

STATE OF RHODE ISLAND  
PROVIDENCE, SC

SUPERIOR COURT

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NEW YORK SOCIETY FOR THE RELIEF OF :  
THE RUPTURED AND CRIPPLED, :  
MAINTAINING THE HOSPITAL FOR :  
SPECIAL SURGERY, :

C.A. No. \_\_\_\_\_

*Plaintiff,* :

- *against* - :

FACTORY MUTUAL INSURANCE :  
COMPANY, :

*Defendant.* :

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**ORIGINAL COMPLAINT AND JURY DEMAND**

Plaintiff, New York Society for the Relief of the Ruptured and Crippled, Maintaining the Hospital for Special Surgery (“HSS” or “Plaintiff” or “Insured”), files this Complaint for damages and declaratory relief against Defendant Factory Mutual Insurance Company (“FM”), alleging the following:

**INTRODUCTION**

1. This action against FM for breach of contract, declaratory judgment, breach of the duty of good faith and fair dealing, and bad faith arises from FM’s refusal to compensate HSS, as required by its “all risk” policy (the “Policy,” **Exhibit 1** hereto), for the significant losses HSS suffered as a result of the novel SARS-CoV-2 coronavirus and COVID-19 (hereafter “COVID-19”), a deadly and highly infectious communicable disease that has caused the most devastating global pandemic (the “Pandemic”) in a century and inflicted untold human suffering. More than 700,000 Americans have died, and millions more have contracted the disease.

2. In addition to the human toll, the physical damage that COVID-19 has caused to properties is undeniable. The SARS-CoV-2 virus that causes COVID-19 is physical—it can be seen, counted, and measured; it replicates itself and destroys other cells and organisms. Importantly, it can exist in the air and on surfaces (physically changing them) for indeterminate periods of time, and be transferred from the air and surfaces into human bodies. Indeed, viral particles circulate through the air in crowded buildings; merge with particulates through chemical reactions; and contaminate ventilation and other building systems, vents, ductworks, and other structures with infectious particles. Those viral particles also fall on surfaces of fixtures and property throughout buildings, where the virus becomes adsorbed into and forms chemical bonds with those surfaces through physical, chemical, and electrostatic reactions. This process physically transforms those building surfaces in a number of ways, such as increasing the roughness and hydroscopic properties of those surfaces. And unless extensive physical repairs and alterations are made, when these viral particles are adsorbed into and become chemically integrated with building surfaces, these viral particles transform building property and fixtures from useful properties into dangerous conduits for the deadly virus that are known as fomites. If someone touches the fomite surfaces, the virus can be carried to his or her nose, mouth, or eyes, where it can enter the body and replicate.

3. COVID-19 damages properties by physically altering their condition such that extensive physical repairs and alterations are necessary to attempt to remediate the damage and make the properties as safe as practical under the circumstances. In structures like hospitals, particularly those required to treat sick patients (including those infected with COVID-19) in close confines with doctors, nurses, staff, vendors, family members and visitors, once COVID-19 is present, substantial physical alterations and repairs to the property must be made in an effort to

limit ongoing and future property damage and protect public health and safety. Without such physical repairs and alterations, the virus would continue unabated to damage the air and make it unsafe to breathe, and attach itself to and physically change the condition of building surfaces and make them unsafe. Without physical alterations, the virus would contaminate building systems, such as ventilation and plumbing. HSS's priority is, and has always been, the safety of its employees, its patients, and the public. Accordingly, HSS immediately undertook these physical alterations in response to COVID-19 in an effort to make the hospital safe.

4. HSS is the Nation's, and likely the world's, leader in specialized, musculoskeletal health. Its flagship hospital, located at 535 East 70<sup>th</sup> Street in Manhattan, New York, regularly rates as the highest quality hospital for orthopedic care in the United States. Most of HSS's care is rendered on an "elective" basis – the timing of surgery to cure an aching back, knee or hip (which can be immobilizing) is generally at the patient's option and personal pain and risk considerations.

5. Although HSS does not generally treat acutely ill patients (particularly those with highly contagious and potentially fatal communicable diseases like COVID-19) or serve as a multi-specialty hospital, it was compelled to fundamentally change the nature of its operations and modify its physical plant and indoor air systems due to the physical damage and loss caused by the presence of COVID-19 on and within 5 miles of its premises, incurring hundreds of millions of dollars in outlays and revenue losses.

6. In compliance with various state and local mandates and in an effort to protect the health and safety of its patients and staff, in mid-March 2020, HSS discontinued all non-essential treatment (surgical and non-surgical), and devoted its resources to the treatment of acute musculoskeletal patients from other neighboring hospitals that were overwhelmed by the

influx of COVID-19 patients. In addition, HSS was required by governmental orders to admit and treat COVID-19 patients, and thus needed to, and did, modify its premises in an effort to address the continuing presence of COVID-19 at HSS' insured locations that was continually causing physical loss and damage. These patients otherwise would not have been admitted to HSS, a hospital that specializes in musculoskeletal health, but instead would have been treated at other local hospitals that treat acutely ill patients.

7. In short, the documented, prolific presence of SARS-CoV-2 and COVID-19 throughout New York City, and, in particular, the five-mile area surrounding HSS's insured locations, caused property damage to the air people were breathing, as well as the physical structures they inhabited and visited. Upon information and belief:

a. individuals who came into contact with such damaged property either contracted COVID-19 and/or spread the virus to others who, in turn, became infected with COVID-19;

b. these infected individuals flooded their local hospitals and medical providers, causing these facilities, in turn, to suffer physical loss and damage when COVID-19 patients exhaled millions of COVID-19 droplets and infectious aerosols into the air inside these facilities, thereby physically altering the air with aerosolized COVID-19 that can be inhaled, and depositing infectious COVID-19 droplets on the surfaces of these facilities, physically altering and transforming those surfaces into disease-transmitting fomites, thereby necessitating that such facilities undertake physical alterations and building system changes to remediate (to the extent possible) the damage caused by the continual presence of COVID-19;

c. these hospitals and medical providers were overwhelmed as their capacity to treat such COVID-19 and other emergency patients was quickly exceeded;

d. this, in turn, prompted the issuance of governmental orders requiring hospitals, like HSS, to restrict access to patients seeking elective procedures and to treat these critically-ill overflow COVID-19 patients, who further damaged HSS's insured locations when they came to HSS, exhaling millions of COVID-19 droplets and infectious aerosols into the air, and depositing infectious COVID-19 droplets on the surfaces of HSS's insured locations, thereby physically altering and transforming those surfaces into disease-transmitting fomites.

8. As a result, the presence of, and the physical loss or damaged caused by, COVID-19 at and within a five-mile radius of HSS's insured locations caused HSS to transform itself into a different kind of hospital, operationally and structurally, to protect, as best as possible under the circumstances, the health and safety of its staff and patients and mobilize in the fight against the Pandemic.

9. In fact, between March 1, 2020 and May 19, 2020, approximately 214 HSS patients tested positive for COVID-19, which includes the COVID-19 positive patients transferred to HSS from other hospitals, including those within a five-mile radius of HSS, and/or directed to HSS by hospitals and other medical personnel. During this same period, the number of positive cases within a five mile radius of HSS's main hospital location exceeded 25,000. And during March to May 2020, over 200,000 laboratory-confirmed COVID-19 cases were reported to the New York City Department of Health and Mental Hygiene. Most of the COVID-19 patients that came to HSS were directed from hospitals and other medical providers within a five-mile radius of HSS's insured locations.

10. As noted, the presence of the SARS-CoV-2 virus and COVID-19 at and within five miles of HSS's insured locations caused physical loss and/or damage to its property in the covered locations by changing the content of indoor air and the character of surfaces. The

continued influx of individuals with and/or exposed to COVID-19, and the governmental mandate to treat COVID-19 and other patients, caused HSS's property and indoor air to be impacted by the presence of communicable disease, notwithstanding HSS's proactive efforts to maintain a clean and safe environment.

11. Despite these extraordinary efforts, the actual presence of the virus at HSS physically damaged its insured properties. Viral particles were released into the air by infected persons at HSS who were breathing, speaking, coughing, gasping, and engaging in physical exertion and other activities. The virus was contained in respiratory droplets and aerosols that circulated throughout HSS's insured locations through indoor airflow and ventilation and air circulation systems. The viral particles were adsorbed into particulates circulating in the air when chemical reactions caused the viral spike proteins to bond chemically with those particles.

12. These infectious viral particles contaminated building systems at HSS's insured locations, such as vents and ductworks of building air and HVAC systems, causing these viral particles to be dispersed throughout HSS's insured locations and to become adsorbed on the surfaces on which they landed.

13. As detailed herein, to assure a safe environment for its staff and patients, the foregoing necessitated costly structural changes to HSS's physical premises and air flow systems, and costly disinfection procedures as part of HSS's effort to mitigate the harm caused by the continuing presences of COVID-19.

14. HSS is insured under a broadly-worded "all risk" insurance policy issued by FM known as the FM Advantage Policy, which covers HSS for all risks of physical loss or damage resulting from any cause not specifically excluded. Unlike many other property insurance policies that have been the subject of litigation across the country, the Policy FM sold to HSS

expressly recognizes that “communicable disease” is a covered cause of loss, and the presence of communicable disease at or around an insured location therefore constitutes physical loss and/or damage of the type insured under the Policy.

15. FM has acknowledged that COVID-19 is “communicable disease,” an insured peril as defined by the Policy FM sold to HSS, and that “communicable disease” was in fact present at HSS’s premises, triggering coverage under the Policy. However, FM wrongly takes the position that coverage under the Policy for loss resulting from the SARS-CoV-2 virus and COVID-19 is limited to \$1 million, even though FM itself conservatively estimated HSS’s net lost revenue from March through May 2020 at over \$188 million, and the Policy provides coverage for business income loss of \$2 billion. Rather than fulfill its obligation under the Policy it sold to HSS, FM wrongfully seeks to cap HSS’s recovery to the \$1 million aggregate limit applicable to two specific “communicable disease” coverages, although the Policy does not say anywhere that that is the maximum amount of coverage available for any and all loss or damage resulting from virus or communicable disease.

16. To minimize coverage, FM erroneously contends that communicable disease is not a type of physical loss or damage covered by the Policy – although the Policy itself says the exact opposite – and that an exclusion for costs due to “contamination” applies, even though, as FM itself admits, the contamination exclusion is inapplicable to communicable disease.

17. FM’s position with respect to coverage for HSS, as well as all other FM policyholders, is dictated by a series of “Talking Points” prepared for FM claims adjusters. The Talking Points instruct FM adjusters to limit coverage under the type of broad “all risk” policy issued to HSS to two specific communicable disease coverage provisions that typically have far lower coverage limits than otherwise provided in the applicable policies, and to deny coverage

under all other policy provisions. The Talking Points are designed to ensure that all FM claims adjusters adhere strictly to the same position with respect to all Pandemic-related claims, thus limiting FM's exposure to a small portion of the respective policy limits.

18. FM's attempt to shoehorn coverage for all losses arising from the Pandemic into the narrow confines of these specific communicable disease coverage provisions while denying coverage under any other policy provision is contrary to the terms of the Policy, to the positions FM itself has taken in other cases about the scope of the undefined terms "physical loss or damage," and to representations FM made to regulatory authorities in seeking approval for communicable disease coverage.

#### **THE PARTIES**

19. Plaintiff HSS is a not-for-profit corporation incorporated in the State of New York in 1863.

20. Upon information and belief, Defendant FM is a company formed under the laws of Rhode Island, with a principal place of business at 270 Central Avenue, Johnston, Rhode Island 02919.

#### **JURISDICTION AND VENUE**

21. This Court has jurisdiction pursuant to the provisions of Rhode Island Superior Court Rules of Civil Procedure 57 and R.I.G.L. § 9-30-2.

22. This matter is subject to the jurisdiction of this Court, as FM is a resident of the State of Rhode Island and does business in the State of Rhode Island, and the value of HSS's claims exceed the jurisdictional requirement

23. This Court has personal jurisdiction over FM because it does business within the State of Rhode Island.



24. Venue is proper in this county as FM was, at all relevant times, a resident of Providence County, in the State of Rhode Island.

### **FACTUAL ALLEGATIONS**

#### **Background of HSS**

25. HSS is a not-for-profit, academic medical center in Manhattan, New York, founded over 150 years ago. HSS's main hospital in Manhattan is recognized as the premier hospital in the United States for musculoskeletal disease. As a tax-exempt, not-for-profit academic medical center, HSS is known for the quality of its teaching and research activities provided to and through its residents, fellows, and faculty physicians, as well as its provision of world-class integrated musculoskeletal care for its patients.

26. HSS is the top-ranked hospital in America for orthopedics (12 years in a row) and the No. 4 ranked hospital in America for rheumatology according to U.S. News & World Report (2021-22). HSS has been recognized for excellence by many other national membership organizations and ratings services, including but not limited to Becker's Hospital Review (100 Great Hospitals in America (2015-20)); the American Nurses Credentialing Center (Magnet recognized – the designation, first bestowed upon HSS in 2002, renewed in 2007, 2011, 2016 and again in 2021, marks the first time any New York State hospital has been honored with a fifth consecutive Magnet designation. Each designation is regarded to be much more difficult to achieve than the last, making this a truly exceptional accomplishment - one that speaks to HSS's efforts to improve patient care); Healthgrades (a recipient of the Healthgrades Outstanding Patient Experience Award (2019-2021); Orthopedic Surgery Excellence Award (2020); America's 100 Best Hospitals for Orthopedic Surgery Award (2021); and America's 100 Best Hospitals for Spine Surgery Award (2019-21)); and CareChex (No. 1 hospital in the country for

medical excellence in major orthopedic surgery and in joint replacement, 2014-19, and No. 1 hospital in the nation in Overall Hospital Care for Medical Excellence, 2020).

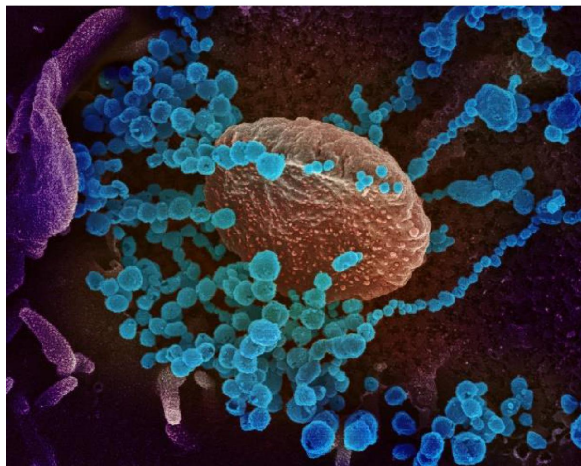
27. HSS performs more than 32,000 surgical procedures annually, and more hip surgeries and knee replacements than any other hospital in the country. HSS is one of the world's largest academic centers devoted to orthopedic imaging, and performs about 300,000 musculoskeletal imaging examinations annually. HSS has an international presence and patients from all over the world travel to HSS to receive medical consultation, surgery and/or treatment. In 2020, its International Center received approximately 1,500 patients from over 89 countries.

28. HSS, however, did not, and was not equipped to, serve as a general, multi-specialty hospital, much less to provide treatment for patients suffering from highly contagious and potentially fatal communicable diseases like COVID-19, particularly in the numbers it was ultimately required to treat during the Pandemic. In fact, pre-Pandemic, HSS only had four critical care beds for patients with complications. However, from March to May 2020, there were 214 COVID-19 positive patients (who either tested positive while at HSS or shortly after being treated) that were treated at HSS' insured locations. During that same time period, there were 165 HSS employees that tested positive for COVID-19.

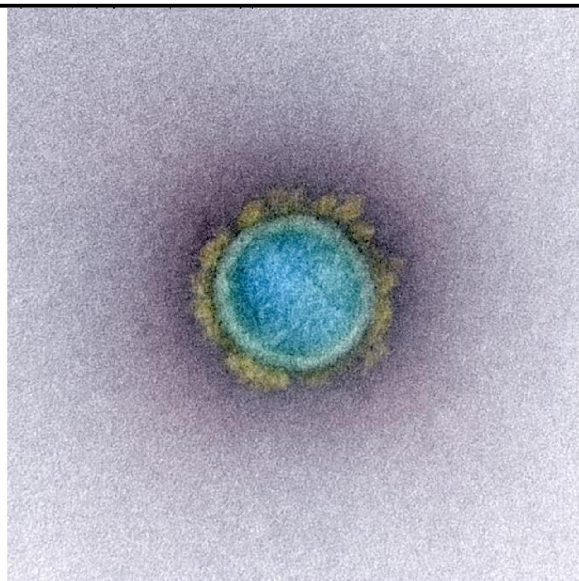
### **COVID-19**

29. Coronaviruses are a family of viruses that can cause illnesses ranging from the common cold to deadly diseases like severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS). Although viruses are invisible to the naked eye, or even a standard optical microscope of the sort used in high school classrooms, electron microscopy has revealed the physical structure of individual virus particles, also known as "virions."

30. Individual virions of COVID-19 have been photographed by the National Institute of Allergy and Infectious Disease using scanning electron (Figure 1) and transmission electron microscopes (Figure 2).



**Figure 1: SEM image of COVID-19 virions (in blue) emerging from surface of cell, taken by NIAID**



**Figure 2: TEM image of individual COVID-19 virion, taken by NIAID**

31. Each coronavirus virion is a physical object with a material existence that can survive outside the human body in viral fluid particles that, like the virion itself, cannot be seen by the naked eye. As with other small particles, the physical viruses linger in the air, traveling on air currents until they attach to an object or other surface.

32. The coronavirus is so named because its physical appearance resembles a corona or crown. SARS-CoV-2 is spherical, with clubs or spikes protruding uniformly from the outer surface. The spikes on the outside of the virus are composed of proteins, which the coronavirus uses to bond with and invade human cells. But when these “spike proteins” are not bound to a

human receptor, they nonetheless impact how the coronavirus interacts with other substances, including property.

33. The spike proteins are made up of different amino acids, which, by virtue of their molecular structure, have distinct chemical properties and carry an electric charge. These chemical and electric properties dictate how the coronavirus behaves in the air and on surfaces.

*See* **Exhibit 2**.

34. In December 2019, the first instance of a respiratory illness caused by a novel coronavirus was identified in Wuhan, China. *See* **Exhibit 3**. In a matter of weeks, the virus quickly spread across Asia, the United States and most of the world. *Id.* In January 2020, the first reported case of COVID-19 occurred in the United States.

35. On January 30, 2020, the WHO designated the COVID-19 outbreak as a Public Health Emergency of International Concern. *See* **Exhibit 4**. On January 31, 2020, United States Health and Human Services Secretary, Alex M. Azar II, declared a public health emergency for the entire United States to aid the nation’s healthcare community in responding to COVID-19. *Id.*

36. On February 11, 2020, the International Committee on Taxonomy of Viruses named this novel coronavirus “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).” The same day, the WHO named the disease COVID-19.

37. On March 1, 2020, New York City confirmed its first case of COVID-19. *See* **Exhibit 5**.

38. On March 11, 2020, the WHO declared the COVID-19 outbreak a worldwide pandemic, the first ever pandemic caused by a coronavirus (*id.*), and noted its deep concern by the alarming levels of spread and severity of COVID-19. According to numerous public health

authorities, everyone is at risk of exposure to and falling ill with COVID-19. Due to its highly contagious and easily transmitted nature, a single instance of COVID-19 in a community can (and as time has progressed, does) quickly and exponentially grow into a massive, uncontrollable outbreak.

39. COVID-19 has caused the most devastating global pandemic in a century and inflicted untold human suffering. In the United States, alone, as of February 2022, it is reported that over 76.7 million Americans have contracted COVID-19 and approximately 903,038 died as a result. *See Exhibit 6*. At the pandemic's peak, over 4,000 Americans were perishing per day from COVID-19. *See Exhibit 7*. A substantial number of Americans are still dying daily, with surges of cases and new and ever more contagious variants of the Coronavirus occurring throughout the U.S. *See Exhibits 6 and 8*. COVID-19 is now the third-leading cause of death in this country, surpassed only by heart disease and cancer. *See Exhibit 9*.

40. In New York City alone (with a population of around 8.81 million), there have been over 2.254 million reported cases of COVID-19, and over 39,012 confirmed COVID-19 deaths. *See Exhibits 10-11*.

41. The existence and presence of COVID-19 are not completely reflected in the reported cases or individuals' positive test results, as only a portion of the population has been tested. For example, in June 2020, the Centers for Disease Control and Prevention ("CDC") estimated that the number of people in the United States who have been infected with COVID-19 was ten times higher than the number of reported cases. *See Exhibit 12*. Additionally, at least 40% of people infected with COVID-19 are asymptomatic. *See Exhibit 13*.

42. A person can contract the coronavirus from (i) exposure to respiratory droplets when an infected person coughs, talks, shouts, or sings; (ii) aerosols produced by normal breathing; or (iii) by touching an infected surface, otherwise known as a “fomite.”

43. SARS-CoV-2 can be released into the air when infected persons breathe, talk, cough, sneeze, or sing, and a person can contract COVID-19 by breathing in infected respiratory droplets. Humans produce a wide range of particle sizes when coughing, sneezing, talking, singing, or otherwise dispersing droplets, with pathogens predominating in the smallest particles. Respiratory particles produced by the average person can travel almost 20 feet by sneezing. *See Exhibit 14.* An M.I.T. researcher has found that virus-laden “clouds” containing clusters of droplets can travel 23 to 27 feet. *See Exhibit 15.*

44. That COVID-19 can be transmitted through aerosols (and particularly by pre-symptomatic and asymptomatic individuals who are not aware that they are infected) makes it particularly dangerous. Unlike larger droplets, which quickly fall to the ground or nearby surfaces, aerosols behave more like smoke. After being expelled, they disperse through the air, to be inhaled by anyone present on the property, circulating through air flow and spreading the virus. Since the diameter of SARS-CoV-2 viral particles themselves is roughly 100 nanometers (*i.e.*, 0.1 microns), even a 5-micron respiratory droplet can easily contain thousands of viral particles.

45. Because COVID-19 spreads throughout a property in airborne particles, it damages building systems, spreads through indoor air flow, and contaminates property throughout a structure. Without proper modifications and added equipment in place, aerosols containing COVID-19 recirculate through building systems, such as air circulation and plumbing

systems, thereby contaminating those systems and spreading the virus to other surfaces and fixtures throughout the building. *See Exhibit 16.*

46. The scientific community has studied the spread of COVID-19 through aerosols in indoor settings (including hospitals) through air circulation and ventilation systems in real world settings, and confirmed the physical damage that the coronavirus can cause to those systems. For example:

a. A study detected the virus inside the HVAC system connected to hospital rooms of patients sick with COVID-19. The study found the virus in ceiling vent openings, vent exhaust filters and ducts located as much as 56 meters (over 183 feet) from the rooms of the sick COVID-19 patients. *See Exhibit 17.*

b. The CDC published a research letter concluding that a restaurant's air conditioning system triggered the transmission of COVID-19, spreading it to people who sat at separate tables downstream of the restaurant's airflow. *See Exhibit 18; see also Exhibit 19.*

c. A study detected a cluster of COVID-19 cases associated with a shopping mall in Wenzhou, China, likely resulting from virus contamination of common objects though virus aerosols in a confined space. *See Exhibit 20.*

47. On May 7, 2021 the CDC issued a scientific brief warning of the risks of airborne indoor transmission from aerosols at distances greater than six feet from the source, stating that "transmission of SARS-CoV-2 from inhalation of virus in the air farther than six feet from an infectious source can occur" and that:

Although infections through inhalation at distances greater than six feet from an infectious source are less likely than at closer distances, the phenomenon has been repeatedly documented under certain preventable circumstances. These transmission events have involved the presence of an infectious person exhaling virus indoors for an extended time (more than 15 minutes and in some cases hours) leading to virus concentrations in the air space sufficient to transmit

infections to people more than 6 feet away, and in some cases to people who have passed through that space soon after the infectious person left. Per published reports, factors that increase the risk of SARS-CoV-2 infection under these circumstances include:

- **Enclosed spaces with inadequate ventilation or air handling** within which the concentration of exhaled respiratory fluids, especially very fine droplets and aerosol particles, can build-up in the air space.
- **Increased exhalation** of respiratory fluids if the infectious person is engaged in physical exertion or raises their voice (e.g., exercising, shouting, singing).
- **Prolonged exposure** to these conditions, typically more than 15 minutes.

*See Exhibit 21.*

48. The CDC has recommended “ventilation interventions” to help reduce (*i.e.*, not eliminate) exposure to the airborne virus in indoor spaces, including increasing airflow and air filtration (such as with high-efficiency particulate air (HEPA) fan/filtration systems). (*See Exhibit 22.*) These and other remedial measures must be implemented, at high cost and extra expense, to reduce (but not eliminate) the amount of COVID-19 present in the space and to make property safer for its intended use. Indeed, such measures cannot entirely eliminate the risk of COVID-19 and the spread of the virus, particularly in a hospital environment – like HSS – where the hospital is required to constantly admit COVID-19 patients who continually re-infect the environment.

49. COVID-19 is also transmitted to people from physical objects, materials or surfaces. Fomites are physical objects or materials that carry, and are capable of transmitting, infectious agents, altering these objects to become vectors of disease. “[C]ontaminated surfaces play a key role in the spread of viral infections.” *See Exhibit 23.* Fomite transmission has been demonstrated as highly efficient for viruses, both from object-to-hand and from hand-to-mouth.

*See Exhibit 20.*



50. Small viral droplets can remain airborne almost indefinitely under most indoor conditions and, like smoke, can travel long distances with air currents. Whatever their size, however, virus-containing droplets eventually encounter physical objects and surfaces and settle onto them. When this occurs, respiratory aqueous droplets that contain virus droplets adhere to those physical objects and surfaces through a series of physical, chemical, and electrostatic reactions in a process called adsorption.

51. Adsorption occurs when the surfaces and internal capillaries and crevices of solid substances attract to their surfaces molecules of gases or solutions with which they are in contact. Adsorption occurs through both physical and chemical reactions. Physical adsorption resembles the condensation of gases to liquids and depends on the physical (van der Waals) force of attraction between the solid surface and the viral molecules. In chemical adsorption, gases are bound to a solid surface by chemical forces that are specific for each surface and each gas.

52. Viral particles adsorbed to a host surface form an actual chemical bond between the viral particle and the surface. This differs from materials that merely are deposited onto a surface, such as dust, where no such chemical bond is formed. Once such a chemical bond is formed, the virus is difficult to detach from the surface of the property.

53. Depending on pH levels, the carboxyl amino groups found on SARS-CoV-2 spike proteins form hydrogen bonds with substances containing oxygen or hydroxyls, such as wood, cotton or glass. Certain positively charged amino acid structures, which are also found on coronavirus spike proteins, bind with negatively charged metallic surfaces. *See Exhibit 24.* Depending on the ambient humidity, moisture levels on different property surfaces may augment chemical interactions between coronavirus spike proteins and the specific property exposed to the virus. Various endogenous polymeric molecules present in respiratory droplets (such as

polysaccharides and proteins) act as a “bridge” binding the virus to the surface. *See Exhibit 2.* Also, electrostatic attraction between the surface and the virus plays a role in addition to basic gravity. *See Exhibit 23.* Porous objects like fabrics represent a special case because they entrap viral particles, thus making them hard to access, inactivate, or remove. In this case, the original respiratory droplets are first adsorbed by the fabric; once their surrounding water subsequently evaporates, the viral particles become embedded and entangled within the bulk of the object.

54. When viral spike proteins bind with property surfaces through physical and chemical adsorption, those surfaces change physically in several ways.

a. *First*, as discussed above, the chemical composition of those surfaces changes based on the chemical reactions between the surfaces and the viral particles’ spike proteins.

b. *Second*, when these physical and chemical reactions occur through adsorption, surface roughness is measurably increased. *See Exhibit 2.*

c. *Third*, property exposed to SARS-CoV-2 also becomes more hydrophobic—more likely to repel water—after interaction with the coronavirus’s spike proteins. *See Exhibits 2 and 24.*

d. Finally, as explained below, when viral particles become physically and chemically adsorbed into the surfaces of buildings, fixtures, systems, and other property, those surfaces are altered from safe surfaces to dangerous surfaces through which this deadly virus spreads.

55. Chemical changes also occur when SARS-CoV-2 is released into the air within buildings. The same spike proteins that become adsorbed on various solid surfaces can also react with particulate matter in ambient air, such as minerals, soot or plastics. Chemical bonding and

electrostatic interaction between SARS-CoV-2 spike proteins and ambient particulate matter causes a physical alteration or physical change in the air upon exposure to the coronavirus. The adsorption of virus spike proteins by airborne particulates extends the time during which these particles remain infectious and dangerous. *See Exhibits 25-26.*

56. Infected COVID-19 respiratory droplets adhere to building surfaces—including fixtures, counters, railings, doors, door handles, floors, restrooms, beds, sheets, clothing and other high touch points. Once deposited, these surfaces are both physically and chemically transformed into disease-spreading fomites. These fomites can pose transmission risks particularly in a hospital environment – like HSS – for patients, doctors, nurses, staff, visitors, vendors, and other persons contacting those surfaces. If someone touches an infected surface, the virus can be carried to his or her nose, mouth, or eyes, where it can enter the body and replicate by the billions.

57. A study published in the *Journal of Epidemiology and Infection* demonstrated that after lockdown in the United Kingdom, COVID-19 transmission via fomites may have contributed to as many as 25% of deaths in that region. *See Exhibit 27.*

58. Scientific studies have confirmed that COVID-19 remains capable of being further transmitted from physical surfaces, creating a dangerous property condition. Significant contamination of inanimate objects, such as floors, ceilings, fans, sinks, toilet bowls, door handles, and floors have been reported even after thorough disinfection. Reusable glasses and other common plastic-based products are easily contaminated and have the potential to spread coronaviruses.

a. COVID-19 can remain infectious for “much longer time periods than generally considered possible.” *See Exhibit 28.*

b. A study of a COVID-19 outbreak published by the CDC identified elevator buttons and restroom taps as possible causes of the “rapid spread of SARS-CoV-2” in a shopping mall in China. *See Exhibit 20.*

c. A study published in the April 16, 2020 *New England Journal of Medicine* reported that COVID-19 persisted on plastic and stainless steel. *See Exhibit 29.*

d. Another study, published in the *Journal of Hospital Infection*, found that COVID-19 can remain infectious on inanimate surfaces at room temperature for well over a week. *See Exhibit 30.*

e. An April 2020 study published in the journal *Emerging Infectious Diseases* found a wide distribution of COVID-19 on surfaces in hospital wards in Wuhan, China, including floors, computer mice, trash bins, bed handrails, patients’ face masks, health workers’ personal protective equipment, and air vents. *See Exhibit 31.*

f. Numerous other scientific studies have found that the virus persists on doorknobs, toilets, faucets, and other high-touch points, as well as on commonly overlooked surfaces such as floors. *Id.*

g. An article in the *Journal of Virology* reported that researchers demonstrated that COVID-19 can survive up to 28 days at room temperature (68°F) on a variety of surfaces including glass, steel, vinyl, plastic, and paper. *See Exhibit 28.*

h. A CDC report from March 27, 2020, stated that COVID-19 was identified on surfaces of the cabins on the Diamond Princess cruise ship 17 days after the cabins were vacated but before they were disinfected. *See Exhibit 32.*

i. The COVID-19 virus can infect and be shed from the human gastrointestinal tract, thereby contaminating public restrooms and creating another pathway for

spread of the disease through property contamination. Viral RNA of SARS-CoV-2 has been detected in stool and RNA shedding in stool was detected in up to 41% of COVID-19 patients. Orofecal transmission of COVID-19 occurs through contamination of public facilities through food-handling, as well as through viral transmission from aerosolized virus following toilet flushing in public restrooms. *See Exhibit 16.*

59. Because COVID-19 can spread throughout a property in airborne particles, it damages building systems, spreads through air flow, and contaminates a structure. Without proper modifications, repairs, and equipment in place, aerosols containing the coronavirus recirculate through building systems, such as air circulation and plumbing systems. Medical researchers have advised that physical alterations to buildings and fixtures are necessary to remediate, as best as possible, the presence of the virus.

60. Cleaning of surfaces alone is insufficient, as touched surfaces will be re-contaminated. Droplets and aerosols expelled from infected persons physically change the surface by becoming a part of that surface. As a result of this physical alteration, human contact with previously safe surfaces become unsafe.

61. Unlike surface cleaning of visible substances like dust or debris, where the degree of “clean” can be visually confirmed to a reasonable degree of certainty, that is not the case for the cleaning and disinfection of COVID-19 because, among other things: (a) COVID-19 is not visible to the naked eye; (b) the degree and magnitude of COVID-19 is undetectable, so the effectiveness of disinfection cannot be determined; and (c) viral inactivation through disinfection is different for different substrates and surfaces (*i.e.*, cardboard, plastic, stainless steel, or copper) and varies for porous versus nonporous surfaces. As compared to the cleaning of visible soiling, dirt, and debris, which typically does not require “disinfection” of surfaces as required for viral

contamination, the uncertainty involved in the effectiveness of disinfection of surfaces for something invisible (*i.e.*, COVID-19) makes cleaning a much more complicated and less effective process.

62. A number of studies have also demonstrated that COVID-19 is “much more resilient to cleaning than other respiratory viruses so tested.” *See Exhibit 33*. The measures that must be taken to attempt to remove and disinfect COVID-19 from property are significant and depend on the concentration of COVID-19, myriad surface characteristics (*e.g.*, type of surface, temperature, porosity) and extend far beyond ordinary or routine cleaning. Indeed, studies of coronaviruses have demonstrated Viral RNA persistence on objects despite cleaning with 70% alcohol. *See Exhibit 34*. Moreover, the toxicity of an agent may inhibit the growth of cells used to determine the presence of virus, making it difficult to determine if lower levels of infectious virus are actually still present on treated surfaces. *Id.*

63. In other words, routine cleaning is not guaranteed to entirely remove the virus, and certain cleaning efforts may make it more difficult to determine if the virus is still present on the “cleaned” surfaces. In addition, the aerosolized SARS-CoV-2 particles and virions cannot be eliminated by routine cleaning. Cleaning surfaces in an indoor space will not remove the aerosolized SARS-CoV-2 particles and virions from the air that people can inhale and develop COVID-19 – no more than cleaning friable asbestos particles that have landed on a surface will remove the friable asbestos particles suspended in the air that people can inhale.

64. In any event, given the ubiquity and pervasiveness of COVID-19, no amount of cleaning or ventilation intervention will prevent an infected person who is contagious from entering an indoor space and exhaling millions of additional COVID-19 droplets and infectious aerosols into the air, thereby further: (a) filling the air and physically altering it with aerosolized

COVID-19 that can be inhaled; and (b) depositing infectious COVID-19 droplets on the surfaces, physically altering and transforming those surfaces into disease-transmitting fomites.

65. In short, COVID-19 damages properties by physically altering their condition such that they are no longer fit for occupancy or use, requiring extensive physical alterations, disinfection, sanitizing, and other safety protocols necessary to attempt to mitigate the harm and make the properties as safe as possible under the circumstances. This is especially true hospitals – like HSS – that are required to continually admit and treat persons infected with COVID-19 who by their very presence are exhaling millions of additional COVID-19 droplets and infectious aerosols. As a result, the virus damages the air within buildings such that the air is no longer safe to breathe, and attaches itself to surfaces, physically changing the condition of those surfaces from safe to unsafe. It contaminates building systems, such as ventilation and plumbing.

**COVID-19 Caused Physical Loss and/or Damage to HSS**

66. As noted, HSS is the largest and most highly-rated orthopedic hospital in the United States, annually performing more than 32,000 surgical procedures. HSS has the capacity for about 120 inpatients and performs the full spectrum of orthopedic surgery, including spine surgery, total joint replacements and sports medicine procedures.

67. Typically, places like HSS – a premier, specialty academic medical center for orthopedics and rheumatology – are spared from disaster by the valiant general and community hospitals that shoulder the burden of treating victims of natural and man-made tragedies. In fact, as noted, pre-Pandemic, HSS only had four critical care beds for patients with complications.

68. Everything changed in March 2020.

69. The State of New York, and more specifically the New York City metropolitan area, was the hardest hit area in the early stages of the Pandemic in the United States. By the end

of March 2020, New York was reporting more than 15,000 confirmed cases of COVID-19, with that number doubling every three or four days. By mid-May 2020, New York City had more than 375,000 confirmed cases of COVID-19 and more than 27,500 COVID-19 deaths, representing nearly one out of every three COVID-19 deaths in the country. The impact on health care systems, including HSS, were particularly acute.

70. In short, the documented, prolific presence of SARS-CoV-2 and COVID-19 throughout New York City, and, in particular, the five-mile area surrounding HSS's insured locations, caused property damage to the air people were breathing, as well as the physical structures they inhabited and visited. Upon information and belief, (a) individuals who came into contact with such damaged property either contracted COVID-19 and/or spread the virus to others who, in turn, became infected with COVID-19; (b) these infected individuals flooded their local hospitals and medical providers, causing these facilities, in turn, to suffer physical loss and damage when COVID-19 patients exhaled millions of COVID-19 droplets and infectious aerosols into the air inside these facilities, thereby physically altering the air with aerosolized COVID-19 that can be inhaled, and depositing infectious COVID-19 droplets on the surfaces of these facilities, physically altering and transforming those surfaces into disease-transmitting fomites, thereby necessitating that such facilities undertake physical alterations and building system changes to remediate (to the extent possible) the damage caused by the continual presence of COVID-19; and (c) these hospitals and medical providers were overwhelmed as their capacity to treat such COVID-19 and other emergency patients was quickly exceeded;

71. By Mid-March, it became clear that drastic action was necessary to slow the rate of infection and to expand hospital capacity. On March 7, 2020, New York State Governor Andrew Cuomo declared the entire State a disaster area. *See Exhibit 4.*



72. On March 11, 2020, the WHO declared the COVID-19 outbreak as a pandemic.

*See Exhibit 5.*

73. On March 12, 2020, New York City Mayor Bill de Blasio declared a state of emergency for New York City. (*Id.*)

74. On March 13, 2020, President Donald Trump declared a national state of emergency. *See Exhibit 3.* In his declaration, the President noted that the “spread of COVID-19 within our Nation’s communities threatens to strain our Nation’s healthcare systems. As of March 12, 2020, 1,645 people from 47 States have been infected with the virus that causes COVID-19. *It is incumbent on hospitals and medical facilities throughout the country to assess their preparedness posture and be prepared to surge capacity and capability.*” *Id.* (emphasis added.)

75. New York City public schools were closed to in-person instruction on March 16, 2020. *See Exhibit 35.* Thereafter, New York state and local governments issued orders suspending or severely curtailing the operations of all non-essential activities and permitted residents to leave their homes only for limited purposes. Those exposed to COVID-19 or in close contact with those exposed were required to quarantine.

76. Because hospitals in New York City were either (or anticipated being) overwhelmed with COVID-19 patients, on March 16, 2020, Mayor de Blasio issued Emergency Executive Order No. 100 (**Exhibit 36**) that, effective as of 4:00 p.m. on March 20, 2020, directed all “hospitals and ambulatory surgery centers in New York City [including HSS] to immediately move to cancel or postpone elective procedures and to cease performing such procedures within 96 hours of the issuance of this Order. Hospitals and ambulatory surgery centers are directed to identify procedures that are deemed ‘elective’ by assessing which procedures can be postponed

or cancelled based on patient risk considering the emergency need for redirection of resources to COVID-19 response.” In issuing this Emergency Order, Mayor de Blasio stated that “this order is given because of the propensity of the virus to spread person to person and also because *the virus physically is causing property loss and damage.*” *Id.* at 2 (emphasis added).

77. Consistent therewith, on March 17, 2020, Mayor de Blasio issued Emergency Executive Order No. 101 (**Exhibit 37**), a stay-at-home order that he said was needed because of the unique characteristics of COVID-19 and, of particular relevance here, the fact that “the Virus physically is causing property loss and damage[.]” In subsequent orders, Mayor de Blasio found that “*the actions taken to prevent [the] spread [of COVID-19] have led to property loss and damage.*” *See, e.g., Exhibit 38.*

78. On March 22, 2020, Governor Cuomo issued Executive Order No. 202.10 (referred to as the “New York State on Pause” order) “eliminating any obstacle to the provision of supplies and medical treatment [] necessary to ensure the New York healthcare system has adequate capacity to provide care to all who need it.” *See Exhibit 39.* To carry out this directive, Governor Cuomo’s Executive Order: (a) “require[d] general hospitals to take all measures necessary to increase the number of beds available to patients, in accordance with the directives set forth in this Executive Order;” (b) “allow[ed] emergency medical services to transport patients to locations other than healthcare facilities with prior approval by Department of Health;” and (c) “direct[ed] all general hospitals, ambulatory surgery centers, office-based surgery practices and diagnostic and treatment centers [including HSS] to increase the number of beds available to patients, including by canceling all elective surgeries and procedures, as the Commissioner of Health shall define.” *Id.*

79. The combination of Executive Orders 100 and 202.10 mandated that HSS and other hospitals gear up to admit the overflow of acutely ill patients, including those with COVID-19. To comply with these mandates, HSS was required to admit overflow patients exposed to and/or suffering from COVID-19, including from NYC hospitals within a five-mile radius of HSS's insured locations such as patients from New York Presbyterian Hospital with whom HSS coordinated to accept overflow patients, which resulted in the continuing presence of COVID-19 at HSS's insured locations causing physical loss and damage at such locations. For HSS, this mandate created unique challenges because, as an orthopedic specialty hospital that does not in the normal course treat critically ill patients (particularly those with highly contagious and potentially fatal communicable diseases like COVID-19), HSS' campus required significant transformation to prepare for a changing patient population.

80. The above NYS and NYC Executive Orders mandating that HSS and other hospitals cancel elective surgeries and devote their resources to the care of acutely ill patients, including those exposed to and/or suffering from COVID-19, were the direct result of the presence of communicable disease and physical loss and/or damage to property within a five-mile radius of HSS's insured locations, including at hospitals who were flooded with COVID-19 patients and other patients they were unable to serve due to capacity limitations.

81. On March 13, 2020, HSS was operating at 100% capacity, and a week later was down to around 10%. Indeed, by March 23, 2020, HSS had already been affected by COVID-19 as approximately 90 staff members were under quarantine, with five employees having tested positive for COVID-19.

82. In accordance with the above governmental orders and in an effort to protect the health and safety of its patients and staff and assist in efforts to combat COVID-19, on March 17,

2020, HSS suspended all nonessential surgeries. This action freed up most of its 215 licensed beds to act as overflow for patients, including those from other Manhattan hospitals within a five-mile radius of HSS's insured locations. HSS also began treating patients without obvious symptoms of COVID-19 from other hospitals in need of emergency orthopedic surgery, medical-surgery and critical care.

83. By April 1, 2020, HSS began treating known COVID-19-positive patients who required ventilators or intensive care, including patients transferred from other hospitals within a five-mile radius of HSS and/or directed to HSS by hospitals and other medical personnel within a five-mile radius of HSS's insured locations.

84. Between March 1, 2020 and May 19, 2020, approximately 214 HSS patients tested positive for COVID-19, which includes the COVID-19 positive patients transferred to HSS from other hospitals, including those within a five-mile radius of HSS, and/or directed to HSS by hospitals and other medical personnel. (And from March 1, 2020 through May 2021, approximately 500 HSS employees, patients and visitors tested positive for COVID-19, which figure also does not include the numerous additional COVID-19 positive patients (a) transferred to HSS from other hospitals, (b) directed to HSS by hospitals and other medical personnel, (c) who tested positive for COVID-19 outside of HSS for whom HSS was never notified, and/or (d) who were pre-symptomatic or asymptomatic.)

85. From March to May 2020, the number of COVID-19 positive cases within a five-mile radius of HSS's main hospital location exceeded 25,000. During March to May 2020, over 200,000 laboratory-confirmed COVID-19 cases were reported to the New York City Department of Health and Mental Hygiene.

86. The existence and presence of COVID-19 at HSS’s insured locations and within a five-mile radius thereof were not reflected completely in the reported cases or individuals’ positive test results, as only a fraction of the population was tested around that time. For example, in June 2020, the CDC estimated that the number of people in the United States who had been infected with COVID-19 was ten times higher than the number of reported cases. *See Exhibit 12.* Additionally, at least 40% of people infected with COVID-19 were asymptomatic. *See Exhibit 13.*

87. The complications with detecting and stopping the spread of COVID-19 is further amplified because COVID-19 has a pre-symptomatic incubation period of up to 14 days, during which time infected people can transmit COVID-19 to other people by releasing infectious droplets and aerosols into the air and onto surfaces without experiencing any symptoms or realizing that they are contagious or infected. *See Exhibits 40-42.*

88. Studies have demonstrated that pre-symptomatic individuals have an even greater ability to transmit COVID-19 than other infected people because they carry high levels of “viral load” during a period when they have no symptoms and therefore are unaware that they are infectious. *See, e.g., Exhibits 43-44.* The National Academy of Sciences has concluded that “the majority of transmission is attributable to people who are not exhibiting symptoms, either because they are still in the pre-symptomatic stage or the infection is asymptomatic.” *See Exhibits 45-46.* Logically, the number of pre-symptomatic and asymptomatic individuals are likely to be even greater in a hospital environment – like HSS – where patients, doctors, nurses, staff, visitors, vendors and other individuals are continually interacting with and/or in the same environment with individuals who have been confirmed as COVID-19 positive, and are thus more likely to contract COVID-19.

89. For the reasons explained herein, the actual presence of COVID-19 at HSS's insured locations physically damaged HSS's property in a number of ways, including the following:

a. Viral particles were released into the air by infected persons at HSS's insured locations who were breathing, speaking, coughing, gasping, and engaging in physical exertion and other activities. The virus was contained in respiratory droplets and aerosols that circulated throughout HSS's insured locations through indoor airflow and ventilation and air circulation systems. The viral particles were adsorbed into airborne particulates when chemical reactions caused the viral spike proteins to bond chemically with those particles. These infectious viral particles contaminated building systems such as vents and ductwork of building air and HVAC systems into which they became adsorbed through physical, chemical, and electrostatic reactions.

b. Viral particles dispersed throughout HSS's insured locations fell onto the surfaces of fixtures and other property in those buildings, such as patient rooms, equipment rooms, doors, counters, railings, stairs and flooring, tables, elevators and control panels, restrooms, toilets, faucets and other frequently-touched areas; and contamination through fecal virus contamination of public restrooms, toilets, faucets, and plumbing fixtures and systems. Upon reaching these surfaces, the viral particles were adsorbed into the surfaces and cracks through physical, chemical, and electrostatic reactions causing the viral particles to bond with, become integrated into, and affixed to, these surfaces. The physical, chemical and electrostatic reactions as part of the adsorption process and resulting chemical bonding of viral particles into these surfaces throughout the buildings damaged the surfaces of these fixtures, furniture, and systems by making them rougher and more hydrophobic; transformed those property surfaces

into virus- contaminated fomites through which the virus spread; and thus physically damaged these fixtures and equipment throughout the arena and contaminated key building systems.

90. Upon information and belief, the actual presence of COVID-19 at hospitals and other medical providers within a five-mile radius of HSS's insured locations caused them to suffer the same or similar type of physical loss or damage that occurred at HSS's insured locations.

91. In short, HSS's required admittance of COVID-19 patients significantly increased the property damage at HSS's insured locations as these patients were continually exhaling millions of COVID-19 droplets and infectious aerosols into the air, thereby further: (a) filling the air and physically altering it with aerosolized COVID-19 that can be inhaled; and (b) depositing infectious COVID-19 droplets on the surfaces, physically altering and transforming those surfaces into disease-transmitting fomites.

92. The physical damage caused by the presence of the virus at HSS's insured locations made it unsafe for patients, doctors, nurses, staff, visitors, vendors, and other persons, so that physical alterations and building system changes needed to be made to remediate (to the extent possible) the damage.

93. In the two weeks starting in mid-March 2020, the above-referenced governmental orders required HSS to radically change its operational model from an orthopedic hospital to a general acute care model to help fight the Pandemic facing New York City, including treating COVID-19 patients. In order to prepare for and undertake efforts to constantly remediate, to the extent possible, the continuous presence of COVID-19 (a deadly and highly infectious communicable disease) at HSS's insured locations resulting from HSS's obligation to treat individuals infected with this disease, HSS underwent substantial transformation at great expense

to be able to care for and treat patients (in as safe an environment as was reasonably feasible under the circumstances), particularly those with COVID-19 (who would have otherwise been treated at other hospitals, including those within a five-mile radius of HSS's insured locations). Such steps included, *inter alia*, implementing essential safety measures to ameliorate (to the extent feasible) the physical loss and damage resulting from the continuing presence of COVID-19 onsite, conversion of operating rooms and patient rooms, conversion to and creation of an Orthopedic Triage Center, and establishment of Urgent Care Facilities. In particular:

a. Starting with the main hospital ambulatory surgery area located on the 9<sup>th</sup> floor, HSS modified the eight ORs (Operating Rooms) into ICRs (Intensive Care Rooms). These eight rooms could support two ventilated patients per room due to each room having a set of existing full medical gas headwalls and emergency power setups. The ORs and surrounding OR spaces have a dedicated Air Handling Unit (AHU). Each OR has its own set of High Efficiency Particulate Air (HEPA) filters in the supply duct so the supply air is HEPA filtered before reaching the patients. To make sure that each room had 100% outside air with no chance of the exhaust air mixing with the supply air, HSS closed, disconnected, and capped the mixing dampers. This meant the AHU for the ORs (ICU) were 100% outside air and 100% exhaust.

b. HSS then rebalanced the ORs to make them negative pressure to the surrounding areas and corridors to protect, as much as possible, the staff. This was accomplished with the assistance of the hospital's mechanical and HVAC controls contractors. They both worked together to measure the air flow (supply and exhaust) to each room to convert them from positive pressure to negative pressure. As well as being made negative pressure, the rooms were supplied with additional air changes per hour to maintain air quality and comfort for the patient and staff. Once the balancing was done, the controls were locked so they could not be changed



remotely and negative pressure would be maintained. Additionally, existing cameras were utilized in the operating rooms to see the patients from the corridor and the monitors were used to be able to check the patient's condition from the corridor.

c. The 9<sup>th</sup> floor PACU (Post-Anesthesia Care Unit)/Prep area is a large twenty-plus bed bay suite with medical gases and emergency power for each bay. In the middle of this PACU suite is the nursing station, which allows the frontline staff to view the patients. In preparing this suite for COVID-19 patients (who would have otherwise been treated at other hospitals, including those within a five-mile radius of HSS's insured locations), multiple physical modifications were made for the safety of the staff and patients.

i. HSS constructed a physical enclosure with sheet rock walls (floor to ceiling), windows, and doors around the nursing station to create a barrier from the patients. This allowed HSS to create a pressure difference between the enclosed nurse station and the patient bays. The patient bay area was made negative pressure to the nursing station area, keeping contaminants out of the staff space. Since the PACU was part of the ORs' AHU system, the exhaust was 100% to the outside.

ii. To further assist the staff, individual patient cameras were installed at each patient bay to be able to monitor the patients. The Prep/Holding area, next to the PACU, was set up to support the patients with all the equipment needed, which included PYXIS and Omnicell (for the automated dispensing of medication). Also, in the holding area, IT provided an EPIC dashboard for constant updates on the patients and their conditions.

e. Dedicated ORs on the 4<sup>th</sup> floor were modified, similar to the 9<sup>th</sup> floor ORs, so that the air did not recirculate: 100% supply and 100% exhaust. These ORs were to be used if HSS had a COVID-19 patient needing surgery. As an additional precaution, HSS added

500CFM portable HEPA units to help “scrub” the air. The scrubbers were put in proximity to the patient’s head to draw air away from the doctors and cross capture any contaminants from the patient. (Additional HEPA units were added to other ORs for use during the intubation and extubation of patients.) HSS also maintained dedicated COVID-19 anesthesia machines.

f. The 5<sup>th</sup> floor has four OSCU (Orthopedic Special Care Unit) rooms. All such rooms had additional enclosures built outside the entrance door to the rooms. This was to create an “ante-room” to separate the actual patient room and the clean corridor. This room was used by staff donning and doffing PPE. The enclosure was kept negative by the negative pressure of the OSCU rooms. Two of the OSCU rooms were designed as isolation rooms and were negative pressure, but the other two OSCU rooms were not isolation rooms. To make them NPRs (Negative Pressure Rooms), HSS installed an exhaust fan in each room ducted directly to the outside and the duct return was capped to create 100% exhaust rooms and increase the negative pressure of each room for staff safety.

g. To the extent not already negative pressure, the 8<sup>th</sup>, 10<sup>th</sup> and 11<sup>th</sup> floor patient rooms were modified to NPRs. This was accomplished by working with the hospital’s mechanical and HVAC controls contractors to measure the air flow – supply and exhaust – to each room to make them negative pressure. As well as being made negative pressure, the rooms were supplied with a minimum of six air changes per hour to maintain air quality and comfort for the patients. Once the balancing was done, the controls were locked so they could not be changed remotely and negative pressure would be maintained. Additionally, the air handler units that supplied these three floors were modified to make sure that each room had 100% outside air with no chance of the exhaust air mixing with the supply air. HSS contractors closed,

disconnected, and capped the mixing dampers to each AHU. This created patient rooms as NPR with 100% outside air and 100% exhaust.

h. For all the floors that had NPR's or isolation rooms, the engineering staff checked them periodically to ensure they remained negative and documented the room inspections.

94. In short, while all hospitals in New York City were hard hit by the Pandemic, HSS – an orthopedic specialty hospital that does not typically treat acutely ill patients (particularly patients with a potentially lethal viral infection such as COVID-19) – had to undergo a substantial transformation and incur great expense to provide lifesaving care for NYC-based COVID-19 patients (who would have otherwise been treated at other hospitals) and constantly remediate, to the extent feasible, the ongoing physical loss and damage resulting from the continuing presence of COVID-19 at HSS's insured locations, which virus was constantly being reintroduced to HSS's insured locations on a daily basis as a result of the need to comply with the governmental orders. The foregoing modifications required a massive amount of work and corresponding expense to HSS, totaling at least \$2,728,000.<sup>1</sup>

95. In addition to the outlay of capital required to make all of the above modifications to address HSS's physical loss and/or damage incurred by reason of COVID-19, including the governmental orders requiring HSS to accept acutely ill patients (including those exposed to and/or suffering from COVID-19 who transferred from other hospitals, including those within a five-mile radius of HSS and/or directed to HSS by hospitals and other medical personnel within a five-mile radius of HSS's insured locations), HSS suffered significant loss of income. In fact,

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<sup>1</sup> Upon information and belief, the actual presence of COVID-19 at hospitals and other medical providers within a five-mile radius of HSS's insured locations caused them to undertake similar physical alterations and building system changes to remediate (to the extent possible) the damage caused by the continual presence of COVID-19.

FM's own expert estimated that for the three-month period from March to May 2020, HSS suffered a net loss of approximately ***\$188,021,000***.

96. Once HSS was no longer required to treat acutely ill patients (*e.g.*, patients exposed to and/or suffering from COVID-19 who transferred from other hospitals, including those within a five-mile radius of HSS and/or directed to HSS by hospitals and other medical personnel within a five-mile radius of HSS's insured locations), its return to a new normal (RTnN) required a long process of cleaning, testing, rebalancing, and, in some cases, deconstruction, of the improvements made to respond to the Pandemic. For example:

a. When the most critical COVID-19 patients were discharged from the 9<sup>th</sup> floor PACU/ICU area, Engineering and Environmental Services began the cleaning and disinfection process. Once the disinfection was done, some baseline testing was done to start restoring the space from a negative pressure area back to a PACU. This process included removing the barrier wall created around the PACU nursing station and separation barrier to the OR corridors. The PACU was terminally cleaned and tested by a third-party industrial hygienist, including testing for COVID-19. Once all the testing reports came back non-detect/negative, HSS's staff started restoring the space back to normal use and air pressures were restored to normal (negative to positive), the caps were removed from the mixing boxes, and the filters changed on the air handlers. Return ductwork in patient areas were also sanitized.

b. This process was followed for the 9<sup>th</sup> floor ORs and all the patient floors where HSS had COVID-19 patients.

c. As a part of the RTnN and because the Pandemic was far from over as additional waves were anticipated to occur, an isolation suite was built on the 8<sup>th</sup> floor to contain

future Pandemic patients, with dedicated negative pressure to each room, with the suite having a dedicated nurse station and patient room sensors and telemetry.

d. The RTnN also included several changes to the environment and social interaction to ensure staff, visitor, and patient safety. This included, *inter alia*: (i) implementation of new cleaning protocols throughout the facility for high touch surfaces; (ii) installation of portable HEPA filters in all ORs; (iii) installation of portable HEPA filters in waiting areas and locker rooms where social distancing could be a challenge to scrub the air; and (iv) the installation of protective barriers at workstations and reception areas.

**The Policy Covers Physical Loss  
and/or Damage Caused by COVID-19**

97. On or about September 30, 2019, FM sold HSS the Policy.

98. FM drafted the Policy.

**COVID-19 and the Governmental Orders Related  
Thereto Triggered Multiple Coverage Provisions in the Policy**

99. The Policy “covers property, as described in the Policy, against ALL RISKS OF PHYSICAL LOSS OR DAMAGE, except as hereinafter excluded, while located as described in this Policy” during the Policy term of October 1, 2019 to October 1, 2020. **Ex. 1** at 1.

100. The Policy provides that FM’s “maximum limit of liability in an **occurrence**, including any insured TIME ELEMENT loss, will not exceed the Policy limit of liability of USD 2,000,000,000 subject to” certain provisions in the Policy and subject to a deductible. *Id.* at 3, 7.

101. The Policy defines an “**occurrence**” as “the sum total of all loss or damage of the type insured, including any insured TIME ELEMENT loss, arising out of or caused by one discrete event of physical loss or damage...” *Id.* at 71.

102. The Policy “insures TIME ELEMENT loss, as provided in the TIME ELEMENT COVERAGES, directly resulting from *physical loss or damage of the type insured...*” *Id.* at 38 (emphasis added). Such damages, includes:

a. HSS’s GROSS PROFIT starting on the date of the physical loss or damage and for a period of twelve months thereafter. “The recoverable GROSS PROFIT loss is the Actual Loss Sustained by the Insured of the following due to the necessary interruption of business during the PERIOD OF LIABILITY: a) Reduction in Sales and b) Increase in Cost of Doing Business.” *Id.* at 5, 40-42, 44; and

b. HSS’s EXTRA EXPENSE, subject to a maximum of \$100,000,000 per occurrence. “The recoverable EXTRA EXPENSE loss will be the reasonable and necessary extra costs incurred by the Insured of the following during the PERIOD OF LIABILITY: 1) extra expenses to temporarily continue as nearly **normal** as practicable the conduct of the Insured’s business; 2) extra costs of temporarily using property or facilities of the Insured or others; and 3) costs to purchase finished goods from third parties to fulfill orders when such orders cannot be met due to physical loss or damage to the Insured’s finished goods, less payment received for the sale of such finished goods.” *Id.* at 5, 42-44.

103. In addition, the “Policy also insures TIME ELEMENT loss, as provided by the TIME ELEMENT COVERAGES of this Policy, for the TIME ELEMENT COVERAGE EXTENSIONS...” The relevant TIME ELEMENT COVERAGE EXTENSIONS include the following:

a. “**CIVIL OR MILITARY AUTHORITY.** This Policy covers the Actual Loss Sustained and EXTRA EXPENSE incurred by the Insured during the PERIOD OF LIABILITY if an order of civil or military authority limits, restricts or prohibits partial or total

access to an insured **location** provided such order is the direct result of *physical damage of the type insured* at the insured **location** or within five statute miles/eight kilometres of it.” (Policy at 50-51 (emphasis added).) This coverage is limited to 60 days from the time of such physical damage. *Id.* at 4.

b. **“INGRESS/EGRESS.** This Policy covers the Actual Loss Sustained and EXTRA EXPENSE incurred by the Insured during the PERIOD OF LIABILITY due to the necessary interruption of the Insured’s business due to partial or total physical prevention of ingress to or egress from an insured **location**, whether or not the premises or property of the Insured is damaged, provided that such prevention is a direct result of *physical damage of the type insured* to property of the type insured.” *Id.* at 51-52 (emphasis added). This coverage is limited to 30 days from the time of such physical damage, and subject a maximum of \$50,000,000 per occurrence. *Id.* at 5.

c. **“CONTINGENT TIME ELEMENT EXTENDED.** This Policy covers the Actual Loss Sustained and EXTRA EXPENSE incurred by the Insured during the PERIOD OF LIABILITY directly resulting from *physical loss or damage of the type insured* to property of the type insured at **contingent time element locations** located within the TERRITORY of this Policy. As respects CONTINGENT TIME ELEMENT EXTENDED: 1) Time Element loss recoverable under this Extension is extended to include the following TIME ELEMENT COVERAGE EXTENSIONS: [a] CIVIL OR MILITARY AUTHORITY[; b] CONTINGENT TIME ELEMENT EXTENDED[; ... and c] INGRESS/EGRESS...” *Id.* at 51 (emphasis added). This coverage subject a maximum of \$25,000,000 per occurrence. *Id.* at 4.

104. The Policy also insures ADDITIONAL TIME ELEMENT COVERAGE EXTNSIONS, including **“PROTECTION AND PRESERVATION OF PROPERTY TIME**

**ELEMENT.** This Policy covers the Actual Loss Sustained by the Insured for a period of time not to exceed 48 hours prior to and 48 hours after the Insured first taking reasonable action for the temporary protection and preservation of property insured by this Policy provided such ***action is necessary to prevent immediately impending insured physical loss or damage to such insured property.*** This Extension is subject to the deductible provisions that would have applied had the physical loss and/or damage happened.” *Id.* at 58 (emphasis added).

105. Each of the above-cited Policy coverage provisions were triggered by the facts described in detail in this Complaint, including, *inter alia*, that the presence of SARS-CoV-2 and COVID-19 (a) caused direct physical loss and/or damage to HSS’s covered locations, which damage was exacerbated by the civil authority orders mandating that HSS treat COVID-19 patients who, by their presence at HSS’s insured locations, caused increased and ongoing direct physical damage to HSS’s insured locations, (b) required physical repair and/or alterations to HSS’s covered locations in an effort to address the ongoing direct physical damage caused by the presence of individuals infected with COVID-19, including those whom the government mandated be admitted and treated at HSS’s insured locations; and (c) interrupted HSS’s full operations during the period of liability, including through the exclusion of patients seeking elective procedures.

106. In addition, the presence of SARS-CoV-2 and COVID-19 caused physical damages at HSS’s insured locations and other buildings (including hospitals and medical providers) within five miles of HSS’s insured locations, which led to multiple orders of civil authority (*e.g.*, NYC Executive Order No. 100 and NYS Executive Order No. 202.10) restricting or prohibiting partial or total access to HSS’s insured locations by banning all elective surgeries. For example, for the reasons discussed herein, the massive outbreak of COVID-19 in New York



City, including within the five-mile area surrounding HSS's insured locations, caused property damage to the air and physical structures inhabited by the people in this geographic area.

Individuals who came into contact with such damaged property, including infected air and surfaces, either contracted COVID-19 and/or spread the virus to others who, in turn, became infected with COVID-19. These individuals then overwhelmed their local hospitals and other emergency treatment centers, which in turn, led to the issuance of civil authority orders requiring hospitals like HSS to restrict access to patients seeking elective procedures and to treat these overflow COVID-19 patients, who further damaged HSS's insured locations when they came to HSS, exhaling millions of additional COVID-19 droplets and infectious aerosols into the air and depositing infectious COVID-19 droplets on the surfaces.

***Communicable Disease Constitutes Physical Loss or Damage of the Type Insured Under the Policy***

107. The Policy defines “**communicable disease**” as a “disease which is: [A] transmissible from human to human by direct or indirect contact with an affected individual or the individual's discharges, or [B] Legionellosis.” *Id.* at 68.

108. FM has admitted that COVID-19 constitutes a communicable disease as defined in the Policy.

109. Among the OTHER ADDITIONAL COVERAGES and ADDITIONAL TIME ELEMENT COVERAGE EXTENSIONS are the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE coverage provisions. *Id.* at 22, 56. In granting these additional coverages for “communicable disease,” FM recognized that the presence of “communicable disease” at a location” is a type of physical loss or damage covered by the Policy.

110. Moreover, the regulatory history relating to these communicable disease provisions further confirms that the presence of “communicable disease” at a location” is a type of physical loss or damage covered by the Policy.

a. In or about 2010, FM submitted to state insurance regulators Form FMG7446, an endorsement for “Communicable Disease Cleanup, Removal and Disposal” (Filing FMIC-2011-13, Form FMG7446, **Exhibit 47** hereto). The proposed amendment – *applicable at the time only to healthcare facilities such as HSS* – appears to be the precursor to the COMMUNICABLE DISEASE provisions in the Policy. FMG7446 states that, “[f]or the purpose of this Additional Coverage, the presence of and spread of communicable disease *will be considered direct physical damage* and the expenses listed above *will be considered expenses to repair such damage.*” *Id.* (emphasis added). In addition, FM represented to regulators in 2010 that its new coverage for “Interruption by Communicable Disease” was based on the same predicate: “[f]or the purpose of this extension, the presence of and the spread of *communicable disease will be considered direct physical damage*” and the expenses “will be considered expenses to repair such damage.” *See Exhibit 48* at 21-22. In other words, these endorsements expressly represented that the presence of communicable disease qualified as physical loss or damage. The state insurance regulators approved FM’s endorsement in September 2011. *See Exhibit 49* at 2.

b. These statements were repeated several years later in FM’s 2015 regulatory filings concerning coverages for “Communicable Disease Cleanup, Removal And Disposal” and “Interruption by Communicable Disease”. Those 2015 regulatory filings affirmatively represented that “[f]or the purpose of this coverage [or extension], the presence [of] and [the] spread of communicable disease will be considered direct physical damage” and

the expenses “will be considered expenses to repair such damage.” See **Exhibit 50** (emphasis added).

c. In 2016, when FM updated the prior version of its Communicable Disease Response endorsement, FM submitted a redline of the changes to the state insurance regulators, together with an explanation of the impact of the redlined changes. See **Exhibit 51** hereto. As seen on the redline, the prior version of the Communicable Disease Response coverage expressly stated that the presence of communicable disease was “physical damage” under the policy, and that cleaning costs were “repair” costs under the policy: “*For the purpose of this Additional Coverage, the presence of and spread of communicable disease will be considered direct physical damage* and the expenses listed above will be considered expenses to repair such damage.” *Id.* at 2 (emphasis added). When FM removed this language from the Communicable Disease Response coverage page, it told regulators in its Explanatory Filing Memorandum that the change did not affect any material change in coverage, stating that the “*changes are grammatical and editorial to clarify intent. There is no material change in coverage.*” See **Exhibit 52** at 29 (emphasis added). To avoid any doubt, FM further explained to the state insurance regulators that “[t]his endorsement was previously approved in filing FMIC-2011-13 as Communicable Disease Cleanup, Removal and Disposal Endorsement. The replaced Endorsement was previously available to insureds with healthcare occupancies only. Grammatical and editorial changes have been made to remove the healthcare facility terms because this coverage is now offered as optional to all clients. The coverage also now allows for an officer of the Insured to trigger the coverage. *This is an expansion in coverage.*” See **Exhibit 53** hereto at 6 (emphasis added). FM’s 2016 filings with respect to its standard policy form substantially repeat the statements made above. See **Exhibit 54** at 2, 4-5.

111. Additionally, the Policy could have stated, but notably does not, that coverage for physical loss or damage caused by communicable disease is limited to the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE coverage sections of the Policy.

112. Also, unlike the peril of “**flood**,” which is capped at \$250,000,000, the peril of “**communicable disease**” is not subject to any aggregate limit under the Policy. **Ex. 1** at 5. Accordingly, there is no basis to suggest that the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE provisions (which are capped annually in the aggregate at \$1,000,000) are the exclusive sources of coverage for loss or damage resulting from and/or related to communicable disease.

113. Furthermore, insurers, such as FM, were repeatedly warned, and have been aware for years, of the potential impact of pandemics. In fact, there were many publicly available reports about the risk of pandemics – and what insurers should do – in the months and years before the COVID-19 Pandemic. For example:

a. For example, in 2013, Towers Watson published the results of a survey of insurance executives from around the world entitled “Extreme Risks 2013” in which more than 30,000 votes were cast. The number one extreme risk identified by survey participants was a pandemic, that is, a “new highly infectious and fatal disease spread[] through human, animal or plant populations worldwide.” *See Exhibit 55.*

b. In 2015, the Society of Actuaries published an article called “Quantifying Pandemic Risk,” containing the byline: “The recent West Africa Ebola outbreak serves as a reminder that it is important for actuaries to account for and quantify pandemic risk.” (**Exhibit 56.**)

c. One article, titled “What the 1918 Flu Pandemic Can Teach Today’s Insurers,” noted in March 2018: “Even with today’s technology, a modern severe pandemic would cause substantive direct financial losses to the insurance community. In addition, indirect losses would be severe, most notably on the asset side of the balance sheet.” *See Exhibit 57.* This article modeled the effects of a modern-day 1918 pandemic and estimated that “a modern day Spanish flu would cause between 21 and 33 million deaths worldwide.”

d. The Insurance Library Association of Boston lists on its website numerous articles, reports, and white papers available to insurers from early 2007 forward, and clearly warns on its website: “The past 20 years has seen the rise of a number of pandemics. Slate recently published an article on what has been learned about treating them in that time. We thought it might be apt for us to take a look back and see what the insurance industry has learned as well.” *See Exhibit 58.* The webpage then lists various articles and reports discussing the risks and impacts of pandemics on the insurance industry.

114. Over the course of decades, courts have held that the presence of a hazardous substance at or on a property, including the air space inside buildings, constitutes property damage. Many courts have also held that the closure of property due to imminent risk of physical loss or damage or danger to inhabitants constitutes physical loss of property. Upon information and belief, insurers, including FM, have been and continue to be aware of these court decisions.

115. FM itself previously argued in court filings that mold infestation in the clean room of a laboratory caused physical loss or damage – despite not causing a structural alteration of the property – and was therefore covered. *See Exhibit 59* hereto.

116. In its motion *in limine*, FM cited with approval the very same cases cited by policyholder attorneys nationwide in COVID-19 insurance recovery actions for the proposition that there is no structural alteration requirement to physical loss or damage and that the loss of use or loss of functional use of property is sufficient to trigger coverage – propositions that FM now strongly contests in COVID-19 cases. (*Id.*)

117. FM stated in its public court filing in the New Mexico Action:

It is undisputed that the mold infestation destroyed the aseptic environment and rendered Room 152 unfit for its intended use –manufacturing injectable pharmaceutical products. Numerous courts have concluded that loss of functionality or reliability under similar circumstances constitutes physical loss or damage. *See, e.g., Western Fire Insurance Co. v. First Presbyterian Church*, 437 P.2d 52 (Colo. 1968) (church building sustained physical loss or damage when it was rendered uninhabitable and dangerous due to gasoline under the building); *Gregory Packaging, Inc. v. Travelers Property and Casualty Company of America*, Civ. No. 2:12-cv-04418 2014 U.S. Dist. LEXIS 165232, 2014 WL 6675934 (D. N.J. 2014) (unsafe levels of ammonia in the air inflicted “direct physical loss of or damage to” the juice packing facility “because the ammonia physically rendered the facility unusable for a period of time.”); *Port Authority of N.Y. and N.J. v. Affiliated FM Ins. Co.*, 311 F.3d 226, 236 (3d Cir. 2002) (asbestos fibers); *Essex v. BloomSouth Flooring Corp.*, 562 F.3d 399, 406 (1st Cir. 2009) (unpleasant odor in home); *TRAVCO Ins. Co. v. Ward*, 715 F.Supp.2d 699, 709 (E.D. Va. 2010), *aff’d*, 504 F. App’x 251 (4th Cir. 2013) (“toxic gases” released by defective drywall).

*Id.* at 3-4.

118. FM’s motion *in limine* in the New Mexico Action also stated that the “period of time as well as the costs required to bring [the Insured’s property] to the level of cleanliness following the mold infestation required by [the Insured’s] customers is also physical loss or damage” as the failure to meet the required level of cleanliness itself constituted damage and rendered the property “unusable as the result of a covered loss.” *Id.* at 4.

119. FM also argued that another insurer’s failure to define “physical loss or damage” (as is the case in FM’s own Policy at issue here) made that term “susceptible of more than one

reasonable interpretation,” rendering the policy “ambiguous,” and stating that it “must be construed against” that insurer. *Id.* at 3, n.1.

120. In 2006, shortly after the 2003 outbreak of Severe Acute Respiratory Syndrome, also known as SARS, which was an airborne viral respiratory disease that spread through small droplets of saliva (**Exhibit 60**), just like COVID-19, the Insurance Services Office, Inc. (ISO), an organization that provides policy writing services to insurers, drafted new endorsements that it filed with state insurance regulators in all ISO jurisdictions and recommended to the independent bureaus in other jurisdictions to address the exclusion of loss due to human disease causing viruses and bacteria. In that circular, ISO cited “rotavirus, SARS [*a variant of COVID-19*], [and] influenza” and observed that “[t]he universe of disease-causing organisms is always in evolution.” *See Exhibit 61* at 5.

121. ISO’s circular recognized that: “Disease-causing agents may render a product impure (change its quality or substance), or enable the spread of disease by their presence on interior building surfaces or the surfaces of personal property.” *Id.* at 5. ISO also expressly warned of a need for its exclusion because “the specter of pandemic or hitherto unorthodox transmission of infectious material raises the concern that insurers employing [property] policies may face claims in which there are efforts to expand coverage and to create sources of recovery for such losses, contrary to policy intent.” *Id.* at 6. With this circular, ISO thus acknowledged that (a) the presence of a human disease-causing virus could give rise to physical loss or damage to property; (b) such damage could trigger coverage under property policies for property losses, including business interruption losses; and (c) absent addition of ISO’s proposed exclusion, the existing language in property policies, like that issued by FM here, did not clearly and unambiguously bar coverage for such losses.

122. ISO therefore introduced with its circular a standard-form exclusion that it entitled “Exclusion Of Loss Due To Virus Or Bacteria” (form CP 014007 06 and, in certain jurisdictions, form CP 01 75 07 06). *Id.* at 8, 12. As noted in the circular, the purpose of this standard form language was to allow those insurers that chose to use it in their insurance policies, to attempt to protect themselves from coverage for loss or damage resulting from infectious material and pandemic.

123. Upon information and belief, since 2006 insurers have had the opportunity to incorporate, and have incorporated, this standard virus exclusion in certain of their policies in an effort to avoid covering loss due to a disease such as COVID-19.

124. FM nonetheless chose to not include the ISO, or other more express pandemic, exclusion in the Policy.

**The Policy’s Contamination Exclusion Does Not Apply**

125. Physical loss or damages caused by communicable diseases, including COVID-19 (as described in detail above), is not excluded by the Policy.

126. The Policy’s Contamination Exclusion (**Ex. 1** at 14) provides, in pertinent part:

This Policy excludes the following unless directly resulting from other physical damage not excluded by this Policy: 1) **contamination**, and any cost due to **contamination** including the inability to use or occupy property or any cost of making property safe or suitable for use or occupancy. If **contamination** due only to the actual not suspected presence of **contaminant(s)** directly results from other physical damage not excluded by this Policy, then only physical damage caused by such **contamination** may be insured. This exclusion D 1 does not apply to radioactive contamination which is excluded elsewhere in this Policy.

127. The Policy (at 68) defines “**contaminant**” as “anything that causes ‘**contamination**’ and defines “**contamination**” as:

any condition of property due to the actual or suspected presence of any foreign substance, impurity, pollutant, hazardous material, poison, toxin, pathogen or pathogenic organism, bacteria, virus, disease causing or illness causing agent, fungus, mold or mildew.



128. The Contamination Exclusion does not apply to HSS's claim under the Policy for numerous reasons, including but not limited to the following:

a. *First*, the Contamination Exclusion does not use the defined term "communicable disease" in the Contamination Exclusion or in the definition of "contamination." Moreover, while FM included within the "contamination" definition the terms "pathogen," "pathogenic organism," "virus," and "disease causing or illness causing agent," FM did not use those terms in its definition of "communicable disease."

b. *Second*, the coverage for physical loss or damage caused by communicable disease in the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE coverage sections of the Policy would be eviscerated if the Contamination Exclusion were to apply generally because (i) the Contamination Exclusion does not exempt from its scope the insurance coverage provided in the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE provisions, and (b) the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE provisions nowhere state that the Contamination Exclusion is inapplicable to the coverage provided therein.

c. *Third*, the Contamination Exclusion explicitly contains a carve-out for radioactive contamination, which is dealt with elsewhere in the Policy. If the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE provisions were intended to be exceptions to the Contamination Exclusion, the Contamination Exclusion would have expressly said so as it did with radioactive contamination.

d. *Fourth*, the Contamination Exclusion excludes only contamination and associated “direct” “costs,” but ***not*** “loss” or “damage,” or even indirect “costs,” such as TIME ELEMENT loss and EXTRA EXPENSES.

e. *Fifth*, the language of the Contamination Exclusion stands in stark contrast to the language of the ISO virus or bacteria exclusion, *i.e.*, “[w]e will not pay for loss or damage caused by or resulting from any virus, bacterium or other micro-organism that induces or is capable of inducing physical distress, illness or disease.” Compare **Exs. 1** and **61**. Had FM wished to exclude pandemic or human-based disease from its Policy, it could have incorporated into the Policy either a specific exclusion (such as a pandemic exclusion), or the ISO virus or bacteria exclusion. Yet, FM did neither.

f. *Sixth*, in contrast, other exclusions in the Policy contain an anti-concurrent cause exclusion. For example, the Section 3(B) exclusions (*e.g.*, for nuclear reaction, nuclear radiation, radioactive contamination, hostile or warlike actions, dishonest acts, and the lack of certain services) “exclude[] loss or damage directly or indirectly caused by or resulting from any of the following regardless of any other cause or event, whether or not insured under this Policy, ***contributing concurrently*** or in any other sequence to the loss...” **Ex. 1** at 11-13 (emphasis added). This language ensures that the Section 3(B) exclusions apply broadly, covering all “loss or damage” even if it is only “indirectly” caused by the excluded item and even if some other causes contributes concurrently to the loss or damage. Because other exclusions in the Policy include an anti-concurrent causation clause, FM was aware of such a clause and intentionally did not include it in the Contamination Exclusion contained in Section 3(D) when drafting the Policy. This evidences an intent that the Contamination Exclusion was meant to be a narrow

exclusion, precluding coverage in a narrow set of circumstances, rather than excluding coverage for any and all losses, even those only partially or indirectly caused by a virus.

**FM Wrongfully Denies HSS's Claim for Coverage Under the Policy**

129. On April 13, 2020, HSS gave prompt notice of its claim for covered losses due to the Pandemic to FM, seeking coverage for “CV-19 - Business Interruption (loss of income and/or product/inventory), Ingress/Egress, Contingent Business Interruption and Extra Expenses as a result of COVID-19, including loss resulting from an order to shut down premises by the government/Civil Authority, and loss related to expenses incurred to have premises sanitized after affected and/or prior to reopening.” *See Exhibit 62.*

130. On May 6, 2020, FM’s New York claims manager, William Reed, acknowledged that “COVID-19 meets the definition of a communicable disease under the Policy[;]” referred solely to the Additional Coverage and Additional Time Element Extension provisions of the Policy for “Communicable Disease Response” and “Interruption by Communicable Disease” as being the “[p]ertinent sections of the Policy[;]” and stated that the aggregate limit of liability under the Policy was \$1,000,000. *See Exhibit 63.*

131. On July 28, 2020, HSS’s claims advocate, David Koch, emailed FM’s claims manager, Melanie Parenteau, stating that: “I have been communicating with Bill Reed on this matter. ***He has confirmed that coverage has been triggered based on documentation provided.*** Now that coverage is in place, ***Bill recommended sending the monthly operating statements prior to and after the Civil Authority Order showing their dramatic loss i[n] revenue. The loss in revenue stemmed from their assistance in helping fight COVID 19 in New York City by making their hospital beds available for treatment and cancelling all non-emergent surgeries, procedures and testing.***” (Emphasis added). By confirming that coverage was triggered under the Communicable Disease Response and Interruption By Communicable

Disease coverage provisions, FM has admitted that one or more of HSS's insured locations "has the actual not suspected presence of **communicable disease** and access to such **location** is limited, restricted or prohibited by: 1) an order of an authorized governmental agency regulating the actual not suspected presence of **communicable disease.**" (**Ex. 1** at 22, 56-57)

132. On July 29, 2020, Ms. Parenteau, sent a letter with the header "Impact associated with COVID-19," which acknowledged that FM had "received the additional information provided by Mr. David Koch via e-mail on July 21 & 28, 2020 regarding the subject COVID-19 loss. The information provided included a redacted record of a positive for COVID-19 medical result and a comparative statement of revenues and expenses." *See Exhibit 64.* As a result, Ms. Parenteau confirmed that "coverage is provided at the referenced location for Communicable Disease Response and Interruption by Communicable Disease subject to a Policy limit of \$1,000,000 combined annual aggregate." *Id.* She further stated that: "Additional comments on Policy coverage will be made at a later date..." *Id.* And consistent with the fact that physical loss or damage attributable to communicable disease is not limited to these policy provisions, Ms. Parenteau's letter stated that FM was "reviewing the financial information submitted by Mr. Koch and will contact you shortly to propose a conference call so we may discuss *the Time Element loss*. Additional documentation or information to measure the loss will be requested at that time if necessary. Once we have received and reviewed the necessary documentation, we will be in a position to proceed with adjustment of the loss." *Id.* (emphasis added).

133. On August 16, 2020, FM's expert, John C. Ganss, CPA, of Lowers Forensics International, reconfirmed that the Communicable Disease Response and Interruption by Communicable Disease provisions were triggered because access to HSS's insured locations was limited or restricted due to governmental orders regulating the actual presence of COVID-19. In

particular, Mr. Ganss advised Ms. Parenteau that: “[u]pon our discussion with the insured, we learned the specific dates of the Governmental Restriction on ‘Elective’ Surgeries (due to Covid 19), which as this hospital is primarily and Orthopedic Procedures Hospital, this mandate affected their operations more significantly than many other hospitals in the area.” Mr. Ganss further reported that as HSS did “receive certain Covid patients, as well as Revenues for these services, albeit at much lower rates than [HSS’s] normal Elective Surgery business.” Mr. Ganss then noted that “for conservatism purposes,” for the period March, April and May 2020, HSS had “Total Net Loss Revenues” of **\$188,021,000**. *See Exhibit 65*.

134. On August 18, 2020, Ms. Parenteau sent a letter to HSS confirming that FM’s “calculation of the actual loss sustained by [HSS] has exceeded the Policy limit of \$1,000,000 combined annual aggregate for COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE as well as the applicable \$250,000 combined deductible. As such, a net payment of \$1,000,000 will be issued to or as directed by” HSS. *See Exhibit 66*.

135. On August 31, 2020, Ms. Parenteau sent a letter to HSS with a check for \$1,000,000, which she claimed “represents the final payment for the above-captioned claim along with a Statement of Settlement of Loss for your records.” *See Exhibit 67*. Ms. Parenteau’s letter further confirmed that HSS “has sustained loss and/or damage for which a claim has been made under the insurance policy identified above.” *Id.*

136. FM’s “Talking Points” state that to trigger coverage under the Communicable Disease Response and Interruption by Communicable Disease provisions “the presence of the communicable disease [must be] the basis for the decision limiting access” to the insured’s location. This is confirmed in the following question and answer in FM’s Talking Points:

- Q. Would an employee at a **location** who is affected with the **communicable disease** be considered the “actual presence” of a **communicable disease**?
- A. Yes – if it can be confirmed the employee actually has the **communicable disease and the presence of the communicable disease is the basis for the decision limiting access** as noted in subsections 1) and 2) under the Advantage Policy or a) and b) under provision Policy.

**Exhibit 68** (emphasis added)

137. *Thus, by granting coverage to HSS under the Communicable Disease Response and Interruption By Communicable Disease provisions, FM admitted that the presence of COVID-19 at HSS’s insured locations (and other hospitals and medical providers in a five-mile radius) was the “basis” of the civil authority orders that restricted access to HSS for elective surgeries, which caused HSS to suffer significant income loss. And, as discussed in detail above, the actual presence of COVID-19 caused physical damages of the type insured. Accordingly, HSS’s right to coverage under the CIVIL OR MILITARY AUTHORITY provision was triggered.*

138. On April 27, 2021, HSS wrote to FM “to determine whether [FM] is prepared to acknowledge coverage for losses incurred by HSS in excess of the \$1 million payment received from FM on August 31, 2020.” See **Exhibit 69**. HSS noted that it has “suffered severe losses in connection with the COVID-19 pandemic, far exceeding the \$1 million aggregate limit for Communicable Disease Response and Interruption by Communicable Disease. HSS provided to FM, as well as to FM’s forensic accountant, documentation of net revenue losses through May 2020 alone that was well in excess of \$150MM. HSS continued to suffer losses related to COVID-19 after May 2020, and can provide updated information if requested. Yet FM has only paid HSS \$1 million.” *Id.*

139. HSS’s letter further noted that: “Although we are aware of the legal positions FM has taken in court cases around the country and elsewhere, in its correspondence in this matter,

FM did not explicitly address HSS's claim of coverage under other portions of the FM Policy included in HSS's notice of claim, including but not limited to coverage for Time Element/Gross Profit, Ingress/Egress, Civil Or Military Authority, Contingent Time Element Extended, Protection and Preservation of Property. HSS believes these other coverages are triggered and that the losses it incurred in excess of \$1 million are covered by the Policy. As FM has acknowledged, coverage under the FM Policy was triggered by the actual presence of communicable disease at insured locations. In addition, HSS was required to make numerous physical and structural plant changes due to the presence of communicable disease and governmental mandates to treat COVID-19 patients, including but not limited to building new structures and changing air flow patterns to protect patients and staff." *Id.*

140. HSS's letter concluded by "request[ing] that FM Global provide its position in writing, on or before May 17, 2021, with respect to the availability of coverage under the Policy for losses sustained by HSS beyond the \$1 million limit provided under the Policy for the coverages denominated Communicable Disease Response and Interruption By Communicable Disease." *Id.*

141. FM responded on May 13, 2021, disclaiming any further coverage under the Policy. In particular, FM claimed that there was no coverage under the TIME ELEMENT loss, CIVIL or MILITARY AUTHORITY, CONTINGENT TIME ELEMENT EXTENDED, INGRESS/EGRESS or PROTECTION AND PRESERVATION OF PROPERTY provisions because "COVID-19 does not constitute 'physical loss or damage insured under this Policy'" and "and it would be excluded as 'contamination'." *See Exhibit 70.*

**FM's Bad Faith Denial of Coverage Under Its Talking Points**

142. The insurance industry has repeatedly and falsely warned courts and the media that COVID-19-related claims would bankrupt insurers and force them to raise premiums and

restrict coverages, but they have reaped enormous profits by denying covered claims and have continued to raise premiums despite refusing to uphold their coverage obligations. For example, FM Global, FM’s parent company, reported an increase of almost \$500 million in net premium for 2020 compared with 2019, and net income of over \$1.7 billion. *See Exhibit 71* at page 40.

143. Upon information and belief, FM’s denial of coverage was not unique to HSS, but rather a systematic claims handling practice and procedure that FM deployed across all COVID-19 claims, as outlined in a set of “Talking Points” (the “FM Talking Points”) prepared for FM claim adjusters to use to ensure that they reach the same conclusion for all COVID-19 claims. *See Exhibit 68.*

144. The FM Talking Points explicitly acknowledge that FM “ha[s] a wide range of clients who may be affected in a variety of ways” by COVID-19. *Id.*

145. The FM Talking Points outline only a few of the many different coverages contained in FM’s standard commercial property policies, including policies of the type FM sold to HSS, that specifically afford coverage for COVID-19 claims. In accordance with these Talking Points prepared for FM claim adjusters, FM unequivocally took the position that provisions such as the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE coverage provisions are the only Policy provisions responsive to losses resulting from the Pandemic under the form of Policy provided to HSS.

146. In fact, the FM Talking Points expressly and unequivocally foreclose the availability of coverage under the Policy’s CIVIL OR MILITARY AUTHORITY, INGRESS/EGRESS, AND CONTINGENT TIME ELEMENT EXTENDED coverage provisions, claiming that these “coverages require physical loss or damage to property of the type insured... The presence of a communicable disease does not constitute physical damage



and is not of the type insured against as a virus falls within the definition of **contamination**, which is excluded.” *Id.*

147. FM’s position that the presence of COVID-19 at a location does not constitute physical loss or damage, and, in any event, fall within the definition of contamination under the Policy and thus are excluded is factually and legally erroneous, and contrary to (a) the scientific evidence concerning the physical impact of COVID-19, (b) the terms of the Policy, (c) the positions FM itself as taken in other cases about the scope of the undefined terms “physical loss or damage,” and (d) representations FM made to regulatory authorities in seeking approval of communicable disease coverage.

148. Upon information and belief, as a result of the Talking Points, FM failed to conduct any investigation with respect to HSS’s claim to determine whether HSS had in fact sustained physical loss or damage as a result of communicable disease.

149. The FM Talking Points direct the claims adjuster to reach conclusions without considering the specific facts of a particular claim or the applicable law that governs interpretation of the relevant insurance policy.

150. Instead, the FM Talking Points coach the adjuster to suggestively steer the policyholder toward the COMMUNICABLE DISEASE RESPONSE and INTERRUPTION BY COMMUNICABLE DISEASE coverages, which provide only a fraction of the coverage limits otherwise available under the Policy.

151. The FM Talking Points are contrary to the accepted practices of good faith insurance claim handling, constitute an unfair or deceptive act or practice in the business of insurance, and reflect a conscious disregard of HSS’s rights under the Policy.

152. Upon information and belief, FM knowingly or recklessly failed to conduct a reasonable investigation of HSS's claim and, therefore, the basis for FM's denial is unreasonable. In denying HSS's claim, FM knew its denial lacked any reasonable basis because it failed to faithfully apply its own Policy language, failed to conduct a reasonable investigation, and failed to consider the facts relevant to HSS's claim against the Policy language as interpreted by Rhode Island law. Because of FM's bad faith conduct, including its wrongful denial and inadequate claim investigation, HSS has and continues to suffer significant damages.

**FIRST CAUSE OF ACTION**  
**(Declaratory Judgment)**

153. HSS incorporates by reference the allegations contained in Paragraphs 1-152, as if set out in full herein.

154. HSS seeks the Court's declaration of the parties' rights and duties under the Policy pursuant to Rhode Island Superior Court Rules of Civil Procedure 57 and R.I.G.L. § 9-30-2. A justiciable controversy exists between HSS and FM regarding the availability of coverage under the Policy for HSS's claims.

155. The controversy between HSS and FM is ripe for judicial review.

156. Therefore, HSS seeks a declaration from this Court that: (a) the various Policy coverage provisions identified in this Complaint are triggered by HSS's claims, including, without limitation, TIME ELEMENT loss (including for GROSS PROFITS and EXTRA EXPENSE), TIME ELEMENT COVERAGE EXTENSIONS for CIVIL OR MILITARY AUTHORITY, INGRESS/EGRESS and CONTINGENT TIME ELEMENT EXTENDED, and ADDITIONAL TIME ELEMENT COVERAGE EXTENSION for PROTECTION AND PRESERVATION OF PROPERTY TIME ELEMENT; (b) no Policy exclusion applies to prohibit or limit coverage for HSS's claims; and (c) the Policy covers HSS's claims.

157. HSS has been required to retain the services of attorneys to commence this action and is further entitled to attorneys' fees and costs.

**SECOND CAUSE OF ACTION**  
**(Breach of Contract)**

158. HSS incorporates by reference the allegations contained in Paragraphs 1-157, as if set out in full herein.

159. The Policy constitutes a valid and enforceable written contract between HSS, on the one hand, and FM, on the other.

160. HSS has complied with all applicable terms and conditions of the Policy, including the timely payment of all premiums due under the Policy.

161. Based on the above-described facts, the following Policy coverage provisions were triggered: TIME ELEMENT loss; TIME ELEMENT COVERAGE EXTENSIONS for CIVIL OR MILITARY AUTHORITY, INGRESS/EGRESS and CONTINGENT TIME ELEMENT EXTENDED; and ADDITIONAL TIME ELEMENT COVERAGE EXTENSION for PROTECTION AND PRESERVATION OF PROPERTY TIME ELEMENT.

162. Based on the above-described facts, HSS incurred substantial covered losses under each of the above-identified Policy coverage provisions.

163. FM breached the Policy by wrongfully denying HSS's claims for coverage under the Policy (including, without limitation, coverage for TIME ELEMENT loss (including for GROSS PROFITS and EXTRA EXPENSE), TIME ELEMENT COVERAGE EXTENSIONS for CIVIL OR MILITARY AUTHORITY, INGRESS/EGRESS and CONTINGENT TIME ELEMENT EXTENDED, and ADDITIONAL TIME ELEMENT COVERAGE EXTENSION for PROTECTION AND PRESERVATION OF PROPERTY TIME ELEMENT) and refusing to

pay HSS's covered losses, other than for \$1,000,000 that FM paid to HSS under the Policy's Communicable Disease Response and Interruption by Communicable Disease provisions.

164. HSS has been damaged and continues to sustain damages due to FM's breaches of the Policy in an amount to be determined at trial but anticipated to be up to the Policy limits.

165. As a result of FM's breaches of the Policy, HSS requests entry of judgment for breach of contract, awarding payment of damages in an amount to be proven at trial.

166. HSS has been required to retain the services of attorneys to commence this action and is further entitled to attorneys' fees and costs.

**THIRD CAUSE OF ACTION**  
**(Breach of the Implied Covenant of Good Faith and Fair Dealing)**

167. HSS incorporates by reference the allegations contained in Paragraphs 1-166, as if set out in full herein.

168. The Policy constitutes a valid and enforceable written contract between HSS, on the one hand, and FM, on the other.

169. HSS has complied with all applicable terms and conditions of the Policy including the timely payment of all premiums due under the Policy.

170. The Policy includes an implied covenant that FM will act in good faith and deal fairly with HSS.

171. FM breached the implied covenant of good faith and fair dealing by among other things: (a) denying HSS's claim for coverage without any reasonable basis; (b) denying HSS's claim without conducting a fair and proper investigation; (c) misrepresenting the terms of the Policy in denying coverage; (d) acting solely in its own economic interests and without any regard for the interests of its policyholder, HSS; and (e) compelling HSS to file this lawsuit to obtain the coverage owed under the Policy.

172. As a result of FM's breaches of the implied covenant of good faith and fair dealing, HSS has incurred substantial damages, including but not limited to the attorneys' fees it is being forced to incur to obtain the coverage owed under the Policy.

173. Because FM's conduct was malicious and oppressive, and because it was part of a broader fraudulent and malicious scheme by FM to avoid its coverage obligations for claims arising out of the Pandemic, HSS is also entitled to punitive damages.

174. As a result of FM's breaches of its duty of good faith and fair dealing, HSS requests entry of judgment, awarding payment of damages, including but not limited to attorneys' fees, as well as punitive damages.

175. HSS has been required to retain the services of attorneys to commence this action and is further entitled to attorneys' fees and costs.

**FOURTH CAUSE OF ACTION**  
**(Bad Faith – Common Law)**

176. HSS incorporates by reference the allegations contained in Paragraphs 1-175, as if set out in full herein.

177. FM's acts and omissions, as described in this Complaint, and also yet to be discovered in this matter, constitute bad faith.

178. HSS sustained damages as described in this Complaint, but FM has failed to comply with its obligation to conduct a reasonable and good-faith investigation of HSS's claim, and has further failed and refused in bad faith to compensate HSS for its claim.

179. HSS is entitled to actual damages and punitive damages as a result of FM's bad faith.

180. HSS has been required to retain the services of attorneys to commence this action and is further entitled to attorneys' fees and costs.

**FIFTH CAUSE OF ACTION**  
**(Bad Faith – R.I.G.L. § 9-1-33)**

181. HSS incorporates by reference the allegations contained in Paragraphs 1-180, as if set out in full herein.

182. FM's acts and omissions, as described in this Complaint, and also yet to be discovered in this matter, constitute bad faith under R.I.G.L. § 9-1-33.

183. HSS sustained damages as described in this Complaint, but FM has failed to comply with its obligations and has failed to compensate HSS for its claim.

184. HSS is entitled to compensatory damages and punitive damages as a result of FM's bad faith.

185. HSS has been required to retain the services of attorneys to commence this action and is further entitled to attorneys' fees and costs.

**REQUEST FOR RELIEF**

**WHEREFORE**, HSS respectfully requests that this Court enter judgment against FM as follows:

1) A declaration from this Court that: (a) the various coverage provisions identified in this Complaint are triggered by HSS's claims, including, without limitation, TIME ELEMENT loss (including for GROSS PROFITS and EXTRA EXPENSE), TIME ELEMENT COVERAGE EXTENSIONS for CIVIL OR MILITARY AUTHORITY, INGRESS/EGRESS and CONTINGENT TIME ELEMENT EXTENDED, and ADDITIONAL TIME ELEMENT COVERAGE EXTENSION for PROTECTION AND PRESERVATION OF PROPERTY TIME ELEMENT; (b) no exclusion in the Policy applies to prohibit or limit coverage for HSS's claims; and (c) the Policy covers HSS's claims;

- 2) For actual, special, compensatory, and consequential damages against FM in an amount to be proved at trial in excess of the minimum jurisdictional limits of this Court;
- 3) For punitive and/or double and/or treble damages due to FM's intentional bad faith conduct;
- 4) Pre- and post-judgment interest as provided by law;
- 5) An award of attorneys' fees and cost of suit incurred; and
- 6) For such other and further relief as the Court deems just and proper.

**JURY TRIAL DEMANDED**

HSS respectfully requests a trial by jury on all issues so triable.

Dated: February 17, 2022

Respectfully submitted,

/s/ Stephen M. Prignano  
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***Counsel for Plaintiff***

\*Applications for admission *pro hac vice* to be filed