

NON-PRECEDENTIAL DECISION - SEE SUPERIOR COURT I.O.P. 65.37

KIMBERLY P. JOHNSON, PERSONAL	:	IN THE SUPERIOR COURT
REPRESENTATIVE OF THE ESTATE OF	:	OF PENNSYLVANIA
SANDRA S. LOBB, DECEASED,	:	
Appellant	:	
	:	
v.	:	
	:	
INDEPENDENCE BLUE CROSS,	:	
Appellee	:	NO. 1310 EDA 2004

Appeal from the Order Entered on April 12, 2004
In the Court of Common Pleas, CHESTER County
Civil Division, No. 01-01070

BEFORE: BOWES, and McCAFFERY, JJ., and McEWEN, P.J.E.

MEMORANDUM:

FILED NOVEMBER 4, 2005

Appellant, Kimberly P. Johnson, personal representative of the estate of Sandra S. Lobb ("Lobb"), appeals from the order entered in the Court of Common Pleas of Chester County, granting summary judgment in favor of Appellee, Independence Blue Cross. We affirm.

The action underlying this appeal arose from the death of Lobb on February 1, 1999. In its order, the trial court set forth the relevant facts of this case as follows:

Lobb was admitted to Chester County Hospital on July 26, 1997 and was diagnosed with acute alcohol pancreatitis and alcohol ketoacidosis, among other physical disorders. Dr. Cecil Pileggi, Lobb's treating physician, attended to her during her hospital stay. Dr. Pileggi's progress notes mention alcohol rehabilitation a number of times between July 28, 1997 and August 1, 1997; however, these notes

do not include certification for Lobb to be admitted into an in-patient alcohol rehabilitation facility and, in fact, refer only to outpatient treatment. Dr. Pileggi's notes document the fact that Lobb was resistant to rehabilitation. According to Dr. Pileggi's progress notes, July 30, 1997 was the first time Lobb expressed any willingness to consider alcohol rehabilitation. On July 31, 1997, Dr. Pileggi noted that Lobb should start outpatient alcohol rehabilitation on August 1, 1997, if discharged from the hospital. However, Lobb's physical and mental demeanor changed drastically on August 1, 1997. Lobb was unsteady on her feet, confused and mentally unstable. At that point, Dr. Pileggi noted that she was too unstable to be discharged from the hospital. Lobb remained in Chester County Hospital until August 12, 1997, when she was transferred to Pembroke Nursing Home (Pembroke) for custodial care.

Exhibit D contains notes made by Kurt Quemore (Quemore), the social worker employed by Chester County Hospital, assigned to develop Lobb's discharge plan. According to Quemore's notes, on July 27, 1997 he "strongly recommended" to Lobb that she consider entering a rehabilitation program now, before she returned to teaching in the fall. Quemore noted on July 31, 1997, that Lobb was open to intensive outpatient treatment for her alcoholism. Quemore called [Appellee] who referred him to TAO Greensprings, who suggested he call Bowling Green of Brandywine, because it was located near Lobb's residence. Lobb was to be evaluated on August 5, 1997 for consideration for outpatient treatment at Bowling Green, but due to her mental confusion, the evaluation did not occur. Quemore noted on August 1, 1997, that Dr. Pileggi informed him that Lobb could be transferred to Brandywine Hall following a psychological and neurological exam. However, Dr. Pileggi also notes on the same date that she "cannot okay [Lobb] to leave at this time." On August 4, 1997, Quemore notes that the transfer to Brandywine Hall was postponed due to Lobb's confusion and the need for one on one care. On August 7, 1997, Dr. Pileggi recommended that care at Pembroke would be

appropriate. Lobb was eventually transferred to Pembroke on August 12, 1997.

[Appellee's] Exhibit K contains the progress notes for Lobb's stay at Pembroke. These notes show no request to [Appellee] for in-patient alcohol treatment for Lobb. [Appellant] relies on Exhibit 25 attached to her response to [Appellee's] motion, in support of [Appellant's] proposition that Lobb's physician at Pembroke authorized a stay at an in-patient alcohol rehabilitation facility. Exhibit 25 simply contains physician's telephone orders asking that Lobb be evaluated for admission to Mirmont [alcohol rehabilitation facility]. There is no evidence that this request was forwarded to [Appellee]. Rather, the notes show that Mirmont recommended intensive out-patient treatment three days per week. Lobb's family was dissatisfied with this recommendation, concerned that Lobb would relapse if left home alone. The family's dissatisfaction caused Pembroke's employee to request Mirmont to consider in-patient treatment. At that point, Michelle Angeline repeated the recommendation for out-patient therapy and opined that [Appellee] would not cover such treatment because of Lobb's alcohol abstinence from August 12 to October 7, 1997. The notes do not indicate that [Appellee] was ever contacted about this request. Clearly, if no request for treatment was made to [Appellee], [Appellee] cannot be held liable for failing to approve it.

Dr. Pileggi's physician's notes and deposition testimony fail to provide evidence that she certified Lobb for in-patient rehabilitation treatment for alcoholism or requested coverage from [Appellee] for this type of treatment. Dr. Pileggi's notes refer only to rehabilitation generally and outpatient treatment specifically. From August 1, 1997 through August 12, 1997, the date of Lobb's discharge from Chester County Hospital and Dr. Pileggi's care, there is no reference to alcohol rehabilitation for Lobb. Dr. Pileggi's notes are clear that after August 1, 1997, Lobb was not able to attend alcohol rehabilitation treatment due to her confused mental state.

After her stay at Pembroke, Lobb entered an intensive outpatient alcohol rehabilitation program at Bowling Green at Brandywine. [Appellee] provided coverage for this outpatient program, which Lobb completed in November of 1997. Dr. Pileggi stated in a letter dated November 7, 1997, that Lobb was "medically stable" to return to work on November 17, 1997. Furthermore, Dr. Pileggi testified during her deposition that as of November 7, 1997 and May of 1998, Lobb appeared to have her alcoholism under control, and there was no reason to know that she did not have the problem under control.

. . . . During the period from July to October 1997, neither Dr. Pileggi[] nor any of Lobb's other treating physicians[] ever requested in-patient alcohol rehabilitation treatment. The record shows no request made by Lobb or her treating physicians to [Appellee] for placement in Mirmont or any other in-patient alcohol rehabilitation facility or a denial of such a request. [Appellee] provided coverage for outpatient alcohol treatment when requested. Lobb completed treatment and returned to work.

(Order dated April 12, 2004, at 2-4) (internal citations omitted). Following Lobb's death, Appellant filed a complaint and, thereafter, several amended complaints against Appellee, asserting breach of contract, breach of the covenant of good faith and fair dealing, fraud, bad faith, misrepresentation, restraint of trade, wrongful death and survival, wrongful confinement, and violation of the Unfair Trade Practices and Consumer Protection Law. The trial court sustained Appellee's preliminary objections to several of these counts, leaving only two: breach of contract and bad faith. After the relevant pleadings were closed, Appellee filed a motion for summary judgment seeking dismissal of Appellant's Fifth Amended Complaint on the basis that

the evidence failed to support Appellant's claims. In her order dated April 12, 2004, the Honorable Jacqueline C. Cody granted the motion.

On appeal, Appellant raises the following issues for our review:

- I. WHETHER THE COURT BELOW ERRED IN FAILING TO TAKE INTO ACCOUNT THE FUNDAMENTAL RIGHT OF AN INSURED TO FREELY AND INDEPENDENTLY CONTRACT AND PAY FOR MEDICAL CARE AND TREATMENT WITHOUT INTERFERENCE FROM ITS HEALTH INSURANCE COMPANY WHEN THE INSURANCE COMPANY THROUGH ITS PRACTICES, POLICIES AND STATE SANCTIONED PROVIDER AGREEMENTS (WHICH ARE ALL WITHHELD FROM ITS INSURED), 1) SET ASIDE HER CONTRACTUAL AND CONFIDENTIAL RELATIONSHIP WITH AND [SIC] HER PERSONAL PHYSICIAN AND 2) INFRINGED HER RIGHT TO CONTRACT AND PAY FOR CARE THAT THE INSURANCE COMPANY REFUSED TO PROVIDE AS A COVERED BENEFIT UNDER HER POLICY?
- II. WHETHER THE COURT'S RULING THAT THE STATE APPROVED PROVIDER CONTRACTS ARE UNAMBIGUOUS CREATES AN UNCONSTITUTIONAL INTERFERENCE WITH A PATIENT'S RIGHT TO FREELY CONTRACT WITH HER PHYSICIAN/HEALTH CARE PROVIDER?
- III. WHETHER THE COURT ERRED BY GRANTING SUMMARY JUDGMENT WHEN THERE ARE SIGNIFICANT DISPUTED MATERIAL FACTS WHICH SHOULD HAVE PRECLUDED SUMMARY JUDGMENT?

(Appellant's Brief at 3).

Appellant's second issue presented on appeal was not raised before the trial court. Further, Appellant did not include this issue in her Pa.R.A.P. 1925(b) statement. As this Court has reiterated:

It has long been settled that issues not raised in the lower court cannot be raised for the first time on appeal and are, therefore, waived. Pa.R.A.P. 302(a); ***ABG Promotions v. Parkway Publishing, Inc.***, 834 A.2d 613, 619 (Pa.Super. 2003) (*en banc*). Further, "this waiver rule applies even if the issue raised for the first time on appeal is a constitutional question." *Id.* at 619. In addition, issues not properly included in an appellant's Concise Statement of Matters Complained of on Appeal pursuant to Pa.R.A.P. 1925(b) are also deemed waived. ***Abrams v. Uchitel***, 806 A.2d 1, 6 (Pa.Super. 2002).

Milicic v. Basketball Marketing Co., Inc., 857 A.2d 689, 693 (Pa.Super. 2004). Therefore, because Appellant did not raise her second appellate issue until she filed her appeal, and compounded her negligence by failing to include this constitutional challenge in her Rule 1925(b) statement, we conclude that this issue is waived.

In her first and third issues which are interrelated, Appellant argues that she presented sufficient evidence regarding Appellee's alleged breach of contract to at least constitute a matter of disputed material fact adequate to survive summary judgment. Specifically, Appellant claims that Appellee breached its contract with the decedent, Sandra Lobb, by interfering with Ms. Lobb's personal relationship with her doctor, as well as with her right to independently contract and pay for her own care as permitted under Lobb's contract with Appellee. After very careful review, we do not agree.

When reviewing the trial court's granting of a motion for summary judgment, we note:

The scope of our review of an order granting or denying a motion for summary judgment is well established. In reviewing an order granting summary judgment, an appellate court must examine the record in the light most favorable to the non-moving party. We will reverse only if there has been an error of law or a clear abuse of discretion.

Abbott v. Schnader, Harrison, Segal & Lewis, LLP, 805 A.2d 547, 552

(Pa.Super. 2002) (citations omitted). Further:

A proper grant of summary judgment depends upon an evidentiary record that either (1) shows the material facts are undisputed or (2) contains insufficient evidence of facts to make out a *prima facie* cause of action or defense. Under Civil Rule 1035.2(2), "if a defendant is the moving party, he may make the showing necessary to support the entrance of summary judgment by pointing to materials which indicate that the plaintiff is unable to satisfy an element of his cause of action." Correspondingly, the non-moving party must adduce sufficient evidence on an issue essential to its case and on which it bears the burden of proof such that a jury could return a verdict favorable to the non-moving party.

Lewis v. Philadelphia Newspapers, Inc., 833 A.2d 185, 190 (Pa.Super.

2003), *appeal denied*, 577 Pa. 690, 844 A.2d 553 (2004) (quotation

omitted). To maintain a cause of action for breach of contract, a plaintiff

must establish "(1) the existence of a contract, including its essential terms,

(2) a breach of a duty imposed by the contract and (3) resultant damages."

Gorski v. Smith, 812 A.2d 683, 692 (Pa.Super. 2002), *appeal denied*, 579

Pa. 692, 856 A.2d 834 (2004) (citation omitted).

Mindful of the above standards and after a meticulous review of the record, we conclude that Appellant did not present sufficient evidence to prove that any **residential alcohol treatment facility** had *ever* refused an offer of payment from the decedent, or anyone acting on her behalf, specifically due to such facility's contract with Appellee. We note that in our esteemed colleague's detailed dissent, much of the testimony cited relates to Appellant's claim regarding the alleged inability of the Lobb family to obtain skilled nursing care for Lobb. However, as aptly noted by the trial court, Appellant did not raise a timely claim regarding skilled nursing care in the context of her breach of contract claim:

[W]e note that [Appellant's] memorandum of law fails to address [Appellee's] allegations regarding the insufficiency of evidence to prove that [Appellee] failed to provide coverage for in-patient alcohol rehabilitation treatment in 1997, as alleged in the Complaint. Rather, [Appellant], in her memorandum, posits a new theory of liability, claiming [Appellee] breached its contract by failing to cover skilled nursing care for Lobb upon her discharge from Chester County Hospital.

Because these allegations were never raised in [Appellant's] Fifth Amended Complaint, we view these arguments as a request to [amend] [her] Fifth Amended Complaint. An amendment to a complaint that adds or changes the theory of recovery is generally viewed as a new cause of action. ***Rachlin v. Edmison***, 813 A.2d 862 (Pa.Super. 2002), *citing*, ***Reynolds v. Thomas Jefferson University Hospital***, 676 A.2d 1205 (Pa.Super. 1996). An amendment will not be permitted after the statute of limitations has run where the amendment would add a new and different cause of action. ***Connor v. Allegheny General Hospital***, 501 Pa. 306, 461 A.2d 600 (1983).

“The test to be applied when the question presented is whether an amended [complaint] presents a new and different cause of action [is], would a judgment bar any further action on either, does the same measure of damages support both, is the same defense open in each, and is the same measure of proof required?” *Davis v. City of Philadelphia*, 650 A.2d 1127, 1130 (Pa.Cmwlt. 1994).

In most cases, the statute of limitations begins to run on the date the injury was sustained. *Haines v. Jones*, 830 A.2d 579 (Pa.Super. 2003). Once the statute of limitations expires, an individual is barred from bringing suit, unless some exception, which tolls the statute of limitations, can be proven. *Ward v. Rice*, 828 A.2d 1118 (Pa.Super. 2003). One such exception is the “discovery rule” which provides that “where the existence of the injury is not apparent or where the existence of an injury cannot be reasonably ascertained, the statute of limitations does not begin to run until such time as the injury’s existence is known or discoverable by the exercise of reasonable diligence.” *Ward*, at 1121.

[Appellant’s] claims for breach of contract and bad faith in her Fifth Amended Complaint are based upon the allegation that [Appellee] denied Lobb coverage for in-patient alcohol treatment. [Appellant’s] new claim that [Appellee’s] failure to cover skilled nursing care in 1997 caused Lobb’s death in 1999 was raised for the first time in [Appellant’s] brief in opposition to [Appellee’s] Motion for Summary Judgment. This allegation raises an entirely new cause of action, which changes the theory of recovery and requires an entirely new set of operative facts. Furthermore, [Appellee’s] alleged denial of this coverage occurred in August of 1997. With the exercise of reasonable diligence, [Appellant] could have included this cause of action in her complaint. [Appellant] has failed to timely file a claim based upon [Appellee’s] alleged failure to provide skilled nursing care.

(Order at 6-7) (emphasis added).

Furthermore, the limited evidence Appellant did present regarding the inability of Lobb or anyone acting on her behalf, to independently pay for treatment in an inpatient alcohol treatment facility due to contractual interference by Appellee, was insufficient. Specifically, Appellant claims that Appellee's contract with various inpatient alcohol treatment facilities prevented those providers from accepting payment from patients themselves once the treatment being sought was deemed "not medically necessary" by Appellee. However, Appellant presented **no evidence** from any representative of any such alcohol treatment facility to confirm this claim regarding that specific facility's contract with Appellee. Nor did Appellant provide any evidence from Appellee which indicated that any contract which the company entered into with an inpatient alcohol treatment facility prevented such provider from accepting payment directly from a patient.¹

¹ Indeed, the lone representative of Appellee whose testimony is included in the record indicated that she was unqualified to testify regarding Appellee's contracts with service providers:

Mr. Keepers [Counsel for Appellant]: What's your understanding about whether a treating physician can accept payment from an [Appellee] member for treatment that [Appellee] says is unnecessary?

Ms. Catherine Dratman, M.D. [employee of Appellee]: That would depend on the contract that the subscriber or member holds at that time.

Mr. Keepers: Are there some contracts under which the provider would not be allowed to provide that care?

Instead, Appellant presented testimony from Dr. Pileggi and social worker Quemore, both of whom were affiliated with Chester County Hospital, not an inpatient alcohol treatment facility.

In addition, the testimony which Appellant did present from the Lobb family regarding alcohol treatment facilities was ambiguous and insufficient. Specifically, as duly noted by the dissent, Mr. Lobb stated that he personally

Ms. Dratman: We never tell the provider what he or she can or cannot do. We only tell the provider what he or she will be paid for.

Mr. Keepers: Are you familiar with the provider contracts?
Ms. Dratman: I am not a person who writes those contracts. I would not want to be quoted as an authority on those contracts.

Mr. Keepers: Have you had contact with those contracts?

Ms. Dratman: Over time.

Mr. Keepers: What sort of contact?

Ms. Dratman: Reviewing the contracts in specific instances looking for specific issues, but those contracts have also changed over time, and I cannot answer questions about what Dr. Pileggi's specific contract with [Appellee] stated at that time.

Ms. Mangold [Counsel for Appellee]: And Eric, I've offered to Joe previously that if you want an [Appellee] representative who would have specific knowledge of the contract, we will provide that person. I just haven't been requested to do that yet.

(Deposition Testimony ("D.T.") of Catherine Dratman, M.D., dated August 7, 2003, at 26-27).

spoke with a representative of Mirmont, an alcohol treatment facility, and was informed that he could not independently pay for Mrs. Lobb's care due to Appellee's refusal to provide coverage for such treatment. (D.T. of Mr. Lobb, dated August 18, 2003, at 60-62). However, Mr. Lobb (and Appellant) failed to provide evidence that Mirmont's alleged refusal to accept payment from Mr. Lobb was due to actual contractual relations between Appellee and Mirmont. Therefore, evidence of a critical element of Appellant's breach of contract claim is missing, *i.e.* that Appellee breached its contract with Lobb by having entered into contracts with alcohol treatment facilities which interfered with Lobb's contract with Appellee. Indeed, as Appellant has proceeded against Appellee in this case and not against Mirmont, it is integral to Appellant's case that she prove that Mirmont actually was offered and then refused payment by Mr. Lobb specifically because of contractual interference by Appellee and not because of any internal Mirmont policy.

In another attempt to prove that Appellee breached its contract with Lobb, Mr. Lobb indicated that his daughter, Kristen McDermott, contacted numerous other inpatient alcohol treatment facilities, but she was unable to obtain treatment for Lobb due again to Appellee's alleged contractual interference. However, Ms. McDermott admitted that she called random facilities listed in the phone book, did not remember which particular

facilities she actually called, and could not confirm exactly why the facilities in question allegedly declined to provide treatment:

Ms. McDermott: The only part that I did do is after I learned that [Appellee] had not authorized any treatment for her and we wanted to pay for it and that we couldn't do that either, I did go to the Yellow Pages and call places because I thought that's ridiculous, I'll find her a place, so I did call places. I had no reason to document them.

Ms. Mangold: Could you tell me any of the names of the places that you telephoned?

Ms. McDermott: Not for sure, no, except that it was a Chester County book.

Ms. Mangold: About how many facilities did you call?

Ms. McDermott: Various ones because I didn't just call in one day. I called them when she was in Chester County Hospital, and I did just a tiny bit of calling when she was in Pembroke and we wanted to get her out.

Ms. Mangold: What types of facilities were you calling?

Ms. McDermott: Hospitals for anything that was mental or alcohol related. I talked to the admissions department[s]. I explained that [Appellee] wouldn't authorize this care or treatment, and that we wanted to pay, and they told me they couldn't help me. Now, I wish I had understood more of what was going on at the time because I did not question beyond that, and they pretty much said they could not help me, and so I went to [the] next one.

Ms. Mangold: Did they give a reason as to why they could not help you?

Ms. McDermott: No.

Ms. Mangold: Do you understand the difference between coverage decisions and treatment decisions?

* * * *

Ms. McDermott: I might not know, maybe not. I'm not sure because I don't know those terms.

(D.T. of Kristen McDermott, dated August 18, 2003, at 24-25).

Moreover, we agree with the trial court's sound reasoning regarding the plain language of Appellee's contracts:

[Appellant's] argument that Lobb's health insurance contract was inconsistent with the contracts [Appellee] had with the physicians and hospitals is equally without merit. [Appellant] contends that her policy allowed her to pay for services herself if [Appellee] refused to pay, while [Appellee's] contracts with the providers prohibited the providers [from] receiv[ing] payments directly from the patient for services rendered.

[Appellant's] Fifth Amended Complaint has attached as Exhibit [6 and] 7, the agreements between [Appellee] and its provider hospitals and the agreement between [Appellee] and Dr. Pileggi. According to Dr. Pileggi's agreement,

Neither a Beneficiary, nor [Appellee] shall be liable to pay Provider for any contracted service rendered by Provider to a Beneficiary, which is determined under a Utilization Management Program not to be Medically Necessary.

(Exhibit [6] at ¶ 3.7) [Appellee's] agreement with provider hospitals states in part,

Covered Services furnished by Hospital shall not be eligible for payment hereunder unless they have been determined by [Appellee] to be Medically Necessary. Without limiting the generality of the foregoing, Hospital shall provide Inpatient, Same Day Surgery and Outpatient Services to a Subscriber only when Hospital

has received Preapproval from [Appellee], as may be applicable. Services, which have not been so Preapproved, shall be the sole financial responsibility of the Hospital. (Exhibit 7 at ¶ 3.3)

* * * *

Where an Admission, Inpatient Day or Outpatient Service is denied as not Preapproved or Medically Necessary, the Hospital shall not charge either [Appellee] or the Subscriber for any health care services rendered or furnished with respect to such Admission, Inpatient Day or Outpatient Service.

(Exhibit 7 at ¶ 5.5) Finally, [Mrs.] Lobb's health insurance provides in part,

The subscriber will not be financially responsible for admission[s] which fail to conform to the previously stated precertification requirements unless the hospital informs the subscriber that the proposed admission does not meet the requirements and will not be covered by [Appellee].

(Exhibit 1 at [11], attached to Exhibit B of [Appellee's Motion for Summary Judgment])

The language of both contracts is clear and unambiguous. It is this Court's duty to interpret the meaning of the contract based upon the plain meaning of the words contained within the document. ***Aloe Coal v. Department of Transportation***, 643 A.2d 757 (Pa.Cmwlt. 1994) [***Estate of Demutis v. Erie Insurance Exchange***, 851 A.2d 172, 174 (Pa.Super 2004)]. The language in Lobb's contract is consistent with the language in the provider's contracts. The provider's contract does not prohibit self-payment by the insured. It simply protects the patient from unwittingly being held financially responsible for services that were not precertified or approved by [Appellee]. As long as the provider informs the patient that the services will not be covered by their health insurance, it will then be

up to the patient whether to accept services and become responsible for payment of the services rendered.

(Order at 4-5). After a careful review of the record, we conclude that the trial court correctly determined that the language of Appellee's contracts is unambiguous and does not prohibit self-payment by the insured. Indeed, as Appellant herself acknowledged, much of the language at issue in Appellee's provider contracts actually mirrors that required under 28 Pa.Code § 9.722(e).² (Appellant's Brief at 11). As such, it belies common sense that

² That section provides:

To be approved by the Department, a standard health care provider contract shall include the following consumer protection provisions:

- (1) Enrollee hold harmless language which survives the termination of the health care provider contract regardless of the reason for termination, and includes the following:
 - (i) A statement that the hold harmless language is construed for the benefit of the enrollee.
 - (ii) A statement that the hold harmless language supersedes any written or oral agreement currently in existence, or entered into at a later date, between the health care provider and enrollee, or persons acting in their behalf.
 - (iii) If the provider contract is a contract that affects plan enrollees, language to the following effect: "In no event including, but not limited to, non-payment by the plan, plan insolvency, or a breach of this contract, shall the provider bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against the enrollee or persons other than the plan acting on the behalf of the enrollee for services listed in this agreement. This provision does not prohibit collecting supplemental charges or co-payments in

such statutory language, enacted to protect patients, actually prohibits them from obtaining treatment via voluntary self-payment. Further, even Appellant's own expert, Dr. Linda Peeno, recognized:

[T]he contract provision in the [Appellee]-Chester contract simply states that when services or days are denied, "the Hospital shall not charge either [Appellee] or the Subscriber for any health care services rendered or furnished with respect to such admission, day of stay, or Outpatient service." In fact, this clause is designed to shift the financial burden of care to the hospital in the event that there is a conflict between the recommendations of a physician and [Appellee].

(Report of Dr. Linda Peeno, dated September 14, 2003, at 30). Thus, again noting our extensive review of the record, we conclude that Appellant has simply not produced any actual evidence that the plain language of Appellee's contracts with service providers operates to preclude patients from independently paying for treatment.

We conclude that Appellant failed to present evidence sufficient to establish a prima facie cause of action that Appellee breached its contract with Lobb through the mechanism of improper restrictions in its contracts with various service providers. Accordingly, we affirm the trial court's order granting summary judgment in favor of Appellee.

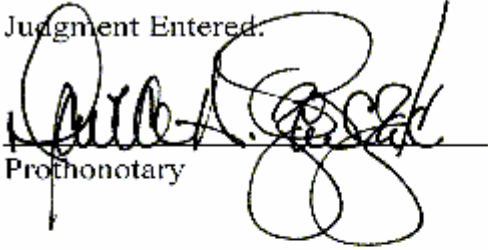
accordance with the terms of the applicable agreement between the plan and the enrollee."

28 Pa.Code § 9.722(e) (i-iii).

Order affirmed.

McEwen, President Judge Emeritus, files a Dissenting Statement.

Judgment Entered.

A handwritten signature in black ink, written over a horizontal line. The signature is highly stylized and cursive, appearing to read "William A. [unclear]".

Prothonotary

Date: _____