729 Phil. 484

FIRST DIVISION

[G.R. No. 195872, March 12, 2014]

FORTUNE MEDICARE, INC., PETITIONER, VS. DAVID ROBERT U. AMORIN, RESPONDENT.

D E C I S I O N

REYES, J.:

This is a petition for review on *certiorari*[1] under Rule 45 of the Rules of Court, which challenges the Decision[2] dated September 27, 2010 and Resolution[3] dated February 24, 2011 of the Court of Appeals (CA) in CA- G.R. CV No. 87255.

The Facts

David Robert U. Amorin (Amorin) was a cardholder/member of Fortune Medicare, Inc. (Fortune Care), a corporation engaged in providing health maintenance services to its members. The terms of Amorin's medical coverage were provided in a Corporate Health Program Contract[4] (Health Care Contract) which was executed on January 6, 2000 by Fortune Care and the House of Representatives, where Amorin was a permanent employee.

While on vacation in Honolulu, Hawaii, United States of America (U.S.A.) in May 1999, Amorin underwent an emergency surgery, specifically appendectomy, at the St. Francis Medical Center, causing him to incur professional and hospitalization expenses of US$7,242.35 and US$1,777.79, respectively. He attempted to recover from Fortune Care the full amount thereof upon his return to Manila, but the company merely approved a reimbursement of P12,151.36, an amount that was based on the average cost of appendectomy, net of medicare deduction, if the procedure were performed in an accredited hospital in Metro Manila.[5] Amorin received under protest the approved amount, but asked for its adjustment to cover the total amount of professional fees which he had paid, and eighty percent (80%) of the approved standard charges based on "American standard", considering that the emergency procedure occurred in the U.S.A. To support his claim, Amorin cited Section 3, Article V on Benefits and Coverages of the Health Care Contract, to wit:

> A. EMERGENCY CARE IN ACCREDITED HOSPITAL. Whether as an in-patient or out-patient, the member shall be entitled to full coverage under the benefits provisions of the Contract at any FortuneCare accredited hospitals subject only to the pertinent provision of Article VII (Exclusions/Limitations) hereof. For emergency care attended by non affiliated physician (MSU), the member shall be reimbursed 80% of the professional fee which should have been paid, had the member been treated by an affiliated physician. The availment of emergency care from

an unaffiliated physician shall not invalidate or diminish any claim if it shall be shown to have been reasonably impossible to obtain such emergency care from an affiliated physician.

B. EMERGENCY CARE IN NON-ACCREDITED HOSPITAL

1. Whether as an in-patient or out-patient, FortuneCare shall reimburse the total hospitalization cost including the professional fee (based on the total approved charges) to a member who receives emergency care in a non-accredited hospital. The above coverage applies only to Emergency confinement within Philippine Territory. **However, if the emergency confinement occurs in a foreign territory, Fortune Care will be obligated to reimburse or pay eighty (80%) percent of the approved standard charges which shall cover the hospitalization costs and professional fees**. x x x[6]

Still, Fortune Care denied Amorin's request, prompting the latter to file a complaint[7] for breach of contract with damages with the Regional Trial Court (RTC) of Makati City.

For its part, Fortune Care argued that the Health Care Contract did not cover hospitalization costs and professional fees incurred in foreign countries, as the contract's operation was confined to Philippine territory.[8] Further, it argued that its liability to Amorin was extinguished upon the latter's acceptance from the company of the amount of P12,151.36.

The RTC Ruling

On May 8, 2006, the RTC of Makati, Branch 66 rendered its Decision[9] dismissing Amorin's complaint. Citing Section 3, Article V of the Health Care Contract, the RTC explained:

Taking the contract as a whole, the Court is convinced that the parties intended to use the Philippine standard as basis. *Section 3* of the *Corporate Health Care Program Contract* provides that:

x x x x

On the basis of the clause providing for reimbursement equivalent to *80% of the professional fee which should have been paid, had the member been treated by an affiliated physician,* the Court concludes that the basis for reimbursement shall be Philippine rates. That provision, taken with Article V of the health program contract, which identifies affiliated hospitals as only those accredited clinics, hospitals and medical centers located "nationwide" only point to the Philippine standard as basis for reimbursement.

The clause providing for reimbursement in case of emergency operation in a foreign territory equivalent to *80% of the approved standard charges which shall cover hospitalization costs and professional fees,* can only be

> reasonably construed in connection with the preceding clause on professional fees to give meaning to a somewhat vague clause. A particular clause should not be studied as a detached and isolated expression, but the whole and every part of the contract must be considered in fixing the meaning of its parts.[10]

In the absence of evidence to the contrary, the trial court considered the amount of P12,15[1].36 already paid by Fortune Care to Amorin as equivalent to 80% of the hospitalization and professional fees payable to the latter had he been treated in an affiliated hospital.[11]

Dissatisfied, Amorin appealed the RTC decision to the CA.

The CA Ruling

On September 27, 2010, the CA rendered its Decision[12] granting the appeal. Thus, the dispositive portion of its decision reads:

> **WHEREFORE**, all the foregoing premises considered, the instant appeal is hereby GRANTED. The May 8, 2006 assailed Decision of the Regional Trial Court (RTC) of Makati City, Branch 66 is hereby REVERSED and SET ASIDE, and a new one entered ordering Fortune Medicare, Inc. to reimburse [Amorin] 80% of the total amount of the actual hospitalization expenses of $7,242.35 and professional fee of $1,777.79 paid by him to St. Francis Medical Center pursuant to Section 3, Article V of the Corporate Health Care Program Contract, or their peso equivalent at the time the amounts became due, less the [P]12,151.36 already paid by Fortunecare.
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> **SO ORDERED**.[13]

In so ruling, the appellate court pointed out that, *first*, health care agreements such as the subject Health Care Contract, being like insurance contracts, must be liberally construed in favor of the subscriber. In case its provisions are doubtful or reasonably susceptible of two interpretations, the construction conferring coverage is to be adopted and exclusionary clauses of doubtful import should be strictly construed against the provider.[14] *Second*, the CA explained that there was nothing under Article V of the Health Care Contract which provided that the Philippine standard should be used even in the event of an emergency confinement in a foreign territory.[15]

Fortune Care's motion for reconsideration was denied in a Resolution[16] dated February 24, 2011. Hence, the filing of the present petition for review on *certiorari.*

The Present Petition

Fortune Care cites the following grounds to support its petition:

I. The CA gravely erred in concluding that the phrase "approved standard charges" is subject to interpretation, and that it did not automatically mean "Philippine Standard"; and

II. The CA gravely erred in denying Fortune Care's motion for reconsideration, which in effect affirmed its decision that the American Standard Cost shall be applied in the payment of medical and hospitalization expenses and professional fees incurred by the respondent.[17]

The Court's Ruling

The petition is bereft of merit.

The Court finds no cogent reason to disturb the CA's finding that Fortune Care's liability to Amorin under the subject Health Care Contract should be based on the expenses for hospital and professional fees which he actually incurred, and should not be limited by the amount that he would have incurred had his emergency treatment been performed in an accredited hospital in the Philippines.

We emphasize that for purposes of determining the liability of a health care provider to its members, jurisprudence holds that a health care agreement is in the nature of non-life insurance, which is primarily a contract of indemnity. Once the member incurs hospital, medical or any other expense arising from sickness, injury or other stipulated contingent, the health care provider must pay for the same to the extent agreed upon under the contract.[18]

To aid in the interpretation of health care agreements, the Court laid down the following guidelines in *Philamcare Health Systems v. CA*[19]:

> When the terms of insurance contract contain limitations on liability, courts should construe them in such a way as to preclude the insurer from non-compliance with his obligation. Being a contract of adhesion, the terms of an insurance contract are to be construed strictly against the party which prepared the contract – the insurer. By reason of the exclusive control of the insurance company over the terms and phraseology of the insurance contract, ambiguity must be strictly interpreted against the insurer and liberally in favor of the insured, especially to avoid forfeiture. This is equally applicable to Health Care Agreements. The phraseology used in medical or hospital service contracts, such as the one at bar, must be liberally construed in favor of the subscriber, and if doubtful or reasonably susceptible of two interpretations the construction conferring coverage is to be adopted, and exclusionary clauses of doubtful import should be strictly construed against the provider.[20] (Citations omitted and emphasis ours)

Consistent with the foregoing, we reiterated in *Blue Cross Health Care, Inc. v. Spouses Olivares*[21]: