserted that if Lori had revealed her diagnosis of endometriosis and disclosed that she had seen Dr. Hartley within 30 days of filling out the application, it would have ordered Lori's medical records, and the information contained in those records would have led Blue Shield to deny coverage. Hagan contends Burke's deposition testimony created a dispute of fact on this point, because he claims she testified there was no *requirement* that Blue Shield order records in such circumstances, but only that Blue Shield *may* order records in those circumstances.

We have reviewed Burke's deposition testimony, and we cannot agree with Hagan's reading of it. In response to a question by Hagan's counsel about whether Blue Shield would order an applicant to have a physical examination before issuing a policy, Burke explained, "We don't order them to have a physical exam – physical examination, pardon me. *We request the results of any – any medical visit within 30 days* . . . ." (Italics added.) Thus, Burke's deposition testimony is entirely consistent with the statement in her declaration.

Hagan relies on another portion of Burke's deposition, but he takes her testimony out of context. Burke responded to a question by Hagan's counsel in which he listed the

circumstances in which Blue Shield would order medical records before approving an application. The circumstances he listed included "situations where [t]he [a]pplicant had a physician visit within 30 days of the application[.]" Hagan's counsel then went on to ask, "*Other than those situations,* are you aware of *any other situation,* based on your company's policies and procedures, where your company would order medical records before issuing a contract?" (Italics added.) Burke responded, "We may order a medical – excuse me. It is not a requirement. It depends on how the explanations are written on the application." Viewing this testimony in the context of the question to which Burke responded, it is apparent that she did not contradict her declaration. Hagan's counsel was not asking her whether Blue Shield would have ordered medical records if an applicant had seen a physician within 30 days prior to signing the application. Instead, he was inquiring about whether there were other circumstances in which Blue Shield would order medical records.

Hagan further argues that even if Burke were to testify at trial that her practice was to order records in all such circumstances, the jury would be entitled to disregard this testimony. He cites language from *Thompson, supra,* 9 Cal.3d 904, in which our Supreme Court noted that "the trier of fact is not required to believe the 'post mortem' testimony of an insurer's agents that insurance would have been refused had the true facts been disclosed." (*Id*. at p. 916.) Unlike the case before us, however, "[t]he *Thompson* judgment resulted from a verdict following a jury trial, and the court was simply following the well-settled principle that a jury need not accept the testimony of any particular witness. Here, however, the evidence in support of the motion for summary judgment was uncontradicted. . . . [B]ecause plaintiff did not present controverting evidence regarding this issue of material fact, the trial court properly determined no factual dispute existed." (*Wilson v. Western National Life Ins. Co.* (1991) 235 Cal.App.3d 981, 995-996 [affirming summary judgment for insurer in rescission case].) The quoted language from *Thompson* is therefore "irrelevant to a motion for summary judgment where no factual dispute exists on the issue of materiality." (*Casey by & through Casey v. Old Line Life Ins. Co., supra,* 996 F.Supp. at p. 948.)

Hagan also takes issue with the portion of Burke's declaration in which she stated Blue Shield would not have issued the policy had it known of Lori's diagnoses of uterine fibroid, enlarged uterus, menorrhagia, and endometriosis. Incredibly, he claims that "neither Question 8.A., nor any of the questions that Blue Shield accused Lori of incorrectly answering, called for this information." But as we have noted above, endometriosis is one of the conditions specifically listed in Question 8.A., a fact Hagan did not dispute in the separate statement of facts he submitted in opposition to Blue Shield's motion for summary judgment. Blue Shield asserted that Lori's diagnosis of endometriosis within less than five years of the application would have caused it to request records concerning the diagnosis, and those records would have led to the discovery of additional medical history that would have caused Blue Shield to deny the application. Hagan has failed to raise a disputed issue of fact on this point.

IX. *Blue Shield Did Not Violate Section 10384's Prohibition on Postclaims Underwriting.*

In its order granting summary judgment, the trial court found there was no evidence Blue Shield had engaged in postclaims underwriting. It ruled, "Blue Shield . . . properly completed medical underwriting as required by . . . [s]ection 10384 prior to issuing the Policy. No information disclosed in the application process triggered any obligation by Blue Shield . . . to have done anything else or taken any additional action before issuing the Policy. There is no legal standard that would have required Blue Shield . . . to automatically contact the doctor disclosed on the Application, obtain medical records or contact Ms. Hagan's prior insurance carrier prior to issuing the Policy. This case is governed by the legal standards concerning underwriting and rescission as set forth in the *Nieto* case. Blue Shield['s] . . . underwriting and subsequent rescission of this Policy met those standards, as well as all other applicable legal standards."

Hagan contends triable issues of fact exist on the issue of whether Blue Shield violated section 10384's prohibition on postclaims underwriting.[20] The principal focus of

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[20] Section 10384 provides: "No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the

this argument is Hagan's claim that Blue Shield rescinded the policy based on conditions never asked about on the application. We have already rejected the argument that the application was insufficiently specific to require disclosure of Lori's medical history. (See part VI, *ante*.) But citing *Nieto, supra,* 181 Cal.App.4th 60, Hagan also asserts Blue Shield failed to complete underwriting in this case because it did not take sufficient steps to verify the accuracy of the information the Hagans submitted on their application.[21] Specifically, Hagan contends the answer to the "last physician visit" question should have prompted Blue Shield to follow up with the Hagans to see how they understood the question. Hagan argues that "the fact that three individuals of different genders and generations . . . had identified the same doctor" in response to this question should have led Blue Shield to make a further inquiry. He contends that in *Nieto,* Blue Shield conducted a follow-up investigation to verify the accuracy of the answers given on an application for insurance, and Blue Shield was obligated to do the same here. For the reasons that follow, we reject this contention as well.

Under the plain language of section 10384, Blue Shield can be guilty of postclaims underwriting only if the "written information submitted on or with" the Hagan's application gave rise to "reasonable questions" that Blue Shield failed to resolve prior to issuing the policy. (§ 10384.) We construe this section against the background of established California law, however, which entitled Blue Shield to rely upon the accuracy

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practice of postclaims underwriting. For purposes of this section, 'postclaims underwriting' means the rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate."

[21] Hagan argues in his reply brief that section 10384 would preclude Blue Shield from rescinding the policy even if it were undisputed that the Hagans had misrepresented or concealed material information on their application for insurance. Hagan did not articulate this argument in his opening brief, and we therefore will not address it. (E.g., *In re Groundwater Cases* (2007) 154 Cal.App.4th 659, 692-693 ["Basic notions of fairness dictate that we decline to entertain arguments that a party has chosen to withhold until the filing of its reply brief, because this deprives the respondent of the opportunity to address them on appeal"].) In any event, as we shall explain, the undisputed facts demonstrate Blue Shield did not engage in postclaims underwriting.

of the information the Hagans provided on their application. (§ 10110.2; *Cohen, supra,* 48 Cal.2d at p. 727-728; *Torbensen v. Family Life Ins. Co., supra,* 163 Cal.App.2d at p. 405.) As we have previously explained, Blue Shield was not required to assume any of the Hagans' statements were false. (*Cohen,* at p. 729.)

In support of Blue Shield's motion for summary judgment, Burke declared that nothing on the Hagans' application triggered any need to obtain additional medical records or other information under its guidelines. Hagan did not dispute Burke's declaration on this point; he simply cited the portions of Burke's deposition testimony in which she discussed the situations in which Blue Shield requests medical records and claimed the application was overbroad, vague, and ambiguous. We have already explained why this deposition testimony did not create a triable issue of fact.

Thus, Hagan's sole remaining argument is that his family's answer to the "last physician visit" question itself raised "reasonable questions" Blue Shield should have resolved prior to issuing the policy. Burke and Hill both stated there was nothing in the Hagan's application that raised questions Blue Shield would have needed to resolve before issuing the policy. We have already concluded the question was not ambiguous, and we see nothing inherent in the Hagan's answer that would have raised questions about the accuracy of the information provided. It hardly seems unusual that three members of the Hagan family would see the same family physician. The dates of their last listed visits with Dr. Donald were all different, and the Hagans listed the name of a different physician for their younger daughter.

Relying on *Nieto, supra,* 181 Cal.App.4th 60, Hagan argues Blue Shield was obligated to take additional steps to ensure the accuracy of the information provided on the Hagans' application. *Nieto* does not assist Hagan. Like the case before us, *Nieto* involved Blue Shield's rescission of an insurance policy after the insurer discovered the applicants had failed to provide material information on the medical history portion of their application. (*Id*. at pp. 67-68.) Although in *Nieto,* multiple Blue Shield employees contacted the applicants to obtain information missing from the application and to inquire

about specific responses that raised concerns (*id*. at p. 85), the case does not hold that an insurer violates section 10384 if it fails to conduct such a follow-up investigation.

Indeed, in the portion of the *Nieto* opinion upon which Hagan relies, the *Nieto* court distinguished the case before it from *Hailey v. California Physicians' Service* (2007) 158 Cal.App.4th 452 (*Hailey*). (*Nieto, supra,* 181 Cal.App.4th at pp. 83-86.) *Hailey* construed a provision of the Knox-Keene Act prohibiting postclaims underwriting by health care services plans licensed by the Department of Managed Health Care.[22] (*Hailey, supra,* 158 Cal.App.4th at pp. 463-464.) *Hailey* focused on the final sentence of the provision at issue and construed it to mean that a health care service plan's right to rescind a policy was unaffected "if the subscriber *willfully misrepresented* his or her health condition in applying for plan coverage." (*Ibid*., italics added.) The court went on to hold that a health care service plan could not complete medical underwriting simply by taking the application and assigning values to the risks disclosed. (*Id*. at pp. 466-469.) Instead, the court interpreted former Health and Safety Code section 1389.3 to require the plan "to make reasonable efforts to ensure a potential subscriber's application is accurate and complete." (*Hailey,* at p. 469.) *Hailey* also rejected the insurer's argument that it was entitled to rely on the truthfulness of an applicant's responses in completing its medical underwriting process. (*Id*. at pp. 469-471.) It explained that the Knox-Keene Act had no counterpart to section 331, which entitles a party to rescind a contract of insurance based on intentional or unintentional concealment. (*Hailey,* at pp. 469-470.) Given that the Knox-Keene Act lacked a provision like section 331, *Nieto* concluded that *Hailey's* medical underwriting requirements were limited to health care service plans

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[22] The wording of the provision construed in *Hailey* is similar to that of section 10384. Former Health and Safety Code section 1389.3 provided: "No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, 'postclaims underwriting' means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. *This section shall not limit a plan's remedies upon a showing of willful misrepresentation.*" (Former Health & Saf. Code, § 1389.3, as added by Stats. 1993, ch. 1210, § 3, italics added.)

subject to the Knox-Keene Act. (*Nieto, supra,* 181 Cal.App.4th at p. 85; accord, *Colony Ins. Co. v. Crusader Ins. Co.* (2010) 188 Cal.App.4th 743, 755-756.)

The *Nieto* court then explained that even if it were to apply *Hailey* to the case before it, the undisputed facts established that Blue Shield had taken appropriate steps to ensure the accuracy and completeness of the application. (*Nieto, supra,* 181 Cal.App.4th at p. 85.) Its employees had contacted the applicants to obtain information missing on the application and had inquired about specific responses that raised concerns. (*Ibid*.) Blue Shield also confirmed in its database that the appellant had no prior claims history. (*Ibid*.) Thus, this portion of the *Nieto* opinion is clearly dictum, and nothing in it suggests that an insurer is *legally obligated* to take such steps in order to avoid liability for postclaims underwriting.

X. *Because Blue Shield Properly Rescinded the Policy, Hagan's Other Claims Fail as a Matter of Law.*

As we have concluded Blue Shield properly rescinded the Hagans' policy, Hagan's claim for bad faith fails as a matter of law. (See *Freeman, supra,* 253 F.3d at p. 537.) Where there is no coverage under a policy, there can be no breach of the covenant of good faith and fair dealing. (See *Waller v. Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1, 36 [implied covenant does not exist independent of contractual right to coverage]; *Ward General Ins. Services, Inc. v. Employers Fire Ins. Co.* (2003) 114 Cal.App.4th 548, 559 [summary judgment on claim for breach of covenant of good faith and fair dealing properly granted where coverage issue was decided against plaintiff].)

The same is true of Hagan's causes of action for intentional and negligent infliction of emotional distress. An insurer does not subject itself to liability for intentional infliction of emotional distress merely by asserting its legal right to rescind a health insurance policy, "even if it is likely the subscriber will suffer emotional distress." (*Hailey, supra,* 158 Cal.App.4th at p. 476.) Indeed, "an insurance company is privileged, in pursuing its own economic interests, to assert in a permissible way its legal rights and to communicate its position in good faith to its insured even though it is substantially certain that in so doing emotional distress will be caused." (*Fletcher v. Western National*

Life Ins. Co. (1970) 10 Cal.App.3d 376, 395.) And where the insurer owes no duty of good faith and fair dealing to an applicant, it also owes no duty giving rise to a claim of negligent infliction of emotional distress. (*Coleman v. Republic Indemnity Ins. Co.* (2005) 132 Cal.App.4th 403, 415-416.)

Hagan's claim under Business and Professions Code section 17200 is predicated solely upon the allegation that Blue Shield engaged in postclaims underwriting. Having concluded that summary judgment was properly granted on that issue, it follows that this claim fails as well.

Finally, because summary judgment was properly granted on all of Hagan's tort claims, it necessarily follows that there is no basis for an award of punitive damages. (See Civ. Code, § 3294, subd. (a); *Nieto, supra,* 181 Cal.App.4th at pp. 86-87.)

XI. *The Trial Court Did Not Abuse its Discretion in Awarding Costs to Blue Shield.*

After the trial court entered judgment, counsel for Blue Shield submitted a memorandum seeking a total of $39,380.17 in costs. Hagan then filed a motion to tax Blue Shield's costs in which he challenged a number of travel, lodging, and meal expenses incurred by Blue Shield's counsel in connection with attendance at hearings and depositions. He contended the costs were neither reasonable nor necessary, and he further argued there was no legal authority for the award of travel costs incurred in connection with attendance at motions hearings. Blue Shield opposed the motion to tax costs and submitted a declaration of counsel explaining the need for certain disbursements and attaching an itemized list of the expenses, together with receipts for the various costs claimed.

The trial court heard the motion to tax costs and granted it in part. It disallowed all lunch expenses claimed by Blue Shield's counsel and all dinner expenses in excess of $50. On the other hand, it found proper the expenses associated with court appearances, because it found the presence of counsel contributed to the decision-making process. It also found it was reasonable for Blue Shield's counsel to stay overnight in advance of hearings and depositions so that counsel's attendance would not be subject to possible flight delays. The trial court therefore awarded a total of $38,542.15 in costs.

On appeal, Hagan claims the trial court abused its discretion because it allowed Blue Shield to recover the cost of "high-priced airline tickets, cab fares, and rental cars," as well as travel expenses for multiple attorneys to attend the same hearing. He also appears to contend the meal expenses were insufficiently documented. Hagan also claims the trial court abused its discretion because Blue Shield's counsel did not present a declaration explaining why less expensive hotels, restaurants, and means of travel were not utilized.

Code of Civil Procedure section 1032, subdivision (b) provides that "a prevailing party is entitled as a matter of right to recover costs in any action or proceeding." Code of Civil Procedure section 1033.5 governs what costs are allowable. Subdivision (c)(4) of that section vests the trial court with discretion to award items not specifically mentioned the statute. Such costs must be "reasonably necessary to the conduct of the litigation" and "shall be reasonable in amount." (Code Civ. Proc., § 1033.5, subd. (c)(2), (3).) Whether a particular cost is reasonably necessary for the conduct of the litigation is a question of fact for the trial court that we review for abuse of discretion. (*Gibson v. Bobroff* (1996) 49 Cal.App.4th 1202, 1209.) On the record before us, we cannot say the trial court abused its discretion.

The trial court had discretion to award counsel the costs of traveling from their offices in southern California to attend depositions in northern California. (See *Thon v. Thompson* (1994) 29 Cal.App.4th 1546, 1548 [trial court did not err in awarding travel costs for Bakersfield attorneys to attend depositions in San Diego County].) Blue Shield presented an itemized accounting of counsel's travel expenses that was supported by a declaration of one of Blue Shield's attorneys. This was sufficient to sustain the trial court's finding of fact that the award of travel costs was reasonably necessary for the conduct of the litigation. (*Ibid*.) And while Hagan challenges the trial court's award of meal expenses, this appellate district has held that a trial court may award such expenses when they are incurred by attorneys attending depositions. (*Howard v. American National Fire Ins. Co.* (2010) 187 Cal.App.4th 498, 541.)

Hagan also complains that certain claimed expenses were unnecessary and/or "exorbitant." His brief refers to "$378 hotel night, $137 cab fare, etc." As he provides no citations to the record for either of the two specifically named expenses, he has forfeited any challenge to them. (See, e.g., *Dominguez v. Financial Indemnity Co.* (2010) 183 Cal.App.4th 388, 392, fn. 2 [appellate court may disregard factual assertions that are unsupported by citations to the record].) And it should be obvious that "et cetera" is not sufficiently specific to identify any other challenged expenses.

We therefore hold that the trial court did not abuse its discretion in ruling on Hagan's motion to tax costs.

DISPOSITION

The judgment and the order on Hagan's motion to tax costs are affirmed. Blue Shield shall recover its costs on appeal. (Cal. Rules of Court, rule 8.278(a)(1), (2).)

NEEDHAM, J.

We concur.

JONES, P. J.

SIMONS, J.