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No. 166772

STATE OF MICHIGAN
IN THE SUPREME COURT

JOSEPH CANTY,

Plaintiff-Appellant,
v.

MICHAEL MASON,

Defendant-Appellee.

ON APPEAL FROM THE COURT OF APPEALS
Court of Appeals Case No. 365327
3rd Circuit Court Case No. 21-004799-NI
Hon. Kathleen McCarthy

PLAINTIFF-APPELLANT'S SUPPLEMENTAL BRIEF APPENDIX

Erik J. Stone (P55304)
Eric M. Noga (P83611)
APPLEBAUM & STONE, PLC
Attorneys for Plaintiff-Appellee CANTY
26777 Central Park Boulevard, #300
Southfield, Michigan 48076
(248) 233-5050 Fax: (248) 359-8550
estone@applebaumstone.com
enoga@applebaumstone.com

Erin J. Rodenhouse (P83676)
Michael J. Cook (P71511)
COLLINS EINHORN FARRELL PC
Attorneys for Defendant-Appellee MASON
4000 Town Center, 9th Floor
Southfield, MI 48076
(248) 355-4141
erin.roldenhouse@cfelawyers.com

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STATEMENT OF QUESTIONS PRESENTED

I. **DID THE COURT OF APPEALS ERRONEOUSLY HOLD THAT ELDERLY MOTORISTS WHO RECEIVE MEDICARE AND OPT OUT OF PIP MEDICAL BENEFITS HAVE A DUTY TO PROVE THAT THEY TRIED TO MITIGATE THE MEDICAL EXPENSES BY SEEKING PAYMENT FROM MEDICARE IN THE FIRST INSTANCE WHERE MEDICARE IS SECONDARY PAYOR IN THIS SITUATION, WHERE THE BURDEN OF PROVING THE ABSENCE OF MITIGATION OF DAMAGES IS ON THE DEFENDANT, AND WHERE THE STATUTE EXPRESSLY HOLDS THAT THE DAMAGES ARE WITHOUT LIMITATION?**

Plaintiff-Appellant answers, "Yes."
Defendant-Appellee answers, "No."
Court of Appeals answers, "No"
The Trial Court interpreted the statute consistent with Plaintiff's view,

II. **DID THE COURT OF APPEALS ERR IN EXPANDING THE FEE CAP LIMITS OF** MCL 500.3157 **TO INCLUDE THIRD-PARTY CLAIMS FOR MEDICAL TREATMENT EXPENSES WHERE THE LEGISLATURE DID NOT INCLUDE THESE CLAIMS IN THEIR LIST OF ADOPTED STATUTES IN** MCL 500.3107**?**

Plaintiff-Appellee answers, "Yes."
The Trial Court answers, "No."
The Court of Appeals, "Yes."
Defendant-Appellant answers, "No."

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JURISDICTION

This involves an accident that took place on February 15, 2021. Plaintiff filed a lawsuit in Wayne County Circuit Court. Defendant subsequently filed motions for summary judgment which were denied. Defendant then filed an Application for Leave to Appeal in the Court of Appeals. This was granted and the case went through full briefing and arguments.

On October 4, 2024, the Court of Appeals reversed the trial court on both issues, Judge Mariani dissenting on the need to follow the statutory amount in tort claims. This Application for Leave to Appeal was filed on October 4, 2024. On September 17, 2025, this Court ordered oral arguments on the Application

> On order of the Court, the application for leave to appeal the October 4, 2024 judgment of the Court of Appeals is considered. We direct the Clerk to schedule oral argument on the application. MCR 7.305(I)(1). The parties shall file supplemental briefs in accordance with MCR 7.312(E), addressing: (1) whether a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) has a duty to mitigate their damages by seeking payment from Medicare; and (2) whether the fee schedules in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c).

Michigan Access to Justice (who filed an amicus brief at the application stage), The Insurance Alliance of Michigan, Michigan Defense Trial Counsel, Inc., and CPAN were specifically invited to file a supplemental brief.

This is Mr. Canty's brief.

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STATEMENT OF FACTS

Plaintiff believes that there are no real disputes as to the facts of the case and thus the facts prior to the Court of Appeals activity are taken from the brief of the Defendant (with minor changes but no additions).

Plaintiff Joseph Canty opted out of PIP benefits because he had Medicare.[1] When he needed medical care, he treated with a Veterans Affairs' provider.[2]

On February 15, 2021, Canty and Defendant Michael Mason got in a car accident.[3] After the accident, Canty treated with no-fault providers.[4] Those providers accepted Medicare, but they didn't bill Medicare or charge Medicare rates.[5] These rates were unrelated to the fee schedule in MCL 500.3157.[6]

Mr. Canty sued Mr. Mason under MCL 500.3135(3)(c) for unlimited allowable expenses.[7] Mason sought summary disposition on the portion of the bills that he argued Medicare would have covered. He argued that Canty had a common law

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[1] Canty's PIP opt-out form. Defendant's MSD, Appx 7-D.

[2] Defendant's MPSD, (7); Appx 7 .

[3] Complaint, Plaintiff's MOA Appx 5.

[4] Medical Bills, Defendant's MPSD MOA Appx 7C.

[5] Participating Insurers, Defendant's COA Appx 8E, p. 164.

[6] Medical Bills, MOA Appx 7C, p. 128-137.

[7] Complaint, MOA Appx 5.

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duty to mitigate his damages and use his Medicare. He also argued that Canty's recovery was limited to allowable expenses as defined in MCL 500.3107, which required applying the fee schedule in MCL 500.3157.[8]

At the hearing on Mason's motion for summary disposition, the trial court agreed that Canty had a duty to mitigate his damages.[9] The trial court found that Canty's providers weren't bound by the fee schedule in MCL 500.3157 because it was a third-party case.[10] Mason submitted an order under the 7-day rule. Canty objected.[11]

The trial court held a hearing on Canty's objections. During that hearing, the trial court reversed its ruling regarding Canty's common-law duty to mitigate damages. The trial court held that Canty had no duty to use his Medicare.[12] The trial court reaffirmed its holding that MCL 500.3107 defines allowable

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[8] Defendant's MPSD, MOA Appx 7.

[9] January 4, 2023 Hearing Transcript, MOA. Appx 9 (p. 13 Transcript.

[10] *Id.* at 23..

[11] Plaintiff's objections to Defendant's proposed 7-day order .

[12] Feb. 7, 2023 Hearing Transcript, Plaintiff S. Ct. Appx 8; Transcript, p. 37.

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expenses as stated in MCL 500.3135(3)(c) but that the fee schedule in MCL 500.3157 didn't apply in third-party cases.[13]

Mr. Mason filed an Application for Leave to Appeal in the Court of Appeals and leave was subsequently granted. After full briefing and argument, the Court reversed the matter in a published opinion. Two judges, Judge Gadola and Judge Swartzle, reversed the trial court on both issues. Judge Mariani concurred in part and dissented in part.

Canty, who had opted out of PIP insurance by relying on Medicare, argued that MCL 500.3135(3)(c) allowed him to recover medical costs without limitation. Mason, however, argued that Canty's recoverable expenses were constrained by the statutory fee schedules and by a duty to mitigate damages by using Medicare [*3].[14]

The majority concluded that MCL 500.3135(3)(c) requires Canty's damages to align with "allowable expenses" as defined in MCL 500.3107. Therefore, Canty's recoverable medical expenses must be "reasonable charges incurred for reasonably necessary products, services, and accommodations," [*8]. The

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[13] *Id.* at 37.

[14] Star pagination markers are tied to the Lexis version of the opinion available at *Canty v Mason*, No. 365327; 2024 Mich App LEXIS 7934 (Mich App 2024). This version of the decision appears in the Appendix to this brief at Appx. 2

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court further ruled that the fee schedules in MCL 500.3157 apply to limit Canty's recovery, as MCL 500.3135(3)(c) incorporates all relevant limitations within Chapter 31 of the Insurance Code, including the fee schedule provision, [*11] .

The majority also held that Canty had a duty to mitigate damages by utilizing available Medicare coverage. Under common-law mitigation principles, which apply by incorporation into MCL 500.3135(3)(c), Canty must take reasonable steps to limit his recoverable expenses. This includes billing Medicare for his treatment. If Canty's chosen providers do not accept Medicare, the trial court must assess the reasonableness of that choice, [*15].

Based on these conclusions, the court affirmed in part and reversed in part, remanding the case for further proceedings to assess the reasonableness of Canty's medical expenses and his provider choices given the duty to mitigate damages, [*17].

In his dissent, Judge Mariani agreed that "allowable expenses" under MCL 500.3107(1)(a) constrains tort damages and concurred with the duty to mitigate. However, he strongly disagreed with the majority's application of the fee schedules in MCL 500.3157 to Canty's tort claim. Mariani argued that the Legislature specifically referenced MCL 500.3107 through MCL 500.3110 in defining "allowable expenses" for tort recovery

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under MCL 500.3135(3)(c) and deliberately excluded the fee schedule in MCL 500.3157 [*19].

Judge Mariani maintained that applying MCL 500.3157 to limit tort damages extended beyond the statute's plain language and legislative intent. He contended that the Legislature intended to impose fee schedules solely on PIP claims, not tort actions. In his view, the statutory structure indicates distinct frameworks for no-fault benefits and tort claims, and the majority's interpretation improperly blurred this boundary, imposing unintended constraints on Canty's tort recovery, [*21].

This Application for Leave to Appeal was filed on October 4, 2024.[15] On September 17, 2025, this Court ordered oral arguments and supplemental briefs on the Application addressing the following: (1) whether a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) has a duty to mitigate their damages by seeking payment from Medicare; and (2) whether the fee schedules in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c). Michigan Access to Justice (who filed an amicus brief at the application stage), The Insurance Alliance of Michigan, Michigan Defense Trial Counsel, Inc., and CPAN were specifically invited to file a supplemental brief.

This is Mr. Canty's brief.

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[15] MOA App'x 1.

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STANDARD OF REVIEW

On appeal, a trial court's grant or denial of summary disposition is reviewed de novo.[16] This Court must review the record in the same manner as the trial court to determine whether the movant was entitled to judgment as a matter of law.[17] "A motion for summary disposition under MCR 2.116 tests whether there is factual support for a claim."[18] "When deciding a motion for summary disposition under MCR 2.116, a court must consider the pleadings, affidavits, depositions, admissions, and other documentary evidence submitted in the light most favorable to the nonmoving party." Id. "[A] court may not weigh the evidence before it or make findings of fact; if the evidence before it is conflicting,

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[16] *First Pub Corp v Parfet*, 468 Mich 101, 104; 658 NW2d 477 (2003).

[17] *Morales v Auto-Owners Ins Co*, 458 Mich 288, 294; 582 NW2d 776 (1998).

[18] *Shepherd Montessori Ctr Milan v Ann Arbor Charter Tp*, 259 Mich App 315, 324; 675 NW2d 271 (2003).

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summary disposition is improper."[19] Michigan courts are liberal in finding factual disputes for summary disposition purposes.[20]

Legal questions are likewise reviewed de novo.[21] This includes the interpretation of Michigan statutes and court rules.[22]

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[19] *Lysogorski v Bridgeport Charter Tp*, 256 Mich App 297, 299; 662 NW2d 108 (2003), citing *DeFlaviis v Lord & Taylor, Inc*, 223 Mich App 432, 436; 566 NW2d 661 (1997) (emphasis in original).

[20] *Piccione as Next Friend of Piccione v Gillette*, 327 Mich App 16; 932 NW2d 197 (2019).

[21] *In re Estate of Moukalled*, 269 Mich App 708, 713; 714 NW2d 400 (2006).

[22] *State Farm Fire & Cas Co v Corby Energy Servs., Inc*, 271 Mich App 480, 483; 722 NW2d 906 (2006); *Webb v Holzheuer*, 259 Mich App 389, 391; 674 NW2d 395 (2003).

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INTRODUCTION

This case involves multiple issues dealing with the appropriate metrics and burdens to be applied in cases involving personal injuries needing medical treatment in automobile negligence cases where the plaintiff has previously opted out of PIP – particularly those who are receiving Medicare. The published ruling below can easily be read to say that the Court of Appeals has placed the burden on the plaintiff to prove that they have mitigated damages. In all other areas of law and consistent with the common law, that burden falls on the Defendant to show a failure to mitigate damages. The last issue holds that the fee schedule contained in MCL 500.3157 for first party claims applies to third party claims even though the medical provider assumes a much higher risk treating these individuals.

A review of the majority opinion by Judge Swartzle and Gadola versus Judge Mariani's dissent in a published opinion shows that this case is an important case for this Court to consider. The panel sharply divided on a number of questions (many of first impression), including:

- *Definition of Allowable Expenses.* The majority interprets "allowable expenses" under MCL 500.3107(1)(a) as reasonable charges for services necessary for the injured party's care, recovery, or rehabilitation. This definition limits Canty's recovery to reasonable, necessary medical costs as specified in the statute, and governs the determination of allowable expenses in tort claims under MCL 500.3135(3)(c) [*8], [*10].

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Judge Mariani superficially concurs with this interpretation, agreeing that allowable expenses must align with the statutory requirement of reasonable charges for necessary medical services. This agreement forms a foundation for assessing Canty's medical costs within the statute's language [*10], but note Judge Mariani's difference about the use of the fee schedule to limit expenses and the differing opinion on the without limitations language.

- *Applicability of Fee Schedule (MCL 500.3157***).** The majority asserts that the fee schedule established in MCL 500.3157 applies to Canty's tort recovery, reasoning that MCL 500.3135(3)(c) implicitly incorporates this provision through the broader framework of Chapter 31. According to the majority, this interpretation prevents Canty from bypassing the fee limitations by pursuing a third-party claim instead of no-fault benefits [*11]. The dissent however believes that MCL 500.3157's fee schedule is intended solely for first-party no-fault claims and was not legislatively intended to constrain tort damages under MCL 500.3135(3)(c). Judge Mariani maintains that applying the fee schedule here improperly broadens the statute beyond its explicit language, thereby contradicting the statutory separation of no-fault benefits and tort claims [*12].

- *Interpretation of "Without Limit" Language in MCL 500.3135(3)(c).* The majority interprets the "without limit" language as indicating that a plaintiff can recover allowable expenses starting from "dollar one" without the need to exhaust PIP benefits. However, it emphasizes that the term does not eliminate the statutory restrictions on recoverable expenses, such as the requirement for reasonableness and necessity, nor does it exclude fee schedules and other Chapter 31 limitations [*10]. Judge Mariani interprets the "without limit" phrase more expansively, contending that it reflects the legislature's intent to exclude fee schedules from tort claims

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under MCL 500.3135(3)(c). The dissent views the majority's limitation on the "without limit" language as narrowing the statutory scope without clear legislative authority to do so [*12];

- *Duty to Mitigate Damages by Utilizing Medicare Coverage.* The majority holds that Canty has a duty to mitigate damages by using available Medicare benefits where applicable. It emphasizes that under common-law principles incorporated by MCL 500.3135(3)(c), Canty cannot recover costs that could have been avoided by utilizing Medicare. If Canty seeks recovery for expenses charged by providers who do not accept Medicare, the reasonableness of his provider choice may be a factual issue for the trier of fact [*9]. The dissent concurs that Canty must mitigate damages by minimizing avoidable costs; however, Judge Mariani does not believe this principle should force Canty to limit his provider choices solely based on Medicare's availability. The dissent argues that tort victims should retain flexibility in their choice of care providers without being subject to rigid Medicare-based constraints [*9].

- *Majority Opinion*: The majority posits that the legislature, by referencing MCL 500.3107 within MCL 500.3135(3)(c), implicitly intended to incorporate all related limitations in Chapter 31, including the fee schedule. The majority argues that interpreting the statute otherwise would render parts of Chapter 31 surplusage and disregard the legislature's presumed awareness of these statutory interconnection. Conversely, Judge Mariani's dissent criticizes this approach, arguing that the majority's reading overreaches by incorporating additional limitations not specified by MCL 500.3135(3)(c). The dissent asserts that the majority's interpretation disregards the distinct statutory purposes of tort recovery and no-fault benefits and effectively rewrites the

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> statute to impose unintended constraints on tort recoveries [*12].

The Court of Appeal ruling, as it stands, has the effect of allowing the Defendant's in these cases to simultaneously maintain that the plaintiff should lose because they failed to take enough efforts to rehabilitate from their injuries or because the plaintiff overworked their rehabilitation thereby failing to minimize the medical expenses. This creates an untenable heads they win; tails we lose situation.

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ARGUMENT

I. OUR LEGISLATURE HAS ALLOWED ELDERLY MOTORISTS WHO RECEIVE MEDICARE TO OPT OUT OF PIP MEDICAL BENEFITS. MEDICARE IS STATUTORILY BARRED FROM BEING THE PRIMARY INSURER IN THESE CASES. THIS HAS CREATED A DIFFICULT SITUATION FOR PATIENTS AND MEDICAL CARE PROVIDERS WHO ARE NECESSARILY TAKING ON AN ADMINISTRATIVE NIGHTMARE AND DELAYED PAYMENTS AT A MINIMUM AND LITIGATION AT WORST. THE COURT OF APPEALS RULING HAS MADE THE SITUATION MUCH WORSE BY NOW POTENTIALLY SAYING THAT THE ELDERLY MOTORIST MUST PROVE THAT THEY MITIGATED DAMAGES AND BY STRONGLY SUGGESTING THAT MEDICARE WILL PAY BENEFITS THAT THEY WILL NOT.

The Court of Appeals' opinion creates a poorly defined duty to mitigate before pursuing third party medical claims. A careful reading of the case shows that a court could easily believe that the Court shifted the burden of proof concerning mitigation of damages to the Plaintiff.

Defendant has not questioned the treatment; he has questioned the prices the Plaintiff's doctors and medical providers

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have chosen for their services. Medical services are, by their definition, highly personal, and a poor choice of doctors can result in catastrophic results. A doctor/patient relationship is highly personal and the selection process of the appropriate doctor should not be curtailed through the Defendant's novel argument.

This brief will argue that a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) does not have a duty to mitigate their damages by seeking payment from Medicare; and (2) whether the fee schedules in MCL 500.3157 do not apply to a tort action under MCL 500.3135(3)(c).

A. A Plaintiff Seeking Allowable Expenses in a Tort Action Under MCL 500.3135(3)(c) Does Not Have a Duty to Mitigate Damages by Seeking Payment from Medicare.

Mitigation of damages is an affirmative defense, and proof of Plaintiff's failure to mitigate rests upon the defendant.[23] Reviewing

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[23] *Fothergill v McKay Press*, 374 Mich 138; 132 NW2d 144 (1965); *Froling v Bischoff*, 73 Mich App 496, 499; 252 NW2d 832 (1977); *Walters v Nadell*, 481 Mich 377; 751 NW2d 431 (2008) (defendant must establish factual basis for affirmative defenses). *See gen* 3 Diana T. Axelrod, Richard P. Goldstein, Clark D. Kimball, Marilyn Minzer, & Jerome H. Nates, Damages in Tort Actions § 16.01 (Matthew Bender & Company, Inc., 2025) ("Mitigation of damages is an affirmative defense on which the defendant bears the burden of proof. The affirmative defense of mitigation of damages requires the defendant to prove that the plaintiff failed to exercise reasonable care to mitigate his or her post-injury damages").

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the Court of Appeals opinion, one would easily believe the law was to the contrary.[24]

The defendant bears the burden of proving that the Plaintiff failed to make reasonable efforts to mitigate damages. *Id.* The question of whether the Plaintiff's efforts to mitigate damages were reasonable under the circumstances is one for the trier of fact.[25] Defendant may very well be entitled to a jury instruction such as M Civ JI 53.05 (Mitigation of Damages--Failure to Exercise Ordinary Care) but they have not demonstrated that they are entitled to summary disposition on this affirmative defense.

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[24] Some examples include the following statements: "It is incumbent on a person who has been harmed by the commission of a tort to use such means that are reasonable under the circumstances to minimize or mitigate the amount of damages" and a plaintiff "is not entitled to recover for any item of damage that could have been avoided." *Canty v Mason*, 2024 Mich App LEXIS 7934, *13–14. The Court further reaffirmed that, because "the no-fault act does not specifically abrogate the common-law principle that a plaintiff is obligated in a tort action to mitigate his or her damages, the defense remains viable," id. at *14, the plaintiff must demonstrate that his conduct was reasonable, including that "the failure to seek payment from Medicare would not have been reasonable as a matter of law if the medical provider accepted Medicare." Id. at *16. Correspondingly, any recoverable damages require proof that the expenses were "reasonably necessary" and that "the charge was reasonable." Id. at *10 n 5 (citing Douglas). The Court also emphasized that "the trier of fact must resolve whether any incurred expenses… were reasonably incurred for purposes of mitigating damages." Id. at *16–17.

[25] *Morris v Clawson Tank Co*, 459 Mich 256, 271; 587 NW2d 253 (1998). See also *Landin v Healthsource Saginaw, Inc*, 305 Mich App 519, 539; 854 NW2d 152 (2014).

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Mitigation of damages is normally a question of fact for a jury, not for summary disposition.[26] There is a real danger that his process will expand the law on first-party claims to much more complex third-party claims where there is no guarantee of ever being paid.

In *Klanseck v Anderson Sales & Serv, Inc*, 426 Mich 78, 91; 393 NW2d 356 (1986), this Court stated that it "is well-settled that an injured party has a duty to exercise reasonable care to minimize damages, including obtaining proper medical or surgical treatment. While the Court found that the evidence was slight supporting that plaintiff's failure to mitigate damages by declining some treatment recommended by his doctor, this Court stated that the issue belonged to a jury. Applying *Klanseck*, the Court of Appeals explained in *Brehmer v. State Farm Mut. Ins. Co.*, No. 318839, 2015 Mich. App. LEXIS 530, at *9 (Ct. App. Mar. 17, 2015) (App. 10:

> An injured party's duty to exercise reasonable care to minimize damages includes the obligation to obtain proper medical or surgical treatment. *Klanseck v*

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[26] *Blatt v Coll of Staten Island*, No. 04-CV-2263 (ERK), 2005 WL 8160053, at *4 (EDNY, November 30, 2005) (App'x 14) ("While this alleged failure to mitigate may be pressed by the defendants at trial, at this juncture there cannot be a determination as a matter of law, to preclude the plaintiff from seeking back pay"). S*ee also Chainey v St*, No. CIV.A. 03-6248, 2005 WL 696883, at *2 (ED Pa, March 22, 2005) (App'x 15) ("There is no doubt that some mitigation of damages may be called for, but at [the summary judgment] stage such a ruling is premature,").

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> *Anderson Sales & Serv, Inc*, 426 Mich 78, 91; 393 NW2d 356 (1986). The defendant has the burden to prove that a plaintiff failed to make a reasonable effort to mitigate his or her damages. *Landin v Healthsource Saginaw, Inc*, 305 Mich App 519, 539; 854 NW2d 152 (2014). "The question whether the plaintiff's efforts to mitigate damages were reasonable under the circumstances is one for the trier of fact." *Id*.

While *Brehmer* is unpublished it nicely explains Michigan law on the subject. *See also Webster v Edward D Jones & Co, LP*, 197 F3d 815, 821 (CA 6, 1999) (applying Michigan law and reversing for new trial on damages and directing that the jury be instructed on the plaintiff's duty to mitigate and on the defendant's burden to show that the plaintiff failed to do so).

Any duty to mitigate, however, does not override a plaintiff's right to choose the doctor of their choosing or to credit their advice. In *Geer v First Nat'l Supermarkets, Inc*,[27] for example, the defendant argued that the plaintiff had failed to mitigate her damages because she did not "pursue a treatment plan advised by the defendant's medical expert." The court rejected that argument unequivocally, holding that it was "not unreasonable for the plaintiff wife to follow the treatment

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[27] *Geer v First Nat Supermarkets, Inc*, 5 Conn App 175, 178; 497 A2d 999 (1985).

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recommendations of her own doctor and that her actions were those of a reasonably prudent person." Id. at 178. *Geer* thus illustrates the well-settled rule that a plaintiff satisfies the duty to mitigate when she follows the advice of her own providers, even when the defendant's expert asserts that a different course of treatment might have been preferable. The law does not penalize a patient for selecting one medically accepted option over another, nor does it require her to choose the least expensive, least invasive, or defendant-endorsed option.

Similarly, the Wisconsin Supreme Court has noted that a plaintiff's duty to mitigate did not require them to go to the nearest hospital or doctor when the plaintiff had a preference to be treated by a more distant doctor and this caused a delay in getting treated. *Burke v Natl Farmers Union Prop & Cas Co*, 36 Wis 2d 427, 439; 153 NW2d 545 (1967) ("an injured person is not required to undergo treatment at the nearest hospital or with the nearest doctor"). *Burke* reinforces that the duty mitigate is a standard of reasonableness, not a mandate to select defense retroactively approved medical providers. A defendant should not be able to dictate the plaintiff's provider selection under the guise of a mitigation defense.

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Mitigation of damages doesn't require the Plaintiff to take the cheapest doctor. In the area of wrongful discharge, the Court of Appeals had the opportunity to remark:[28]

> It is well established that a plaintiff must make every reasonable effort to mitigate damages. *Edgecomb v Traverse City Sch Dist*, 341 Mich 106, 115; 67 NW2d 87 (1954); *Rich v Daily Creamery Co*, 296 Mich 270, 282; 296 NW 253 (1941). Such a defense, however, is an affirmative one, and proof of Plaintiff's failure to mitigate rests upon the defendant. *Fothergill v McKay Press*, 374 Mich 138; 132 NW2d 144 (1965); *Froling v Bischoff*, 73 Mich App 496, 499; 252 NW2d 832 (1977). A wrongfully discharged employee is obligated to mitigate damages by accepting employment of a "like nature". *Flickema v Henry Kraker Co*, 252 Mich 406; 233 NW 362 (1930); *Michigan Employment Relations Comm v Kleen-O-Rama*, 60 Mich App 61; 230 NW2d 308 (1975). The criteria for determining "like nature" include the type of work, the hours of labor, the wages, tenure, working conditions, etc. Whether or not an employee is reasonable in not seeking or accepting particular employment is a question for the trier of fact. 2 Restatement (Second) of Agency § 455 (1958), comment d, p. 373, Restatement (First) of Contracts §

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[28] *Higgins v Lawrence*, 107 Mich App 178, 181–82; 309 NW2d 194 (1981).

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> 336 (1932) Williston, Contracts (3rd ed.), s 1359, p. 306.
>
> In the instant case, the trial court made the following pertinent findings of fact: that the evidence gave no indication that if Plaintiff sought employment he would have obtained it within the 60-day period; that the contract limited plaintiff to seeking employment in an area outside of a ten mile radius; that podiatry is a profession rather than a job; and that Plaintiff required at least 60 days to find proper employment. Hence, the trial court concluded that the burden of proof on mitigation of damages had not been met by defendant.

While the appellate court played lip service to this principle, their opinion also suggests that the Plaintiff has a duty of showing an objective reason for choosing a course of treatment which results in additional costs to the Defendant.[29]

As noted earlier in this issue, the Court of Appeals opinion may easily be read as saying that someone who opts out of PIP coverage because they have Medicare assumes the burden for their own medical treatment even though federal law passed long before

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[29]*Canty*, 2024 Mich App LEXIS 7934, at *16 ("if necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages").

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this amendment reduced Medicare to a secondary payor in this situation.[30]

The duty to mitigate damages also does not mean that the Plaintiff had to follow the Defendant's previously undisclosed roadmap.[31] Claims are time sensitive, and the Plaintiff has to make the choice early to determine the most appropriate course to deal with an ailment which could be cured with one session or require continuous course of treatments.[32]

Mitigation of damages should not be used as an exercise in armchair quarterbacking the Plaintiff's decisions. Defendant's viewpoint would attribute to the Plaintiff a duty to know the insurance and coverage ramifications of his decisions very early in

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[30] *Canty*, 2024 Mich App LEXIS 7934, at 15–16 (rejecting the trial court's suggestion that Medicare could not be considered on mitigation because Medicare is "exempt from the no-fault statute," and explaining that federal law "did not prohibit Canty from receiving Medicare benefits for medical expenses incurred as a result of the accident," and that failure to seek Medicare payment would be unreasonable if a provider accepted Medicare).

[31] *See Aristocrat Leisure Ltd v Deutsche Bank Tr. Co Americas*, 727 F Supp 2d 256, 279 (SDNY, 2010) ("Proof of mitigation of damages requires only a showing that plaintiff took reasonable steps to cut its losses, not that plaintiff did what the defaulting defendants would have had it do, or what in hindsight seems most effective to reduce the defaulting defendants' damages.").

[32] *Aristocrat Leisure Ltd*, 727 F Supp 2d at 279 ("'[D]efendant [must] establish not only that the plaintiff unreasonably failed to mitigate, but that reasonable efforts would have *reduced* the damages.' ").

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the proverbial game and it is has not even been demonstrated Medicare coverage would have been available to him for accident related coverage. Placing the burden on the Plaintiff would allow the Defendant to fault the Plaintiff for receiving too much (not reasonable actions) or too little treatment (failing to mitigate).

While the Defendants have previously spoken contemptuously of doctors who service automobile victims, they also neglect to indicate that these doctors may have developed an infrastructure to assist people with these injuries. These doctors may well be the best equipped and most willing to assume the risks and complexities of handling a case involving state laws and federal laws which are at sometimes at odds with each other. They also assume a much greater risk of non-payment of fees.

B. Medicare as a Unique Secondary Payer With Very Limited Responsibilities in a Third Party Claim Under Michigan's No Fault Law.

Medicare is strictly a secondary payer whenever a "primary plan," including automobile liability insurance, is available.[33] Medicare may make conditional payments, but only if

[33] 42 USC 1395y(b)(2).

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reimbursement is guaranteed; it may not be treated as an ordinary primary insurer.[34]

Because Mason carried automobile liability insurance, Medicare cannot be the primary payor as a matter of federal law, and any payment would be conditional and must be reimbursed from the tort judgment. This extinguishes any conceivable mitigation argument.

Mitigation requires reasonable steps a plaintiff can lawfully take. A duty to seek illegal primary payment from Medicare is neither lawful nor reasonable. In fact, the trial court initially recognized exactly this: submitting to Medicare only creates a lien and therefore *does not reduce the harm*. That is the opposite of mitigation.

C. *Even assuming Medicare paid, Michigan law prohibits the introduction or use of Medicare payments to reduce damages. Medicare is expressly excluded from the collateral-source statute. A plaintiff cannot mitigate with something the Legislature has declared inadmissible and legally irrelevant.*

[34] *Marietta Mem Hosp Employee Health Benefit Plan v DaVita Inc*, 596 US 880; 142 S Ct 1968; 213 L Ed 2d 376 (2022); *Aetna Life Ins Co v Big Y Foods, Inc*, 52 F4th 66 (CA 2, 2022) (discussed extensively in the MAJ original amicus brief at p.23).

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Even assuming Medicare paid, Michigan law prohibits the introduction or use of Medicare payments to reduce damages.[35] Medicare is expressly excluded from the collateral-source statute. A plaintiff cannot mitigate with something the Legislature has declared inadmissible and legally irrelevant.

MCL 600.6303 clearly provides that in a personal-injury action seeking recovery for medical expenses and other enumerated losses, the court may consider evidence *after a verdict and before entry of judgment* that some or all of the claimed losses were paid or are payable by a collateral source. If the court determines that a collateral source has paid or owes payment for part of the plaintiff's economic loss, the court must reduce the economic-loss portion of the judgment by that amount, subject to the limitations in subsection. The Court then deducts from that figure any premiums the plaintiff, the plaintiff's family, or the plaintiff's employer paid to obtain the particular benefit, except premiums for insurance mandated by law. For purposes of this section, a "collateral source" includes insurance benefits; benefits under contracts with health-care, dental-care, or HMO corporations; employee benefits; Social

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[35] MCL 600.6303(4); *Tebo v Havlik*, 418 Mich 350; 343 NW2d 181 (1984); *Nasser v Auto Club Ins Ass'n*, 435 Mich 33; 457 NW2d 637 (1990); *Greer v Advantage Health*, 305 Mich App 192; 852 NW2d 198 (2014)

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Security; workers' compensation; and *Medicare*.[36] In fact, the exclusion applies by its plain terms to all benefits "paid or payable" by a legal entity that timely asserts a contractual lien pursuant to MCL 600.6303(3).[37]

D. Defendant Has the Burden of Proof on a Failure to Mitigate Defense.

At various points in the Court of Appeals opinion, the majority stated that the Plaintiff rather than the Defendant carried the burden of proving reasonable efforts to mitigate damages.

Specifically, the court determined that Canty had to show that the charges by his medical providers were reasonable and necessary under MCL 500.3107 and its interpretation of allowable expenses. This could be easily read to mean that Canty must demonstrate that the medical expenses incurred were not only necessary but also reasonable, which could extend to proving the reasonableness of his choice in medical providers.[38]

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[36] It does not include life-insurance proceeds or payments by entities entitled to a statutory lien against the plaintiff's recovery.

[37] *Greer*, 305 Mich App at 207

[38] The opinion additionally makes clear that a plaintiff pursuing allowable-expenses damages must select medical providers in a manner consistent with cost efficiency and economic reasonableness. The Court emphasized that recoverable allowable expenses must be "reasonable charges" for "reasonably necessary" services, *Canty*, 2024 Mich App LEXIS 7934, *10 n 5, thereby placing the burden on the plaintiff to demonstrate that the chosen treatment and associated costs were prudent. The Court further held that, under both MCL 500.3109(1) and common-

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As noted above, the Defendant *not* the Plaintiff has to prove failure to mitigate. Nothing in this statute purports to abrogate this common law defense. As this Court has recently noted:[39]

> We presume that the Legislature "know[s] of the existence of the common law when it acts. heretofore, we have stated that "[w]e will not lightly presume that the Legislature has abrogated the common law" and that "the Legislature should speak in no uncertain terms when it exercises its authority to modify the common law.

The fact that the Defendant's doctor may have accepted Medicare for some procedures does not prove they would have accepted it for these procedures and/or more importantly that Medicare would have agreed to pay the claim. As is discussed later in this issue, Medicare has actually promulgated policies stating that the automobile insurer is the primary provider of coverage in

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law mitigation principles, "the failure to seek payment from Medicare would not have been reasonable as a matter of law if the medical provider accepted Medicare," id. at *16, directly signaling that a plaintiff may not unreasonably bypass lower-cost, Medicare-participating providers or payment avenues. Reinforcing this, the Court concluded that the trier of fact must determine "whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages," id. at *17, confirming that the plaintiff bears the burden to justify the cost-efficiency of selecting higher-priced, non-Medicare providers.

[39] *Murphy v Inman*, 509 Mich 132, 153; 983 NW2d 354 (2022)

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accident-related treatment and they are secondary. The Defendant has presented no evidence showing that Medicare would have covered this accident.

Because the Defendant was permitted, over Plaintiff's objection, to prematurely appeal on the duty to mitigate issue before the issue was ripe, there is not a proper record below. From the limited record available, the Court of Appeals assumed that: "Canty was covered by an automobile insurance policy; however, he had "elect[ed] to not maintain coverage for [PIP] benefits payable under section 3107(1)(a)."[40] He was able to do so because he otherwise had "qualified health coverage," MCL 500.3107d(1), in the form of "parts A and B of the federal Medicare program," MCL 500.3107d(7)(b)(ii). The Court of Appeals noted that "[b]enefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the [PIP] benefits otherwise payable for the injury under this chapter." MCL 500.3109(1).[41]

The Court of Appeals remanded the matter to allow Mr. Canty to show why he opted for treatment outside the Medicare regime, but it is not entirely clear that this remand also allowed him to explain why Medicare is not the primary insurer in this situation and that the Michigan scheme in fact allows seniors to opt out of PIP

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[40] MCL 500.3107d(1).

[41] *Canty* at *3.

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coverage even though Medicare will never be the primary insurer under these circumstances. That Court's exact language was: "that, if necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages."[42]

42 U.S.C. § 1395y(b)(2)(A)(ii) ("MSP") states that Medicare is a secondary provider and that their duty is subordinate to any automobile negligence policy which might be responsible for costs related to the accident. 42 CFR 489.20(g) states that providers commit "[t]o bill other primary payers before Medicare").[43]

> "Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan."[44] Medicare has a

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[42] *Canty* at *16

[43] *See also Gregg v Providence St Joseph Health*, 519 F Supp 3d 693, 701 (ND Cal, 2021).

[44] Medicare Secondary Payer (MSP) Manual, Ch. 2, s. 40 -Liability Insurance (2023). As one federal judge explained the purpose of this manual:

> The Medicare Secondary Payer manual is a lengthy and comprehensive agency manual governing the complex workings of the Medicare Secondary Payer program and reflects the longstanding policy of the agency. While the majority opinion is correct when it

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> "statutory, direct right of recovery from liability insurance was well as any entity that has received payment directly or indirectly from the proceeds of liability insurance payments. Medicare's recovery rights take precedent over the claims of any other party, including Medicaid." *Id,* 40.1.

This statute was enacted in 1980 to reduce federal health care costs by transforming Medicare from the primary payer to the secondary payer, with a right of reimbursement.[45] The MSP "makes Medicare the secondary payer for medical services provided to Medicare beneficiaries whenever payment is available from another primary payer."[46] "This means that if payment for covered services

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> says that such policy statements and guidance interpretations are not entitled to the force of law, it ignores what is required of us in the way of deference to agency interpretations of the complex statutory and regulatory schemes they administer. Statements and guidance interpretations such as the Medicare Secondary Payer manual "reflect 'a body of experience and informed judgment to which courts and litigants may properly resort for guidance."

Bradley v Sebelius, 621 F3d 1330, 1341 (CA 11, 2010) (Martin, J. dissenting).

[45] *See United States v Baxter Intern, Inc*, 345 F3d 866, 874 (CA 11, 2003); *Bradley*, 621 F3d at 1335–37.

[46] *Cochran v US Health Care Fin Admin*, 291 F3d 775, 777 (CA 11, 2002).

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has been or is reasonably expected to be made by someone else, Medicare does not have to pay . . . ."[47]

Medicare is expressly precluded from making payment where payment "'has been made or can reasonably be expected to be made' under liability insurance including*** no-fault insurance."[48] Providers who accept Medicare, must generally bill the providers, physicians, and other suppliers "prior to the expiration of the promptly period rather than bill Medicare."[49]

Medicare was not a viable alternative and forcing the U.S. Government to assume Defendant's legal obligation of damages shifts financial responsibility to the taxpayers rather creating a method to mitigate damages. At the very least, this Court should modify the Court of Appeals opinion to allow the Plaintiff to present evidence concerning what Medicare will cover in this matter.

E. A Doctor Who Chooses to Treat a Patient Based on the Hopes that a Third Party Will Ultimately be Deemed Responsible for the Payment is Not Analogous to a First Party Claimant Where Prompt Payments are Guaranteed and Where Fault Does Not Need to be Determined.

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[47] *Id.; see* 42 USC 1395y(b)(2)(A)(i) (2006).See also 1 Guide to Medicare Secondary Payer Compliance § 1.01 (Matthew Bender, 2024).

[48] MSP Manual, Ch. 2, s. 40.2(A) – Difference Between Liability Insurance and Other Primary Plans.

[49] Id. s. 40.2(B) – Billing Options and Requirements Alternate Billing.

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A doctor who agrees to treat under these circumstances is not akin to a PIP treater. They are not assured prompt payment of a claim, the patient may not be able to directly afford to pay the doctor and even if they are, it might take years to become whole assuming the patient does not declare bankruptcy.

A physician who opts to treat a person based on the hope that they prevail against a third party is taking a much greater risk than collecting against a third party and thus is similar to the increase in hourly attorney fees in civil rights cases..[50] In litigation under 42 USC 1983, courts can increase attorney fees somewhat to compensate for the risk an attorney takes taking a case on a contingency basis.[51]

As the *Mitchell* Court recognized:[52]

> [In] Certain conditions, courts have recognized an upward or downward adjustment of attorney fees. *Id.* at 434; *Howard v Canteen Corp*, 192 Mich App 427, 439; 481 NW2d 718 (1991), Rafferty v Markovitz, 461 Mich 265; 602 NW2d 367 (1999). The burden of establishing the circumstances under which an enhancement is appropriate is on the fee applicant. Blum, supra at 898. Conclusory statements regarding the complexity of the

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[50] Cf Mitchell v Cole, 196 Mich App 675, 680; 493 NW2d 427 (1992).

[51] Id.

[52] *Mitchell*, 493 NW2d at 430.

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> case and significant results are not enough to justify enhancement. Id. The determination whether an enhancement is appropriate in each case is within the discretion of the trial court. *Pennsylvania v Delaware Valley Citizens' Council for Clean Air*, 483 US 711, 728; 107 S Ct 3078; 97 L Ed 2d 585 (1987). We have recently recognized that this discretion is limited and that an enhancement should be saved for those rare circumstances where an attorney's work is so superior and outstanding that it exceeds the client's expectations. Howard, supra at 439. In addition, where the enhancement is necessary to attract competent counsel, the court may apply a multiplier within reason. Id. at 439-440.

The Legislature may very well have considered this purpose when not applying the feel schedule contained in MCL 500.3107.

Moreover, choosing a doctor is an incredibly personal decision. The Plaintiff has the right to choose his medical provider based on his comfort with the provider, his belief in their medical abilities, and his experience in the relevant areas of medicine. A person's decisions regarding their physical treatment are deeply personal.[53] At the summary disposition hearing, Plaintiff presented

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[53] *See, e.g. Cruzan by Cruzan v Dir, Missouri Dept of Health*, 497 US 261, 287; 110 S Ct 2841; 111 L Ed 2d 224 (1990) (O'Connor, J. concurring).

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evidence that he attempted to be reimbursed by Medicare for these treatments and was denied.

F. *Like the Court of Appeals, this Court Should Decline to Address Defendant's Passing Comments About Potential Veteran's Benefits.*

It should be noted that while Defendant briefly mentioned that Plaintiff had access to Veteran's benefits, their question presented and their brief speaks about Medicare.[54] Issues are necessarily limited by their Statement of Questions Presented, and Plaintiff will confine himself to that point.[55] Should the Defendant make the needed correction to the point issue and advance this issue

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[54]Mason referenced the Veterans Administration only in passing to describe his pre-accident medical history, noting merely that he had previously received his medical care through a VA provider, (Appellee's Ans. to App, p. 4), and asserting that after the accident he chose neither Medicare nor the VA but instead sought treatment from well-known no-fault providers who accepted Medicare but did not bill it, (Appellee's Ans. to App, p. 4), while later reiterating that Canty "apparently treated with a Veterans Affairs provider" such as a local VA clinic before the crash, (Appellee's Ans. to App, p. 6), yet nowhere in its brief did the Appellee articulate, develop, or rely upon a Veterans Administration payor theory, nor did it analyze VA eligibility, VA billing rules, coordination with Medicare, or any statutory mechanism by which VA care could reduce tort damages, confirming that the VA was invoked only as factual background and not as a serious payor-defense argument, (Appellee's Ans. to App, p. 6).

[55] The scope of this appeal is limited to those issues that are set forth in defendant's statement of questions presented. *City of Lansing v Hartsuff*, 213 Mich App 338, 351; 539 NW2d 781 (1995); *Meagher v McNeely & Lincoln, Inc*, 212 Mich App 154, 156; 536 NW2d 851 (1995).

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which would give the Defendant further and difference relief before this Court, then this Court should ignore the same because it was never addressed by the Court of Appeals, there are no reasons for this Court to entertain such an issue for the first time on appeal to this Court, and it would require factual development.

The Veteran's Administration and the level of medical treatment it provides to veterans have been a sore spot in our nation's history.[56] As noted above, failure to mitigate damages is an affirmative defense which the Defendant must shoulder the burden. They have not offered any evidence suggest the unreasonableness of the Defendant's choices of doctors.

This Court should affirm the trial court's ruling and reverse the Court of Appeals ruling.

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[56]See, eg. A Continued Assessment of Delays In Va Medical Care And Preventable Veterans Deaths, COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED THIRTEENTH CONGRESS, SECOND SESSION, Serial No. 113-64, U.S. GOVERNMENT PUBLISHING OFFICE (Washington DC, 2015).

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II. THIRD-PARTY CLAIMS FOR MEDICAL TREATMENT EXPENSES ARE NOT SUBJECT TO THE LIMITATIONS OF MCL 500.3107, WHICH APPLIES ONLY TO FIRST PARTY PERSONAL PROTECTION INSURANCE BENEFITS; THE COURT OF APPEALS ERRED IN IMPOSING SUCH LIMITATIONS ON THIRD-PARTY CLAIMS.

Plaintiff's third-party claim for the allowable expenses of his medical treatment is not restricted by MCL 500.3107. That statute on its face is restricted to first party claims for "personal protection insurance benefits. The Court of Appeals erred in engrafting this limitation into third party claims. The doctors who choose to treat cases such as this one are not guaranteed prompt payment; they may not be paid at all. Even if they are ultimately paid, the payments are significantly more complicated to obtain. They must first bill the third-party driver's insurance. If that fails, they may be able to bill Medicare as a secondary provider. These files are far from routine and providers may ultimately decide that it "just isn't worth treating these individuals.

A. The Court of Appeals Erred in Engrafting the 1st Party Fee Schedule to 3rd Party Claims. The Legislature Did Not Specifically Adopt the Schedule and the Court of Appeals Erred Pulling it in from the Penumbra of the Statute.

While the Defendant and the Court of Appeals majority spent a great deal of time speaking about some undisputed canons of

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statutory construction they avoid the text of the statutes at issue and effectively make a policy based argument that this Court should treat the cardinal principle of the no-fault statute as not increasing the cost of health care, and then propose an activist construction of the statute to reach their policy based aim. They infer that this Court should second guess the Plaintiff's choice of doctor, treatment, and then engraft provisions on third party claims that were made expressly applicable to first party claims.

The first piece in the Defendant's convoluted road map is MCL 500.3135 which provides:

> (3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:
>
> (c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies. The party liable for damages is entitled to an exemption reducing his or her liability

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> by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

MCL 500.3135. Defendant theorizes that this Court should read this phrase to mean the same thing as the phrase allowable expenses under MCL 500.3107 which provides in relevant part:[57]

> Sec. 3107. (1) Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, *personal protection insurance benefits* are payable for the following:
>
> (a) Allowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses do not include either of the following:
>
> (*i*) Charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations, unless the injured person requires special or intensive care.
>
> (*ii*) Funeral and burial expenses in excess of the amount set forth in the policy, which must not be less than $1,750.00 or more than $5,000.00.

[57] MCL 500.3107.

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Defendant glazes over the express inclusion of the phrase "personal protection insurance benefits" contained in MCL 500.3107 and argues that notwithstanding this definitional limitation, the Court should apply this definition to third party claims. Strangely, the Defendant seems to invoke the plain meaning rule to reach this goal. Defendant's Answer to Application, p. 35.[58]

B. *The "Without Limits" Language in the Statute Needs to be Given Full Effect.*

In both issues, this Court is presented with the "without limits" issue mentioned in the statute and inadequately addressed by the Court of Appeals. Mr. Canty was allowed to seek "[d]amages for allowable expenses… …without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d…" through tort.[59]

As the Massachusetts Supreme Judicial Court has noted: "we understand the phrase 'without limitation' to mean the broadest reasonable definition of acts, without exception.[60] It also should be

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[58] In the original application for leave to appeal, the Plaintiff stated that the Defendant has misapplied the "absurd results" doctrine of statutory construction. Answer to Application, p. 35. Based on this, the Plaintiff has removed this argument from this brief.

[59] MCL 500.3135(3)(c)

[60] *Fed Nat Mortg Ass'n v Nunez*, 460 Mass 511, 519; 952 NE2d 923 (2011) (quoting *Pyle v Sch Comm of S Hadley*, 423 Mass 283, 285–286; 667

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noted that 2021 MI H.B. 5931 would have eliminated the without limitation language and failed to pass.

The Court of Appeals erred in divining into the statute an overarching purpose (viz. that the Legislature must have intended parity between tort claim medicals and PIP medicals) and then ignoring the Legislature words to carry out their supposed intent.

As Justice Zahara recently noted,[61] this Court has reaffirmed on multiple occasion that: "no intent may be imputed to the legislature in the enactment of a law other than such is supported by the face of the law itself. The courts may not speculate as to the probable intent of the legislature beyond the words employed in the act."[62]

C. *The Court of Appeals Should Have Applied Textualist Principles in Interpreting the Statute.*

NE2d 869 (1996) (without limitation "leaves no room to construe exceptions other than as listed in the statute")).

[61] *In re H.R. Request for Advisory Op. Regarding Constitutionality of 2018 PA 368 & 369,* 505 Mich. 884, 936 N.W.2d 241 (2019) (Zahra, J.)

[62] *Id. (Quoting City of Lansing v Lansing Tp*, 356 Mich 641, 649–650; 97 NW2d 804 (1959) (Not surprisingly, we have recognized that it is error to "focus[]on the history behind [a constitutional provision] and the intent of the constitutional convention delegates in proposing it, rather than on the interpretation that the people would have given the provision when they adopted it").

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Part of this rule includes the doctrine that "this Court must presume that every word, phrase, and clause in the statute has meaning and must avoid any construction that would render any part of the statute surplusage or nugatory." *People v Aguwa*, 245 Mich App 1, 3–4; 626 NW2d 176 (2001). If the Legislature intended this statute to apply to third party as well as first party expenses it would have said so. There is considerable difference between a tortfeasor and a first party insurer and this Court should presume that the Legislature's express limitation was intentional.

With legislation, "[i]f a statute specifically defines a term, the statutory definition is controlling." *People v Lewis*, 302 Mich App 338, 342; 839 NW2d 37 (2013). However, when "'terms are not expressly defined anywhere in the statute, they must be interpreted on the basis of their ordinary meaning and the context in which they are used.' "[63] It is well settled that a Michigan court cannot fill possible gaps in legislation.[64]

Congress or the Michigan Legislature is free to affix any definition it wishes to a particular statute, but that act does not transform it into a universal truth. For example, at one time

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[63] *Id.*, quoting *People v Zajaczkowski*, 493 Mich 6, 13; 825 NW2d 554 (2012).

[64] *Cnty. of Ingham v Michigan Cnty. Rd Comm Self-Ins Pool*, 508 Mich 461, 489; 975 NW2d 826 (2021) (Viviano, J.).

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Congress defined Lake Champlain to be a "Great Lake."[65] Senator Patrick J. Leahy, Democrat of Vermont, inserted this provision into a Bill to give Vermont and New York federal research money destined for the Great Lakes.[66] For purposes of that one Act, only Lake Champlain was briefly a Great Lake, but this did not make it a universal truth and amend other statutes by implication.

This Court should reject Defendant's skillful but misplaced wordsmithing.

D. The Limited Value of House Fiscal Analysis.

Defendant also relies on the House Fiscal Analysis at various points in its brief. Significantly, the Michigan Court of Appeals chose not to similarly rely on this analysis. Nonetheless, it is to remind this Court of the limitations of these histories.

While they can be considered, they are "generally unpersuasive tool[s] of statutory construction."[67] This is because legislative analyses are prepared by House and Senate staff members and do not necessarily represent the views of any individual legislator.[68] The problem with the Defendant's approach

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[65] https://www.nytimes.com/1998/03/07/us/champlain-becomes-the-sixth-great-lake.html

[66] *Id.*

[67] *Frank W Lynch & Co v Flex Techs., Inc*, 463 Mich 578, 587; 624 NW2d 180 (2001).

[68] *Id*. at 588 n. 7.

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is that it imputes a generalized intent to lower insurance rates to the Legislature and then treats this as a shopping list to import any doctrines it wishes.

E. Michigan's No-Fault Law Has Been Extensively Modified Over the Years. The Drafter's Decision Not to Include MCL 500.3157's Fee Schedule Must be Regarded as Purposive.

Michigan's no-fault statute has been subject to numerous amendments, yet the Legislature has never deleted the language limiting the definition at issue to first party suits. This Court should not do it for them. As Judge McKee of the Third Circuit noted in his concurrence: "it is not our job to rewrite what Congress has decreed unless a literal application of the statute would "lead to a patently absurd result that no rational legislature could have intended."[69] "The words chosen by Congress are a restraint upon the courts, and if we are not tethered by them in all but the most compelling of cases, then there is left no restraint effectively to corral the power of the courts from substituting their judgment of proper public policy for that of the legislature's."[70]

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[69] *People v McIntire*, 461 Mich 147, 153; 599 NW2d 102 (1999)

[70] *State of NY by Coughlin v Poe*, 835 F Supp 585, 589 (1993).

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The Court of Appeals majority's correctly found that MCL 500.3135(3)(c) incorporates the definition of the "allowable expenses" in MCL 500.3107(1)(a). Here, Mr. Canty's tort-damages claim for medical expenses comprises "reasonable charges incurred for reasonably necessary products, services and accommodations." Defying principles of textualism, the majority found that the fee schedule set forth in MCL 500.3157 applies to a tort-damages claim under MCL 500.3135(3)(c).

Plaintiff's tort-damages claim was proceeding under MCL 500.3135(3)(c), which preserves from abolition by the no-fault act third-party tort liability for certain damages—namely, as relevant here, "[d]amages for allowable expenses . . . as defined in sections 3107 to 3110[.]" The Legislature clearly identified the precise range of statutory provisions to define the scope of these available tort damages.

MCL 500.3157 is not in this list, nor does that provision itself say otherwise. While the Legislature could have expressly identified MCL 500.3157 to help define the scope of these damages, as it did with the other handful of statutory sections it designated for the task. The Legislature chose not to which must be deemed intentional. This principle is further supported by the doctrine of *expressio unius est exclusio alterius*. *Expressio unius* is a principle of statutory interpretation meaning "the expression of one thing is the

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exclusion of another."[71] Nothing could be clearer than a roadmap which adopted some provisions, but not others by analogy. The majority erred in rewriting MCL 500.3135(3)(c) to include it.

The majority grounds its conclusion otherwise on MCL 500.3107, which is one of the provisions expressly identified in MCL 500.3135(3)(c). Section 3107 contains a subsection specifically defining the term "allowable expenses." While it is true that when the Legislature said "[d]amages for allowable expenses . . . as defined in section[] 3107," it meant to adopt that specific definition to help delineate the scope of tort damages preserved via MCL 500.3135(3)(c).

This, however, does not mean that this statutory language is proof of an intent to apply MCL 500.3157 to those tort damages as well. The majority finds such intent in Section 3107's general prefatory language, which states, "Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, personal protection insurance benefits are payable for the following"—with the section then proceeding to provide specific definitions of various things, including allowable expenses. "[T]his chapter" is Chapter 31 of the Insurance Code, which spans all of MCL 500.3101 (West) through MCL 500.3179.

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[71] *Michigan Ambulatory Surgical Ctr v Farm Bureau Gen Ins Co of Michigan*, 334 Mich App 622, 632; 965 NW2d 650 (2020).

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The majority reasons that, because MCL 500.3157 is among "the exceptions and limitations in" Chapter 31, it is a part of what MCL 500.3135(3)(c) incorporated when referring to Section 3107—a conclusion that presumably would hold for any other potentially relevant "exceptions and limitations" in Chapter 31 as well.

In a third-party action, the question of what an allowable expense is a question of fact for the jury. This Court should reverse the Court of Appeals. Alternatively, this Court should grant full leave to appeal.

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RELIEF

WHEREFORE, Plaintiff-Appellee asks this Court to REVERSE the Court of Appeals and/or to grant full leave to appeal to hear this issue.

Respectfully submitted,

APPLEBAUM & STONE, PLC

BY: /s/ Erik J. Stone

ERIK J. STONE (P55304)
Attorney for Plaintiff-Appellant
26777 Central Park Blvd, Ste 300
Southfield, MI 48076
(248) 233-5050
Fax: (248) 359-8539
estone@applebaumstone.com

DATED: December 10, 2025

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CERTIFICATION

The attached Brief contains 8,173 words. The cover page, table of contents, statement of questions, table of authorities, this certification, request for oral arguments, and proof of service are excluded. This brief was produced using Microsoft Office 365 (2022 version).

Respectfully submitted,

APPLEBAUM & STONE, PLC

BY: /s/ Erik J. Stone

ERIK J. STONE (P55304)
Attorney for Plaintiff-Appellant
26777 Central Park Blvd, Ste 300
Southfield, MI 48076
(248) 233-5050
Fax: (248) 359-8539
estone@applebaumstone.com

DATED: December 10, 2025

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PROOF OF SERVICE

STATE OF MICHIGAN)
) SS.
COUNTY OF OAKLAND)

The undersigned declarant being first duly sworn, deposes and says that on December 10, 2025, (s)he did mail a copy of the attached PLAINTIFF-APPLICATION FOR LEAVE TO APPEAL, on all counsel of record via the Court's True Filing System.

Declaration in Lieu of Notarization. I declare that the foregoing is true and correct to the best of my information, knowledge, and belief.

Respectfully submitted,

/s/ Erik J. Stone

Declarant

DATED: December 10, 2025

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MOA App'x 1: MOA Order 09/17/2025

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Canty v. Mason

Supreme Court of Michigan

September 17, 2025, Decided

SC: 167772

Reporter
25 N.W.3d 131 *; 2025 Mich. LEXIS 1653 **; 2025 LX 419558; 2025 WL 2671263

JOSEPH CANTY, Plaintiff-Appellant, v MICHAEL CHESTER MASON, Defendant-Appellee.

Prior History: [**1] COA: 365327. Wayne CC: 21-004799-NI.

Canty v. Mason, 2024 Mich. App. LEXIS 7934, 2024 WL 4428146 (Mich. Ct. App., Oct. 4, 2024)

Judges: Megan K. Cavanagh, Chief Justice. Brian K. Zahra, Richard H. Bernstein, Elizabeth M. Welch, Kyra H. Bolden, Kimberly A. Thomas, Noah P. Hood, Justices.

Opinion

[*131] **Order**

On order of the Court, the application for leave to appeal the October 4, 2024 judgment of the Court of Appeals is considered. We direct the Clerk to schedule oral argument on the application. MCR 7.305(I)(1). The parties shall file supplemental briefs in accordance with MCR 7.312(E), addressing: (1) whether a plaintiff [*132] seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) has a duty to mitigate their damages by seeking payment from Medicare; and (2) whether the fee schedules in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c).

Amici who appeared at the application stage are invited to file supplemental briefs amicus curiae. The Insurance Alliance of Michigan, Michigan Defense Trial Counsel, Inc., and CPAN are invited to file briefs amicus curiae. Other persons or groups interested in the determination of the issues presented in this case who are not exempt from the motion requirement under MCR 7.312(H) may move the Court for permission to file briefs amicus curiae.

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MOA App'x 2: Court of Appeals Opinion 10/04/2024

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Canty v. Mason

Court of Appeals of Michigan

October 4, 2024, Decided

No. 365327

Reporter
2024 Mich. App. LEXIS 7934 *

JOSEPH CANTY, Plaintiff-Appellee, v MICHAEL CHESTER MASON, Defendant-Appellant.

Notice: THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE FINAL PUBLICATION IN THE MICHIGAN COURT OF APPEALS REPORTS.

Prior History: [*1] Wayne Circuit Court. LC No. 21-004799-NI.

Canty v. Mason, 2023 Mich. App. LEXIS 3121 (Mich. Ct. App., May 3, 2023)

Core Terms

expenses, coverage, mitigate, damages, fee schedule, benefits, medical expenses, limitations, summary disposition, tort damages, trial court, no-fault, providers, statutory provisions, prefatory, elected, insurance benefits, statutory language, tort action, insurance policy, incorporates, principles, provisions

Case Summary

Overview

HOLDINGS: [1]-Any damages recoverable by plaintiff under *MCL 500.3135(3)(c)* must constitute "allowable expenses" under *MCL 500.3107* to *MCL 500.3110*; [2]-The fee schedules in *MCL 500.3157* applied to his action; [3]-Common-law, mitigation-of-damages principles were also applicable; [4]-Under either *MCL 500.3109(1)* or common-law mitigation principles, defendant was entitled to a setoff for medical expenses that would have been covered by Medicare, and [5]-If necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages. With these guideposts in place, defendant was free to renew his motion for summary disposition should he be so inclined.

Outcome
Affirmed in part and reversed and remanded in part for further proceedings.

LexisNexis® Headnotes

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN1 **Personal Injury Protection, Medical Benefits**

MCL 500.3157 contains fee schedules that limit a medical provider's reimbursement amount.

Civil Procedure > Appeals > Standards of Review > De Novo Review

Governments > Legislation > Interpretation

Civil Procedure > ... > Summary Judgment > Appellate Review > Standards of Review

HN2 **Standards of Review, De Novo Review**

The court reviews de novo a trial court's ruling on a motion for summary disposition. This court also reviews de novo issues of statutory construction. De novo

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review means that the court reviews the issues independently, with no required deference to the trial court.

Civil Procedure > Judgments > Summary Judgment > Burdens of Proof

Civil Procedure > Judgments > Summary Judgment > Entitlement as Matter of Law

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

Civil Procedure > ... > Summary Judgment > Burdens of Proof > Nonmovant Persuasion & Proof

Civil Procedure > Judgments > Summary Judgment > Partial Summary Judgment

HN3 **Summary Judgment, Burdens of Proof**

In Anderson, this Court recited the principles that govern the analysis of a motion brought pursuant to MCR 2.116(C)(10): MCR 2.116(C)(10) provides that summary disposition is appropriate when, except as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law. A motion brought pursuant to MCR 2.116(C)(10) tests the factual support for a party's action. Affidavits, depositions, admissions, or other documentary evidence in support of the grounds asserted in the motion are required. when judgment is sought based on subrule (C)(10), MCR 2.116(G)(3)(b), and such evidence, along with the pleadings, must be considered by the court when ruling on the (C)(10) motion, MCR 2.116(G)(5). When a motion under subrule (C)(10) is made and supported., an adverse party may not rest upon the mere allegations or denials of his or her pleading, but must, by affidavits or as otherwise provided in this rule, set forth specific facts showing that there is a genuine issue for trial. MCR 2.116(G)(4).

Civil Procedure > ... > Summary Judgment > Supporting Materials > Affidavits

Civil Procedure > Judgments > Summary Judgment > Entitlement as Matter of Law

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

Civil Procedure > ... > Summary Judgment > Appellate Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

HN4 **Supporting Materials, Affidavits**

A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the pleadings, affidavits, and other documentary evidence, when viewed in a light most favorable to the nonmovant, show that there is no genuine issue with respect to any material fact. A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds might differ. The trial court is not permitted to assess credibility, weigh the evidence, or resolve factual disputes, and if material evidence conflicts, it is not appropriate to grant a motion for summary disposition under MCR 2.116(C)(10). Like the trial court's inquiry, when an appellate court reviews a motion for summary disposition, it makes all legitimate inferences in favor of the nonmoving party. Speculation is insufficient to create an issue of fact. A court may only consider substantively admissible evidence actually proffered by the parties when ruling on the motion.

Governments > Legislation > Interpretation

HN5 **Legislation, Interpretation**

With respect to the rules of statutory interpretation, this Court in observed: This Court's role in construing statutory language is to discern and ascertain the intent of the Legislature, which may reasonably be inferred from the words in the statute. The court must focus its analysis on the express language of the statute because it offers the most reliable evidence of legislative intent. When statutory language is clear and unambiguous, the court must apply the statute as written. A court is not permitted to read anything into an unambiguous statute that is not within the manifest intent of the Legislature. Furthermore, this Court may not rewrite the plain statutory language or substitute its own policy decisions

Canty MOA App'x, p.003a

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for those decisions already made by the Legislature. Judicial construction of a statute is only permitted when statutory language is ambiguous. A statute is ambiguous when an irreconcilable conflict exists between statutory provisions or when a statute is equally susceptible to more than one meaning. When faced with two alternative reasonable interpretations of a word in a statute, we should give effect to the interpretation that more faithfully advances the legislative purpose behind the statute.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN6 **Personal Injury Protection, Medical Benefits**

With respect to MCL 500.3135(3)(c), an injured person with standard personal protection insurance (PIP) coverage under a no-fault insurance policy and an injured person who elected not to maintain such coverage and instead had a qualified-health-coverage (QHC) plan can both recover damages in a traditional tort action for allowable expenses as defined in MCL 500.3107 to MCL 500.3110. A distinction between these two individuals is that the person carrying PIP coverage under a no-fault policy is limited to recovering only amounts in "excess of" certain statutory limitations on the payment of PIP benefits, but recovery of allowable expenses by a person who elected not to maintain PIP coverage is "without limit." MCL 500.3135(3)(c).

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN7 **No Fault Coverage, Personal Injury Protection**

The "without limit" language of MCL 500.3135(3)(c) cannot be construed to mean that there are no parameters whatsoever on the amount of recovery. Rather, the "without limit" phrase, when read in context, simply means that the recovery of allowable expenses does not solely encompass amounts in excess of the statutory limitations, as is the case with respect to a party pursuing a tort action after no more personal protection insurance (PIP) benefits are available under a no-fault policy because the statutory limitations on coverage were met or exhausted.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN8 **No Fault Coverage, Personal Injury Protection**

Under MCL 500.3107(1)(a), allowable expenses are defined as reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN9 **No Fault Coverage, Personal Injury Protection**

The introductory or prefatory language of MCL 500.3107(1) states that the provisions found within the statute, which includes the definition of allowable expenses, are subject to the exceptions and limitations in this chapter. And that chapter is Chapter 31 of the Insurance Code of 1956, MCL 500.100 et seq. Chapter 31 encompasses MCL 500.3157; therefore, MCL 500.3135(3)(c), by incorporating MCL 500.3107, necessarily also incorporates the fee schedules in MCL 500.3157.

Governments > Legislation > Interpretation

HN10 **Legislation, Interpretation**

The Legislature is presumed to be aware of and to have considered existing statutes when enacting new laws.

Governments > Legislation > Interpretation

HN11 **Legislation, Interpretation**

In construing statutory language, every word should be given meaning, and the court must avoid an interpretation that would render any part of a statute surplusage or nugatory.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN12 **No Fault Coverage, Personal Injury Protection**

Canty MOA App'x, p.004a

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The court recognizes that MCL 500.3107(1) limits the recovery of PIP benefits on the basis of any pertinent provisions in Chapter 31, but the prefatory language also necessarily places a limit on the calculation of recoverable allowable expenses. The recovery of personal protection insurance (PIP) benefits encompasses the recovery of compensation to pay for allowable expenses; the two are inextricably intertwined. If an expense is not an allowable expense, one cannot recover PIP benefits in relation to that expense. The court does not believe that there is a relevant distinction between PIP benefits and allowable expenses for purposes of employing Chapter 31 in relation to calculating damages under MCL 500.3135(3)(c).

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

Torts > Remedies > Damages > Reductions of Damages

HN13 **No Fault Coverage, Personal Injury Protection**

Mitigation of damages is a legal doctrine that seeks to minimize the economic harm arising from wrongdoing. It is incumbent on a person who has been harmed by the commission of a tort to use such means that are reasonable under the circumstances to minimize or mitigate the amount of damages. A person wronged by a tortfeasor is not entitled to recover for any item of damage that could have been avoided. This Court had held that because the no-fault act does not specifically abrogate the common-law principle that a plaintiff is obligated in a tort action to mitigate his or her damages, the defense remains viable. Moreover, and importantly, MCL 500.3135(3)(c) carves out an exception to the abolishment of tort liability arising from the ownership, maintenance, or use of a motor vehicle.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN14 **No Fault Coverage, Personal Injury Protection**

MCL 500.3135(3)(c) incorporates MCL 500.3109(1), which provides that benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from benefits otherwise payable for the injury under this chapter. In general, Medicare healthcare benefits constitute benefits provided under the laws of the federal government. See 42 U.S.C.S. § 1395 et seq.

Counsel: For JOSEPH CANTY, Plaintiff - Appellee: ERIK J. STONE.

For MICHAEL CHESTER MASON, Defendant - Appellant: ERIN J. RODENHOUSE; MICHAEL J. COOK.

Judges: Before: MARKEY, P.J., and SWARTZLE and MARIANI, JJ. MARIANI, J. (concurring in part and dissenting in part).

Opinion

PER CURIAM.

In 2019, the Michigan Legislature made sweeping changes to the no-fault act, MCL 500.3101 et seq., through the enactment of 2019 PA 21 and 2019 PA 22. This appeal requires us to construe the interplay between several statutory provisions that were subject to amendment. Plaintiff, Joseph Canty, seeks to recover medical expenses incurred to treat injuries allegedly sustained in a motor-vehicle accident involving defendant, Michael Chester Mason. In pursuing the action, Canty is relying on the tort exception found in MCL 500.3135(3)(c), allowing recovery of "allowable expenses" by persons who elect not to maintain personal protection insurance (PIP) coverage under their automobile insurance policies. Canty was permitted to make that election because he has Medicare coverage; however, it was not used to pay for any of his accident-related medical expenses. Mason moved for partial summary disposition under MCR 2.116(C)(10), arguing that Canty's medical **[*2]** expenses had to be reasonable under MCL 500.3107(1)(a), that Canty had a duty to mitigate his damages by employing his Medicare coverage to pay the medical bills, and that the no-fault fee schedules in MCL 500.3157 apply to a suit brought under MCL 500.3135(3)(c). The trial court granted in part and denied in part Mason's motion for summary disposition. The court concluded that Canty's allowable medical expenses had to be reasonable, that he had no duty to mitigate damages by using his Medicare coverage, and that the fee schedules were inapplicable. Mason appeals by leave granted. We affirm in part and reverse in part.

I. BACKGROUND

Canty MOA App'x, p.005a

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This case arose out of an automobile accident that occurred in February 2021. Canty filed a complaint against Mason, alleging that Mason negligently caused the accident by, in part, traveling too fast for conditions and failing to maintain proper distance, which resulted in Mason's vehicle skidding and rear-ending Canty's car. Canty alleged that he sustained physical injuries in the accident and, as a result, incurred medical expenses for treatment rendered by healthcare providers. Canty asserted that he had a statutory right to recover those expenses from Mason under MCL 500.3135(3)(c), which provides, in pertinent part: **[*3]**

> (3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:
> * * *
>
> (c) Damages for allowable expenses, work loss, and survivor's loss *as defined in* sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, *or without limit for allowable expenses if an election to not maintain that coverage was made under* section 3107d or if an exclusion under section 3109a(2) applies. . . . [Emphasis added.[1]]

Canty was covered by an automobile insurance policy; however, he had "elect[ed] to not maintain coverage for [PIP] benefits payable under section 3107(1)(a)." MCL 500.3107d(1).[2] He was able to do so because he otherwise had "qualified health coverage," MCL 500.3107d(1), in the form of "parts A and B of the federal Medicare program," MCL 500.3107d(7)(b)(ii). We note that "[b]enefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the [PIP] benefits otherwise payable for the injury under this chapter." MCL 500.3109(1). **HN1** Additionally, relevant to this case and appeal, **[*4]** MCL 500.3157 contains fee schedules that limit a medical provider's reimbursement amount.

Subsequently, Mason moved for partial summary disposition under MCR 2.116(C)(10). He argued that the "without limit" nomenclature used in MCL 500.3135(3)(c) does not mean that there are no limits on Canty's recovery of allowable expenses.[3] Rather, the medical charges had to be reasonable and incurred for reasonably necessary services so as to be in compliance with the definition of "allowable expenses" in MCL 500.3107(1)(a), which provision is incorporated by express reference in MCL 500.3135(3)(c). Further, Mason contended that Canty and his healthcare providers had a duty to mitigate damages by utilizing Canty's Medicare coverage, which was not done. Mason maintained that Canty treated with many providers who accepted Medicare, yet Medicare was not billed for the services, nor were Medicare rates charged for the care and treatment. Mason asked the trial court to dismiss all claims for which Canty did not attempt to bill Medicare. He additionally argued that any recovery of allowable expenses is subject to the fee schedules in MCL 500.3157. In response, on the issue of mitigation, Canty argued that MCL 500.3135(3)(c) did not restrict his choice of medical providers, nor did it require him to submit claims **[*5]** to Medicare for purposes of his cause of action. Moreover, according to Canty, MCL 500.3135(3)(c) allows recovery "without limit" and does not reference or otherwise incorporate MCL 500.3157, thereby excluding application of the fee schedules.

Eventually, at a hearing to settle an order regarding a ruling made by the trial court from the bench on Mason's motion for summary disposition, the court entertained further argument on the motion and partially altered its prior ruling, which we need not explore. The trial court now ruled that Canty had no duty to mitigate damages or expenses "because Medicare and Medicaid are exempt from the no fault statute." The court further determined that Canty had to show that the charges by his medical providers were reasonable and necessary under MCL 500.3107(1)(a)'s definition of "allowable

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[1] We note that Canty also alleged a claim for noneconomic damages, asserting that he suffered a serious impairment of body function as a result of the accident. See MCL 500.3135(1) and (5).

[2] MCL 500.3107(1)(a) provides that PIP benefits are payable for, in part, "[a]llowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."

[3] Mason posited that the phrase "without limit" in MCL 500.3135(3)(c) simply references the fact that there is no PIP coverage limit to exhaust before seeking damages from a tortfeasor, and not that an injured party is entitled to unlimited expenses from the tortfeasor.

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expenses." Thus, the charges and expenses were not without some limit. But the trial court also found that the fee schedules in MCL 500.3157 do not apply to Canty's action brought under MCL 500.3135(3)(c). The court entered an order granting in part and denying in part Mason's motion for summary disposition. Mason appeals by leave granted. *Canty v Mason*, unpublished order of the Court of Appeals, entered August 28, 2023 (Docket No. 365327, 2023 Mich. App. LEXIS 6164). **[*6]**

II. ANALYSIS

A. STANDARD OF REVIEW

HN2 We review de novo a trial court's ruling on a motion for summary disposition. Champine v Dep't of Transp, 509 Mich 447, 452; 983 NW2d 741 (2022). This Court also reviews de novo issues of statutory construction. Estes v Titus, 481 Mich 573, 578-579; 751 NW2d 493 (2008). De novo review "means that we review the issues independently, with no required deference to the trial court." People v Beck, 504 Mich 605, 618; 939 NW2d 213 (2019).

B. SUMMARY DISPOSITION PRINCIPLES — MCR 2.116(C)(10)

HN3 In Anderson v Transdev Servs, Inc, 341 Mich App 501, 506-507; 991 NW2d 230 (2022), this Court recited the principles that govern the analysis of a motion brought pursuant to MCR 2.116(C)(10):

> MCR 2.116(C)(10) provides that summary disposition is appropriate when, "[e]xcept as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law." A motion brought pursuant to MCR 2.116(C)(10) tests the factual support for a party's action. "Affidavits, depositions, admissions, or other documentary evidence in support of the grounds asserted in the motion are required . . . when judgment is sought based on subrule (C)(10)," MCR 2.116(G)(3)(b), and such evidence, along with the pleadings, must be considered by the court when ruling on the (C)(10) motion, MCR 2.116(G)(5). "When a motion under subrule (C)(10) is made and supported . . ., an adverse party may not rest upon the mere allegations or denials of his or her pleading, but must, by affidavits or as otherwise **[*7]** provided in this rule, set forth specific facts showing that there is a genuine issue for trial." MCR 2.116(G)(4).
>
> ***HN4*** A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the pleadings, affidavits, and other documentary evidence, when viewed in a light most favorable to the nonmovant, show that there is no genuine issue with respect to any material fact. A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds might differ. The trial court is not permitted to assess credibility, weigh the evidence, or resolve factual disputes, and if material evidence conflicts, it is not appropriate to grant a motion for summary disposition under MCR 2.116(C)(10). Like the trial court's inquiry, when an appellate court reviews a motion for summary disposition, it makes all legitimate inferences in favor of the nonmoving party. Speculation is insufficient to create an issue of fact. A court may only consider substantively admissible evidence actually proffered by the parties when ruling on the motion. [Quotation marks, citations, and brackets omitted.]

C. RULES OF STATUTORY CONSTRUCTION

HN5 With respect to the rules **[*8]** of statutory interpretation, this Court in Slis v Michigan, 332 Mich App 312, 335-336; 956 NW2d 569 (2020), observed:

> This Court's role in construing statutory language is to discern and ascertain the intent of the Legislature, which may reasonably be inferred from the words in the statute. We must focus our analysis on the express language of the statute because it offers the most reliable evidence of legislative intent. When statutory language is clear and unambiguous, we must apply the statute as written. A court is not permitted to read anything into an unambiguous statute that is not within the manifest intent of the Legislature. Furthermore, this Court may not rewrite the plain statutory language or substitute its own policy decisions for those decisions already made by the Legislature.
>
> Judicial construction of a statute is only permitted when statutory language is ambiguous. A statute is ambiguous when an irreconcilable conflict exists between statutory provisions or when a statute is equally susceptible to more than one meaning. When faced with two alternative reasonable interpretations of a word in a statute, we should give effect to the interpretation that more faithfully advances the legislative purpose behind the statute. [Quotation **[*9]** marks and citations

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omitted.]

D. DISCUSSION AND RESOLUTION

Abiding by the plain and unambiguous language of the various statutory provisions implicated in this case and the uncontroverted caselaw on mitigation of damages, we conclude that resolution of this appeal is fairly straightforward. ***HN6*** With respect to MCL 500.3135(3)(c), an injured person with standard PIP coverage under a no-fault insurance policy *and* an injured person who elected not to maintain such coverage and instead had a qualified-health-coverage (QHC) plan can both recover damages in a traditional tort action for "allowable expenses" as defined in MCL 500.3107 to MCL 500.3110. A distinction between these two individuals is that the person carrying PIP coverage under a no-fault policy is limited to recovering only amounts in "excess of" certain statutory limitations on the payment of PIP benefits, but recovery of allowable expenses by a person who elected not to maintain PIP coverage is "without limit." MCL 500.3135(3)(c). ***HN7*** We conclude that the "without limit" language of MCL 500.3135(3)(c) cannot be construed to mean that there are no parameters whatsoever on the amount of recovery. Rather, the "without limit" phrase, when read in context, simply means that the recovery of allowable expenses does **[*10]** not solely encompass amounts in excess of the statutory limitations, as is the case with respect to a party pursuing a tort action after no more PIP benefits are available under a no-fault policy because the statutory limitations on coverage were met or exhausted. In other words, a person in Canty's shoes who elected not to have PIP coverage through an auto insurance policy can recover *dollar one* in allowable expenses from the tortfeasor.[4] The "without limit" terminology in MCL 500.3135(3)(c) cannot be viewed in a vacuum, and the grammatical structure of Subsection (3)(c) supports our interpretation of the provision.

Furthermore, under MCL 500.3135(3)(c), the "allowable expenses" available to Canty, if successful in his tort action, are those defined in MCL 500.3107 to MCL 500.3110. ***HN8*** And, as noted earlier, under MCL 500.3107(1)(a), "allowable expenses" are defined as "reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."[5] We therefore conclude that the trial court properly ruled that MCL 500.3107(1)(a) limits any recovery by Canty under MCL 500.3135(3)(c) to those expenses that were reasonable and that were for reasonably necessary services.[6]

The next issue posed in this case is whether the fee schedules in MCL 500.3157 apply to a tort **[*11]** action under MCL 500.3135(3)(c). MCL 500.3135(3)(c), while referencing and incorporating MCL 500.3107 to MCL 500.3110, makes no express mention of MCL 500.3157. ***HN9*** But the introductory or prefatory language of MCL 500.3107(1) states that the provisions found within the statute, which includes the definition of "allowable expenses," are "[s]ubject to the exceptions and limitations in this chapter[.]" And that chapter is Chapter 31 of the Insurance Code of 1956, MCL 500.100 et seq. Chapter 31 encompasses MCL 500.3157; therefore, MCL 500.3135(3)(c), by incorporating MCL 500.3107, necessarily also incorporates the fee schedules in MCL 500.3157, making them applicable to this case. Accordingly, the trial court erred by ruling that the fee schedules cannot be applied to limit Canty's recovery.

Our concurring-dissenting colleague disagrees with our analysis and resolution of the issue concerning the fee schedules in MCL 500.3157. He argues that the Legislature did not expressly identify MCL 500.3157 in the language of the tort-damages provision, MCL 500.3135(3)(c); therefore, we should not construe MCL 500.3135(3)(c) as if the Legislature had done so. We respectfully disagree. ***HN10*** The Legislature is presumed to be aware of and to have considered existing statutes when enacting new laws. See Milne v Robinson, 513 Mich 1, 18; 6 NW3d 40 (2024). We must thus assume that when the Legislature crafted MCL 500.3135(3)(c), which expressly references MCL 500.3107, it knew quite well that MCL 500.3107 placed restrictions on the amount of recoverable allowable expenses **[*12]** through limitations and exceptions found in Chapter 31, including the fee schedules.

---

[4] This proposition is subject to our holding regarding the duty to mitigate damages.

[5] Our Supreme Court has "recognized that the plain language of this provision imposes four requirements that a . . . claimant must prove before recovering benefits for allowable expenses: (1) the expense must be for an injured person's care, recovery, or rehabilitation, (2) the expense must be reasonably necessary, (3) the expense must be incurred, and (4) the charge must be reasonable." Douglas v Allstate Ins Co, 492 Mich 241, 259; 821 NW2d 472 (2012).

[6] There are additional qualifiers, criteria, and exceptions in MCL 500.3107 to MCL 500.3110 for purposes of identifying allowable expenses that are recoverable under MCL 500.3135(3)(c).

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Effectively, the Legislature did indeed identify MCL 500.3157 as a statutory provision that is to be considered for purposes of setting tort damages under MCL 500.3135(3)(c).

The concurrence/dissent asserts that our interpretation disregards the legislatively-chosen range specifically targeted in MCL 500.3135(3)(c), i.e., MCL 500.3107 to MCL 500.3110, improperly expanding the range to incorporate all of Chapter 31, which the Legislature could have stated outright in MCL 500.3135(3)(c) had that been its intent. We again disagree. First, for the reasons discussed above, we conclude that if MCL 500.3157 is not taken into consideration, the plain and unambiguous language of MCL 500.3107(1) referencing Chapter 31, as incorporated by MCL 500.3135(3)(c), is not being honored and is, instead, rendered surplusage and nugatory. See Empire Iron Mining Partnership v Tilden Twp, 337 Mich App 579, 586; 977 NW2d 128 (2021) **HN11** (in construing statutory language, every word should be given meaning, and we must avoid an interpretation that would render any part of a statute surplusage or nugatory). Moreover, folding Chapter 31 into the definition of "allowable expenses" does not implicate each and every provision in Chapter 31, but only those few that would restrict or limit the amount of allowable expenses, such as MCL 500.3157.

The concurrence/dissent **[*13]** also contends that the prefatory language of MCL 500.3107(1) that references Chapter 31 pertains to the availability of insurance or PIP benefits, while MCL 500.3135(3)(c) concerns the availability of tort damages. Therefore, the prefatory language is inapplicable in relation to MCL 500.3135(3)(c). But the same can be said with respect to the definition of "allowable expenses" in MCL 500.3107(1)(a): it regards the availability of insurance or PIP benefits, yet there is no dispute, and the concurrence/dissent agrees, that it also sets the parameters of tort damages available under MCL 500.3135(3)(c).[7]

The final question concerns mitigation of damages, which requires us to also consider the impact of the setoff language in MCL 500.3109(1). **HN13** "Mitigation of damages is a legal doctrine that seeks to minimize the economic harm arising from wrongdoing." Morris v Clawson Tank Co, 459 Mich 256, 263; 587 NW2d 253 (1998). It is incumbent on a person who has been harmed by the commission of a tort to use such means that are reasonable under the circumstances to minimize or mitigate the amount of damages. *Id.* A person wronged by a tortfeasor is not entitled to recover for any item of damage that could have been avoided. Id. at 263-264.

This Court had held that because the no-fault act does not specifically abrogate the common-law principle that **[*14]** a plaintiff is obligated in a tort action to mitigate his or her damages, the defense remains viable. Lee v Detroit Med Ctr, 285 Mich App 51, 67; 775 NW2d 326 (2009); Bak v Citizens Ins Co of America, 199 Mich App 730, 737-738; 503 NW2d 94 (1993).[8] Moreover, and importantly, MCL 500.3135(3)(c) carves out an exception to the abolishment of tort liability arising from the ownership, maintenance, or use of a motor vehicle. Consequently, Canty's lawsuit *is a true tort action*. Thus, the doctrine of mitigation of damages is applicable.

We reject the trial court's finding or suggestion that Medicare benefits cannot be taken into consideration on the issue of mitigation of damages because such benefits were not available to cover Canty's medical expenses given that the case arises out of the no-fault act and Medicare is exempt from the act. In John Hancock Prop & Cas Ins Cos v Blue Cross & Blue Shield of Mich, 437 Mich 368, 373; 471 NW2d 541 (1991), the Michigan Supreme Court, citing 42 USC 1395y(b)(2)(A) (Medicare secondary payer), which is part of the Omnibus Reconciliation Act of 1980, stated:

> A federal statute provides that Medicare benefits are not payable where the medical expense is covered under an automobile insurance policy or plan or under no-fault insurance. The federal statute thus allocates to automobile insurers the primary burden of paying the medical expense,

---

[7] **HN12** We recognize that MCL 500.3107(1) limits the recovery of *PIP benefits* on the basis of any pertinent provisions in Chapter 31, but the prefatory language also necessarily places a limit on the calculation of recoverable *allowable expenses*. The recovery of PIP benefits encompasses the recovery of compensation to pay for allowable expenses; the two are inextricably intertwined. If an expense is not an allowable expense, one cannot recover PIP benefits in relation to that expense. We do not believe that there is a relevant distinction between PIP benefits and allowable expenses for purposes of employing Chapter 31 in relation to calculating damages under MCL 500.3135(3)(c).

[8] The Supreme Court in Marquis v Hartford Accident & Indemnity, 444 Mich 638, 651; 513 NW2d 799 (1994), voiced its approval of the Bak decision on the mitigation-of-damages issue in the context of the no-fault act.

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arising out of automobile accidents, of persons covered by the Medicare program.

In this case, Canty did not have PIP coverage for allowable **[*15]** medical expenses through an automobile insurance policy or no-fault insurance plan because he had healthcare coverage under parts A and B of Medicare, as expressly permitted by the Legislature under MCL 500.3107d(1) and (7)(b)(ii). The trial court's ruling circumvents the legislative goal of allowing motorists to opt out of PIP coverage where they have QHC through Medicare, leaving the motorist without any medical coverage for injuries sustained in a motor-vehicle accident. Accordingly, federal law did not prohibit Canty from receiving Medicare benefits for medical expenses incurred as a result of the accident.

HN14 Furthermore, MCL 500.3135(3)(c) incorporates MCL 500.3109(1), which, as quoted earlier, provides that "[b]enefits provided *or required to be provided* under the laws of any state *or the federal government* shall be subtracted from . . . benefits otherwise payable for the injury under this chapter." (Emphasis added.) In general, Medicare healthcare benefits constitute benefits provided under the laws of the federal government. See 42 USC 1395 et seq. And Canty has Medicare coverage. Apparently, no Medicare benefits have been provided to or on behalf of Canty in relation to medical expenses incurred as a result of the accident. Therefore, the question becomes **[*16]** whether Medicare benefits would have been *required to be provided* to him or his providers had any of the pertinent medical bills been submitted to Medicare for payment. And to that extent, Mason is entitled to a setoff under MCL 500.3109(1) for purposes of any damage calculation on a finding of liability. We would also reach that same conclusion solely under common-law mitigation principles because the failure to seek payment from Medicare would not have been reasonable as a matter of law if the medical provider accepted Medicare.[9]

III. CONCLUSION

We conclude (1) that any damages recoverable by Canty under MCL 500.3135(3)(c) must constitute "allowable expenses" under MCL 500.3107 to MCL 500.3110, (2) that the fee schedules in MCL 500.3157 apply to Canty's action, (3) that common-law, mitigation-of-damages principles are also applicable, (4) that under either MCL 500.3109(1) or common-law mitigation principles, Mason is entitled to a setoff for medical expenses that would have been covered by Medicare, and (5) that, if necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages. With these guideposts in place, Mason is free to renew his motion **[*17]** for summary disposition should he be so inclined.

We affirm in part and reverse and remand in part for further proceedings consistent with this opinion. We do not retain jurisdiction. We decline to tax costs under MCR 7.219.

/s/ Jane E. Markey

/s/ Brock A. Swartzle

Concur by: Philip P. Mariani (In Part)

Dissent by: Philip P. Mariani (In Part)

Dissent

MARIANI, J. (*concurring in part and dissenting in part*).

I agree with the majority's conclusions that (1) per MCL 500.3135(3)(c)'s incorporation of the "allowable expenses" definition in MCL 500.3107(1)(a), Canty's tort-damages claim for medical expenses comprises "reasonable charges incurred for reasonably necessary products, services and accommodations"; and (2) the trial court erred by concluding that no duty to mitigate applies his claim. I respectfully disagree, however, with the majority's conclusion that the fee schedule set forth in MCL 500.3157 applies to a tort-damages claim under MCL 500.3135(3)(c).

As the majority aptly explains, Canty's tort-damages claim is proceeding under MCL 500.3135(3)(c), which preserves from abolition by the no-fault act third-party tort liability for certain damages—namely, as relevant here, "[d]amages for allowable expenses . . . as defined in sections 3107 to 3110[.]" The Legislature thus expressly identified a discrete range of statutory

[9] We wish to make clear that if Canty received pertinent medical services and treatment from a provider who did not accept Medicare, those expenses might still be recoverable. In that situation, the issue to be resolved by the trier of fact in relation to mitigation would concern whether it was reasonable under all of the surrounding circumstances for Canty to see a provider who did not accept Medicare.

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provisions **[*18]** to define the scope of these available tort damages; MCL 500.3157 is not within it, nor does that provision itself say otherwise. Of course, the Legislature could have expressly identified MCL 500.3157 to help define the scope of these damages, as it did with the other handful of statutory sections it designated for the task. The Legislature chose not to, however, and I do not believe MCL 500.3135(3)(c) should be read as if it had.

The majority grounds its conclusion otherwise on MCL 500.3107, which is one of the provisions expressly identified in MCL 500.3135(3)(c). Section 3107 contains a subsection specifically defining the term "allowable expenses," and I certainly agree that, when the Legislature said "[d]amages for allowable expenses . . . as defined in section[] 3107," it meant to adopt that specific definition to help delineate the scope of tort damages preserved via MCL 500.3135(3)(c). But I do not see in the statutory language an intent to apply MCL 500.3157 to those tort damages as well. The majority finds such intent in Section 3107's general prefatory language, which states, "Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, personal protection insurance benefits are payable for the following"—with the section then proceeding to provide specific definitions of various things, **[*19]** including allowable expenses. "[T]his chapter" is Chapter 31 of the Insurance Code, which spans all of MCL 500.3101 through MCL 500.3179. The majority reasons that, because MCL 500.3157 is among "the exceptions and limitations in" Chapter 31, it is a part of what MCL 500.3135(3)(c) incorporated when referring to Section 3107—a conclusion that presumably would hold for any other potentially relevant "exceptions and limitations" in Chapter 31 as well.

I struggle to square this reading with Section 3135(3)(c)'s plain language. As noted, the Legislature, in Section 3135(3)(c), expressly chose to designate a narrow and specific range of statutory provisions within Chapter 31—Sections 3107 to 3110—to define the scope of available tort damages. The majority's interpretation of Section 3107, however, effectively reads that designated range out of the statute. Rather than being defined by the specific sections of Chapter 31 that the Legislature expressly identified, tort damages under MCL 500.3135(3)(c) are instead defined—and limited—by every potentially applicable provision in Chapter 31. That reading strikes me as at odds with MCL 500.3135(3)(c)'s plain language, and leaves the Legislature's specifically chosen range of provisions without due meaning or effect.

Nor, in my view, do MCL 500.3107's own plain terms require that reading. Instead, I read "[s]ubject to the exceptions **[*20]** and limitations in this chapter" not to define allowable expenses per se—and thus be a part of what MCL 500.3135(3)(c) means when it speaks of those expenses "as defined by section[] 3107"—but instead to attach to and modify the language that immediately follows it: "personal protection insurance benefits are payable for the following." In other words, Section 3107's prefatory language, by its own terms, helps define what insurance benefits are payable, making clear that the payability of those benefits is subject to the exceptions and limitations of the rest of Chapter 31.[1] MCL 500.3135(3)(c), however, pertains not to the payability of insurance benefits, but to liability for tort damages—a distinction that is at the core of MCL 500.3135(3)(c), and that places that subsection to the side of what MCL 500.3107's prefatory language is addressing. In my view, MCL 500.3107's prefatory language certainly has meaning—just, by its plain terms, for something distinct (the payability of insurance benefits) from what MCL 500.3135(3)(c) specifically addresses and defines (available tort damages).

Correspondingly, in MCL 500.3135(3)(c), the Legislature did not simply say that the tort damages available for allowable expenses are "as defined in this chapter," or are the same as what are payable for insurance benefits under Chapter 31, **[*21]** or something to that effect. Instead, it was much more targeted and precise, carving out from Chapter 31 a discrete and expressly circumscribed range of provisions to mark the bounds of allowable expenses that can be pursued as tort damages. MCL 500.3157 is not among those legislatively chosen provisions, and I would not read it into them.[2]

---

[1] And this makes good sense, given that the payability of benefits is what Chapter 31 largely deals with—including MCL 500.3157, which speaks in terms of payment for treatment of injuries "covered by personal protection insurance."

[2] Furthermore, that the scope of available tort damages may, as a result, be different than the scope of payable insurance benefits does not strike me as interpretively odd or concerning, given the fundamental difference in character between tort damages and insurance benefits (and with it, the different policy judgments that the Legislature may have brought to bear on them—that, for instance, it could strike the right cost-savings balance by imposing a fee schedule on the benefits that can be recovered via first-party claims but not on the tort damages that can be pursued via third-party lawsuits).

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In sum, I would conclude that MCL 500.3135(3)(c) does not incorporate MCL 500.3157's fee schedule into its defined scope of available tort damages, as that reading, in my view, best reflects and effectuates the plain terms of the relevant statutory provisions. Accordingly, I respectfully dissent from the majority in that regard.

/s/ Philip P. Mariani

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MOA App'x 3: Order Re: Summary Disposition Motion, 02/23/2023

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APPLEBAUM & STONE, PLC
26777 Central Park Blvd, Suite 300
Southfield, MI 48076
(248) 233-5050

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH CANTY,

Plaintiff,

Case No. 21-004799-NI
Honorable Kathleen M. Mccarthy

v.

MICHAEL MASON,

Defendant.
_____/

Erik J. Stone (P55304)
Eric M. Noga (P83611)
APPLEBAUM & STONE, PLC
Attorneys for Plaintiff
26777 Central Park Boulevard, Ste 300
Southfield, Michigan 48076
(248) 233-5050 / FAX: (248) 359-8550
estone@applebaumstone.com
enoga@applebaumstone.com

Angela Esseily (P81816)
KRAMER CORBETT HARDING & DOMBROWSKI
Attorney for Defendant
PO Box 8084
Royal Oak, Michigan 48068-8084
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com

_____/

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S MOTION FOR PARTIAL SUMMARY DISPOSITION

At a session of court held in the courthouse
in Detroit, Michigan, on 2/23/2023
Present: Honorable Kathleen M. Mccarthy
Circuit Court Judge

This matter having come before the Court on Motion of the Plaintiff, oral arguments being heard and the Court being otherwise fully advised in the premises;

IT IS HEREBY ORDERED that the Defendant's Motion is GRANTED IN PART and DENIED IN PART for the reasons stated on the record;

IT IS FURTHER ORDERED Plaintiff may claim all allowable expenses through this third party suit;

IT IS FURTHER ORDERED The Personal Injury Protection fee schedule does not apply to this third-party auto negligence cause of action.

IT IS FURTHER ORDERED Allowable expense claims are limited to "…reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.", as under MCL 500.3107(1)(a).

IT IS SO ORDERED

THIS IS NOT A FINAL ORDER AND DOES NOT CLOSE THE CASE.

Date: 2/23/2023

/s/ Kathleen M. McCarthy 2/23/2023
HON. KATHLEEN M. MCCARTHY

Approved as to form; notice of entry waived:

APPLEBAUM & STONE, PLC

/s/ Eric M. Noga
ERIK J. STONE (P55304)
ERIC M. NOGA (P83611)
Attorney for Plaintiff
26777 Central Park Blvd, Ste 300
Southfield, MI 48076
(248) 233-5050 / Fax: (248) 359-8539
estone@applebaumstone.com
enoga@applebaumstone.com
Dated: February 23, 2022

KRAMER CORBETT HARDING & DOMBROWSKI

/s/ Angela Esseily
ANGELA ESSEILY (P81816)
Attorney for Defendant
PO Box 8084
Royal Oak, Michigan 48068-8084
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com

APPLEBAUM & STONE, PLC
26777 Central Park Blvd, Suite 300
Southfield, MI 48076
(248) 233-5050

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MOA App'x 4: Circuit Court Register of Actions

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REGISTER OF ACTIONS

CASE NO. 21-004799-NI

PARTY INFORMATION

		Attorneys
Defendant	**Mason, Michael Chester**	**Angela Esseily** *Retained* (313) 237-5636(W)
Plaintiff	**Canty, Joseph William**	**Erik J. Stone** *Retained* (248) 233-5050(W)

EVENTS & ORDERS OF THE COURT

OTHER EVENTS AND HEARINGS

04/15/2021 **Complaint, Filed**
04/15/2021 **Service Review Scheduled**
04/15/2021 **Status Conference Scheduled**
04/15/2021 ~~Case Filing Fee - Paid~~
05/11/2021 ~~Service of Complaint, filed~~
05/11/2021 ~~Proof of Service, Filed~~
05/25/2021 ~~Proof of Service, Filed~~
05/25/2021 ~~Jury Demand Filed & Fee Paid~~
05/25/2021 ~~Answer to Complaint, Filed~~
06/14/2021 ~~Answer to Affirmative Defenses, Filed~~
06/14/2021 ~~Reliance on Jury Demand, Filed~~
06/14/2021 ~~Proof of Service, Filed~~
07/15/2021 **Status Conference** (8:00 AM) (Judicial Officer Popke, Lita Masini)
Result: Reviewed by Court
07/15/2021 ~~Status Conference Scheduling Order, Signed and Filed~~
07/16/2021 ~~Proof of Service, Filed~~
07/16/2021 ~~Proof of Service, Filed~~
08/23/2021 **Case Reassigned**
09/20/2021 ~~Proof of Service, Filed~~
09/20/2021 ~~Proof of Service, Filed~~
09/20/2021 ~~Miscellaneous Pleadings, Filed~~
09/20/2021 ~~Miscellaneous Pleadings, Filed~~
09/20/2021 ~~Proof of Service, Filed~~
09/20/2021 ~~Proof of Service, Filed~~
09/20/2021 ~~Notice of Taking Deposition, Filed~~
09/20/2021 ~~Witness List, Filed~~
11/11/2021 ~~Proof of Service, Filed~~
11/15/2021 ~~Order Adjourning Mediation and Settlement Conference, S/F~~
11/15/2021 ~~Notice of Taking Deposition, Filed~~
11/15/2021 ~~Proof of Service, Filed~~
11/16/2021 ~~Proof of Service, Filed~~
11/16/2021 ~~Notice of Taking Deposition, Filed~~
12/09/2021 ~~Witness List, Filed~~
12/09/2021 ~~Proof of Service, Filed~~
12/20/2021 ~~Proof of Service, Filed~~
12/20/2021 ~~Witness List, Filed~~
01/25/2022 ~~Notice of Taking Deposition, Filed~~
01/25/2022 ~~Proof of Service, Filed~~
04/20/2022 **Case Evaluation - General Civil**
05/18/2022 **Case Evaluation - No Acceptance**
06/06/2022 **Settlement Conference** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.)
~~Parties Present~~
03/01/2022 Reset by Court to 06/01/2022
06/01/2022 Reset by Court to 06/06/2022
Result: Held
10/04/2022 **Settlement Conference** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.)
Result: Held
10/04/2022 **Case Scheduled for Trial** (Judicial Officer: McCarthy, Kathleen M.)
10/05/2022 ~~Order for Miscellaneous Action, Signed and Filed~~
10/25/2022 ~~Motion for Summary Judgment/Disposition, Filed~~
10/25/2022 ~~Proof of Service, Filed~~
11/07/2022 ~~Praecipe, Filed~~ (Judicial Officer: McCarthy, Kathleen M.)
11/08/2022 ~~Notice of Hearing, Filed~~
11/08/2022 ~~Proof of Service, Filed~~
12/19/2022 ~~Proof of Service, Filed~~
12/19/2022 ~~Answer to Motion, Filed~~
01/03/2023 ~~Reply to Brief, Filed~~
01/03/2023 ~~Proof of Service, Filed~~

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01/04/2023	**Motion Hearing** (10:00 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
01/04/2023	~~**Notice of Presentment**~~
01/04/2023	~~**Objection to 7-Day Order, Filed**~~
01/04/2023	~~**Proof of Service, Filed**~~
01/04/2023	~~**Notice of Hearing, Filed**~~
01/04/2023	**Motion Granted in Part/Denied in Part, Order to Follow** (Judicial Officer: McCarthy, Kathleen M.)
01/04/2023	~~**Proof of Service, Filed**~~
01/05/2023	~~**Proof of Service, Filed**~~
01/05/2023	~~**Notice of Hearing, Filed**~~
02/02/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/02/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/02/2023	~~**Notice of Hearing, Filed**~~
02/02/2023	~~**Proof of Service, Filed**~~
02/03/2023	~~**Reply to Brief, Filed**~~
02/03/2023	~~**Proof of Service, Filed**~~
02/03/2023	~~**Proof of Service, Filed**~~
02/07/2023	**Final Pre-Trial Conference** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
02/07/2023	**Motion Hearing** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
02/07/2023	**Motion Granted, Order to Follow** (Judicial Officer: McCarthy, Kathleen M.)
02/10/2023	~~**Motion for Stay of Proceedings, Filed**~~
02/10/2023	~~**Proof of Service, Filed**~~
02/10/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/10/2023	~~**Proof of Service, Filed**~~
02/10/2023	~~**Notice of Hearing, Filed**~~
02/14/2023	~~**Proof of Service, Filed**~~
02/14/2023	~~**Objection, Filed**~~
02/15/2023	~~**Witness List, Filed**~~
02/15/2023	~~**Proof of Service, Filed**~~
02/15/2023	~~**Proof of Service, Filed**~~
02/15/2023	~~**Notice of Hearing, Filed**~~
02/21/2023	~~**Answer to Motion, Filed**~~
02/21/2023	~~**Proof of Service, Filed**~~
02/21/2023	~~**Answer to Motion, Filed**~~
02/21/2023	~~**Proof of Service, Filed**~~
02/21/2023	~~**Motion in Limine, Filed**~~
02/21/2023	~~**Proof of Service, Filed**~~
02/21/2023	~~**Miscellaneous Pleadings, Filed**~~
02/22/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/22/2023	~~**Proof of Service, Filed**~~
02/22/2023	~~**Proof of Service, Filed**~~
02/23/2023	**Motion Hearing** (9:30 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
02/23/2023	~~**Order Adjourning Trial, Signed and Filed**~~
02/23/2023	~~**Order Granting in Part/Denying in Part, Signed and Filed**~~
02/23/2023	~~**Proof of Service, Filed**~~
02/23/2023	~~**Proof of Service, Filed**~~
02/23/2023	~~**Proof of Service, Filed**~~
02/23/2023	~~**Notice of Hearing, Filed**~~
02/28/2023	*CANCELED* **Motion Hearing** (10:00 AM) (Judicial Officer McCarthy, Kathleen M.) *Case Disposed/Order Previously Entered*
03/06/2023	**Trial** (8:30 AM) (Judicial Officer McCarthy, Kathleen M.)
03/06/2023	**Motion Hearing** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.)

Financial Information

Plaintiff Canty, Joseph William

	Total Financial Assessment			320.00
	Total Payments and Credits			320.00
	Balance Due as of 03/02/2023			**0.00**
04/15/2021	Transaction Assessment			175.00
04/15/2021	eFiling	Receipt # 2021-29974	Applebaum & Stone, PLC	(175.00)
05/26/2021	Transaction Assessment			85.00
05/26/2021	eFiling	Receipt # 2021-40545	Kramer, Corbett, Harding & Dombrowski	(85.00)
10/26/2022	Transaction Assessment			20.00
10/26/2022	eFiling	Receipt # 2022-76838	Kramer, Corbett, Harding & Dombrowski	(20.00)
02/10/2023	Transaction Assessment			20.00
02/10/2023	eFiling	Receipt # 2023-09947	Kramer, Corbett, Harding & Dombrowski	(20.00)
02/22/2023	Transaction Assessment			20.00
02/22/2023	eFiling	Receipt # 2023-11988	Kramer, Corbett, Harding & Dombrowski	(20.00)

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MOA App'x 5: Complaint

Approved, SCAO | Original - Court; 1st Copy- Defendant | 2nd Copy - Plaintiff; 3rd Copy -Return

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	SUMMONS	CASE NO. 21-004799-NI Hon.Lita Masini Popke

Court address : 2 Woodward Ave., Detroit MI 48226 | Court telephone no.: 313-224-2953

Plaintiff's name(s), address(es), and telephone no(s)		Defendant's name(s), address(es), and telephone no(s).
Canty, Joseph William	v	Mason, Michael Chester
Plaintiff's attorney, bar no., address, and telephone no Erik J. Stone 55304 26777 Central Park Blvd Ste 300 Southfield, MI 48076-4172		

Instructions: Check the items below that apply to you and provide any required information. Submit this form to the court clerk along with your complaint and, if necessary, a case inventory addendum (form MC 21). The summons section will be completed by the court clerk.

Domestic Relations Case

- ☐ There are no pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint.
- ☐ There is one or more pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint. I have separately filed a completed confidential case inventory (form MC 21) listing those cases.
- ☐ It is unknown if there are pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint.

Civil Case

- ☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035
- ☐ MDHHS and a contracted health plan may have a right to recover expenses in this case. I certify that notice and a copy of the complaint will be provided to MDHHS and (if applicable) the contracted health plan in accordance with MCL 400.106(4).
- ☐ There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.
- ☐ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has

been previously filed in ☐ this court, ☐ _____ Court,

where it was given case number _____ and assigned to Judge _____.

The action ☐ remains ☐ is no longer pending.

Summons section completed by court clerk. **SUMMONS**

NOTICE TO THE DEFENDANT: In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons and a copy of the complaint to **file a written answer with the court** and serve a copy on the other party **or take other lawful action with the court** (28 days if you were served by mail or you were served outside this state).
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.
4. If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

Issue date	Expiration date*	Court clerk
4/15/2021	7/15/2021	Laverne Chapman

Cathy M. Garrett- Wayne County Clerk.

*This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

MC 01 (9/19) **SUMMONS** MCR 1.109(D), MCR 2.102(B), MCR 2.103, MCR 2.104, MCR 2.105

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21-004799-NI FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 4/15/2021 10:20 AM Laverne Chapman

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STATE OF MICHIGAN
IN THE CIRCUIT COUNTY FOR THE COUNTY OF WAYNE
CIVIL DIVISION

JOSEPH WILLIAM CANTY,

Plaintiff,

v.

MICHAEL CHESTER MASON,

Defendant.
_____/

Case No. 21- -NI
Hon.

Erik J. Stone (P55304)
Eric M. Noga (P83611)
APPLEBAUM & STONE, PLC
Attorney for Plaintiff
26777 Central Park Boulevard, Suite 300
Southfield, Michigan 48076
(248) 233-5050 Fax: (248) 359-8550
enoga@applebaumstone.com
estone@applebaumstone.com
_____/

There is no other pending or resolved civil action arising out of the occurrence alleged in the Complaint.

COMPLAINT

NOW COMES Plaintiff, JOSEPH WILLIAM CANTY, by and through their undersigned counsel, and for their Complaint against Defendant, MICHAEL CHESTER MASON, and their agents, servants, representatives, or employees, either real or ostensible, and hereby respectfully represents unto this Honorable Court as follows:

PARTIES, JURISDICTION AND VENUE

1. Plaintiff, JOSEPH WILLIAM CANTY ("Plaintiff"), is a resident of Detroit, Wayne County, Michigan.

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2. Upon information and belief, Defendant, MICHAEL CHESTER MASON ("Michael Mason"), is a resident of Canton Township, Wayne County, Michigan.

3. The amount of controversy regarding Plaintiff's claims exceeds Twenty-Five Thousand Dollars ($25,000.00) and it is properly placed within this Court.

4. This Court has the power to declare the rights and other legal relations of an interested party seeking a declaratory judgment in a case of actual controversy within its jurisdiction.

5. This Court has jurisdiction over Plaintiff's claims since this Court would have jurisdiction of an action on the same claim or claims in which Plaintiff sought relief other than a declaratory judgment.

6. A declaratory judgment may be necessary to guide Plaintiff's future conduct in order to preserve their legal rights and, therefore, a case of actual controversy exists between Plaintiff and Defendant.

7. Plaintiff has standing, having suffered an actual or imminent invasion of a legally protected interest, which may be redressed by this Court.

8. Plaintiff has suffered, and continues to suffer, dire and imminent financial hardship by Defendant's wrongful acts.

9. Plaintiff is without an adequate remedy at law under the Michigan No-Fault Act.

10. All conditions precedent to recovery have been performed and/or have occurred.

11. Declaratory and/or equitable relief is sought.

GENERAL ALLEGATIONS

12. Plaintiff re-alleges and reincorporates by reference each of the preceding paragraphs as though fully set forth herein.

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13. On or about February 15, 2021, at approximately 6:35 a.m., Plaintiff was the owner and operator of a 2015 Chevrolet Malibu LT sedan four door motor vehicle bearing Michigan registration 0095K8.

14. At that time, Michael Mason was the owner and operator of a 2018 Lincoln Navigator Reserve Four Door Wagon Sport Utility motor vehicle bearing Michigan registration EFJ6900.

15. At that time, Plaintiff's vehicle was travelling in the 2nd to right lane on northbound Telegraph Road, north of the intersection with Schoolcraft Road, located in Redford Township, Wayne County, Michigan.

16. At that time and place, Michael Mason was travelling northbound on Telegraph Road, north of the intersection with Schoolcraft Road, in the right curb lane.

17. There were icy conditions on the roadway at the time Plaintiff and Michael Mason were travelling.

18. Plaintiff was not speeding or driving recklessly or negligently.

19. As Plaintiff travelled northbound on Schoolcraft Road, their vehicle hit a patch of ice and began to skid.

20. Michael Mason was travelling at speed too fast for the roadway conditions and was not maintaining an assured clear distance from Plaintiff's vehicle.

21. Michael Mason hit the same ice patch that Plaintiff's vehicle did, having not paid attention to the roadway or Plaintiff's vehicle.

22. Michael Mason's vehicle skidded until it struck the rear-end of Plaintiff's vehicle with substantial force.

Canty MOA App'x, p.020a

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23. Plaintiff was improperly held at fault for the motor vehicle accident and did not lose control of their vehicle as the police reported Plaintiff did.

24. Michael Mason was at fault for the motor vehicle accident.

25. As a direct and proximate result of the motor vehicle accident and the negligence of Michael Mason, Plaintiff sustained accidental bodily injuries and required reasonable and necessary medical treatment, services, or accommodations.

COUNT TWO – AUTOMOBILE NEGLIGENCE AGAINST DEFENDANT MICHAEL CHESTER MASON

26. Plaintiff re-alleges and reincorporates by reference each of the preceding paragraphs as though fully set forth herein.

27. On the date and time aforesaid, Defendant Michael Mason owed duties to Plaintiff to operate said motor vehicle with reasonable care and caution under the Motor Vehicle Code of the State of Michigan, Ordinances of Redford Township, and the common law in such cases made and provided.

28. Defendant Michael Mason breached said duties owed to Plaintiff in at least one or more of the following particulars, so far as it is presently known:

a. operated said vehicle without having it under constant control.
b. failed to make proper observation and failed to observe the presence of other users of the road and/or failed to take timely or proper action on such observation as was made in order to avoid a collision.
c. operated said vehicle in a careless and heedless manner, without due regard for the rights and safety of others, particularly Plaintiff herein, and operated said vehicle without due care and circumspection and at a speed and in a manner so as to endanger or be likely to endanger persons and property in violation of Michigan Statute.

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d. failed to maintain the horn, brakes and other equipment of the motor vehicle in good working order as required by Michigan Statute, and/or failed to sound the horn of the vehicle or to apply the brakes when, in sufficient time to take such action, they saw or should have seen that it was necessary to avoid a collision.

e. failed to use ordinary care in the operation of a motor vehicle.

f. operated said vehicle in a reckless manner.

g. operated said vehicle while intoxicated and/or under the influence of intoxicating liquor with driving ability impaired in violation of Michigan Statute.

h. operated said vehicle at a speed in excess of the legal rate of speed posted or otherwise provided.

i. overtook and struck the rear of said vehicle proceeding in the same direction as it was lawfully [slowing down, stopped, proceeding} on said highway.

j. operated said vehicle at a careless and imprudent rate of speed greater than was reasonable and proper, having no due regard to the traffic, surface and width of said highway and of other conditions then existing, and operated the aforesaid vehicle at a speed greater than would permit it to be brought to a stop within the assured clear distance ahead, and failed to bring the vehicle to a stop within the assured clear distance ahead, in violation of Michigan Statute.

k. failed, upon approaching an open intersection, to yield the right-of-way to another vehicle simultaneously entering an open intersection from the right, in violation of Michigan Statute.

l. failed, upon approaching an open intersection, to yield the right-of-way to another vehicle which had already entered the intersection from a different highway, in violation of Michigan Statute.

m. failed, upon approaching an intersection where there was a sign bearing the message "yield right of way," to stop or slow to a reasonable speed and to yield the right-of-way to all traffic on the intersecting street which was so close as to constitute an immediate hazard, in violation of Michigan Statute.

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n. failed to obey the red light of the traffic control signal facing the vehicle, and failed to come to a stop before entering the intersection, and failed to remain standing until green was shown alone, in violation of Michigan Statute.

o. operated said vehicle on the left half of the highway in violation of Michigan Statute.

p. failed to approach for a right turn as close as practical to the right-hand curb or edge of the roadway and/or failed to make a right turn from the lane as close as practical to the right-hand curb or edge of the roadway in violation of Michigan Statute.

q. failed to observe traffic signals and/or signs placed on said highway, and failed to obey said traffic signals and/or signs.

r. failed to give any signal by hand, arm, mechanical or electrical means to signal or warn others that Defendant was going to [move his/her vehicle from one lane to another on the highway][turn right/left], in violation of Michigan Statute.

s. failed to drive the vehicle as nearly as practicable entirely within a single lane.

t. operated said vehicle from one lane to another lane of traffic without first ascertaining that such movement could be made safely.

u. failed to remain at the scene of a personal injury accident, provide information and give or offer assistance to the injured, in violation of Michigan Statute.

v. intending to turn left, did not yield the right-of-way to Plaintiff's vehicle, which was closely approaching from the opposite direction, in violation of Michigan Statute.

w. before turning left, did not ascertain that such movement could be made safely and did not give a warning signal to other drivers, in violation of Michigan Statute.

x. failed, upon approaching an intersection where there was a sign bearing the message "stop," to stop and yield the right-of-way to all traffic on the intersecting street, which was so close as to constitute an immediate hazard.

y. failed to obey the flashing red light of the traffic control signal facing Defendant, and failed to come to a stop before entering the intersection, and failed to remain stopped until all traffic on the intersecting street, which was so close as to constitute an immediate hazard, had passed.

z. driving said vehicle upon the highway or other places open to the general public without lighted lamps and illuminating devices as required under the conditions then and there existing in violation of Michigan Statute.

aa. in other ways that may become known through discovery.

29. Plaintiff sustained personal injuries as a direct and proximate result of the negligence of Defendant Michael Mason.

30. As a direct result and proximate result of the negligence of Defendant Michael Mason, and/or their agents, servants and/or employees, either real or ostensible, Plaintiff has:

a. sustained severe bodily injuries which were painful disabling and necessitated medical care.

b. suffered shock and emotional damage.

c. sustained possible aggravation of pre-existing conditions and/or reactivation of dormant conditions.

d. was and/or may continue to be unable to attend to his usual affairs and daily activities including, but not limited to, household chores, and personal needs.

e. was and/or may continue to be unable to render services as formerly including, but not limited to, household chores, and personal needs.

f. suffered from a loss of enjoyment of life and/or was and may continue to be hampered in the enjoyment of the normal pursuit of life.

g. sustained injuries that are or may be permanent to the degree that Plaintiff suffered a loss in ability to earn money as before and may have impaired earning capacity in the future.

h. may continue to have pain and suffering in the future and impairment and disabilities as well as permanency.

i. suffered mental anguish.

j. suffered fright.

k. suffered from embarrassment and humiliation.

l. sustained any and all hedonic damages, both past and future.

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m. sustained injuries that are or may be permanent and may continue to have said damages in the future.

n. suffered excess economic damages, wage loss, and replacement services.

o. sustained damages that are past and future; and/or

p. sustained any other damages which are applicable, and which are recoverable pursuant to statute, case law, and Michigan Court Rules.

31. As a direct and proximate result of the negligence of Defendant Michael Mason and the resulting injuries to Plaintiff, they have sustained a serious impairment of a bodily function as an objectively manifested impairment of an important body function that affects a person's ability to lead their normal life, and/or a permanent, serious disfigurement and/or a serious neurological defect (closed-head injury).

32. In addition to aforementioned injuries sustained by Plaintiff as a direct and proximate result of their motor vehicle accident, Plaintiff required reasonable and necessary medical treatment with health care providers.

33. Defendant Michael Mason is liable to reimburse Plaintiff's claims for unpaid medical expenses incurred as a proximate result of their negligent motor vehicle operation.

34. Plaintiff has incurred unpaid medical expenses arising from medical treatment provided for their accidental bodily injuries arising from the use, operation, maintenance, or ownership of a motor vehicle as a motor vehicle.

35. Defendant Michael Mason is obligated to reimburse Plaintiff for unpaid medical expenses arising from their negligent motor vehicle operation.

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36. Defendant Michael Mason has unreasonably and unlawfully refused and/or neglected to compensate Plaintiff for their bodily injuries sustained as a result of Defendant's negligent motor vehicle operation or reimburse them for unpaid medical expenses.

37. Demand for payment and proof in support of the same has been made, but Defendant Michael Mason has refused or neglected to reimburse Plaintiff for medical expenses incurred as a result of Defendant's negligent motor vehicle operation.

38. More than thirty (30) days has passed since supplying Defendant Michael Mason with the documentation.

39. Defendant Michael Mason has failed, refused, or neglected, to reimburse Plaintiff for their medical expenses incurred as a result of receiving reasonable and necessary medical treatment.

40. Defendant Michael Mason owes Plaintiff reimbursement for medical expenses incurred as a result of Defendant's negligent motor vehicle operation.

41. Defendant Michael Mason's violation of their duties and obligations owed to Plaintiff has proximately caused Plaintiff to sustain damages.

42. Plaintiff is eligible and entitled to the relief requested herein.

WHEREFORE, Plaintiff prays for damages in their favor, and against Defendant Michael Mason, whatever amount Plaintiff is found to be entitled, together with interest, costs, actual attorneys' fees, and any other such just and equitable relief deemed reasonable and necessary.

Respectfully submitted,

APPLEBAUM & STONE, PLC

BY: */s/ Erik J. Stone*

Erik J. Stone (P55304)
Eric M. Noga (P83611)
Attorneys for Plaintiff
26777 Central Park Boulevard, Suite 300
Southfield, Michigan 48076
(248) 233-5050 Fax: (248) 359-8550
enoga@applebaumstone.com
estone@applebaumstone.com

Dated: April 15, 2021

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MOA App'x 6: Plaintiff Response to Motion for Summary Judgment with Appendix

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Appendix Attachment 7

21-004799-NI FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 12/19/2022 3:28 PM Jacqueline Ruff

APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH CANTY,

Plaintiff,

Case No. 21-004799-NI
Honorable Kathleen M. McCarthy

v.

MICHAEL MASON,

Defendant.
_____/

Erik J. Stone (P55304)
Eric M. Noga (P83611)
APPLEBAUM & STONE, PLC
Attorneys for Plaintiff
26777 Central Park Boulevard, Ste 300
Southfield, Michigan 48076
(248) 233-5050 / FAX: (248) 359-8550
estone@applebaumstone.com
enoga@applebaumstone.com

Angela Esseily (P81816)
KRAMER CORBETT HARDING & DOMBROWSKI
Attorney for Defendant
1450 W. Long Lake Rd, Ste 100
Troy, MI 48098
(248) 712-0590 / FAX: (248) 480-4576
aesseily@acg.aaa.com
_____/

PLAINTIFF'S AMENDED RESPONSE TO DEFENDANT MICHAEL MASON'S PARTIAL MOTION FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(10)

NOW COMES Plaintiff JOSEPH CANTY, by and through his attorneys, APPLEBAUM & STONE, PLC, and for his Amended Response To Defendant Michael Mason's Partial Motion For Summary Disposition Pursuant To MCR 2.116(C)(10), states as follows:

1. Admitted.

2. Neither Admitted nor Denied. Plaintiff leaves Defendant to his proofs.

3. Neither Admitted nor Denied. Plaintiff leaves Defendant to his proofs. By way of further response, Plaintiff states that Defendant's affirmative defenses 30 and 31 cannot apply to this matter, as Plaintiff opted out of PIP coverage and may therefore seek allowable expenses "without limit." MCL 500.3135(3)(c)

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APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

4. Admitted.

5. Admitted. By way of further response, Plaintiff states that he seeks "Damages for allowable expenses… …**without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c) through tort.

6. Denied. The requirement for PIP coverage opt-out under MCL 500.3107d(1) is "qualified health coverage." Medicare is considered "qualified health coverage" as under MCL 500.3107d(7)(b)(ii), but Medicare coverage is not a prerequisite to opt out. Further, Defendant has fabricated whole cloth any duty for Plaintiff to mitigate damages. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers in a manner that benefits the tortfeasor who injured them. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers who accept his medical insurance, even if it is Medicare. A motor vehicle accident victim may even choose to pay out of pocket for medical treatment. The only applicable law regarding this matter is MCL 500.3135(3)(c), which specifically grants *greater* ability to recover allowable expenses if a motor vehicle accident victim 'opts out' of PIP coverage: "Damages for allowable expenses… …**without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c).

7. Plaintiff objects to this claim as irrelevant to the instant matter. Nevertheless, Plaintiff Admits.

8. Plaintiff objects to this claim as irrelevant to the instant matter. Nevertheless, Plaintiff Admits. By way of further response, Plaintiff states that Defendant has fabricated whole cloth any duty for Plaintiff to mitigate damages. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers in a manner that benefits the

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APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

tortfeasor who injured them. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers who accept his medical insurance, even if it is Medicare. A motor vehicle accident victim may even choose to pay out of pocket for medical treatment. The only applicable law regarding this matter is MCL 500.3135(3)(c), which specifically grants *greater* ability to recover allowable expenses if a motor vehicle accident victim 'opts out' of PIP coverage: "Damages for allowable expenses… …**without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c).

9. Plaintiff objects to this claim as irrelevant to the instant matter. No no-fault PIP benefits have been sought in this matter. Defendant has fabricated whole cloth any duty for Plaintiff to mitigate damages. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers in a manner that benefits the tortfeasor who injured them. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers who accept his medical insurance, even if it is Medicare. A motor vehicle accident victim may even choose to pay out of pocket for medical treatment. The only applicable law regarding this matter is MCL 500.3135(3)(c), which specifically grants *greater* ability to recover allowable expenses if a motor vehicle accident victim 'opts out' of PIP coverage: "Damages for allowable expenses… …**without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c). Nevertheless, Plaintiff Admits that he treated with the listed providers.

10. Neither Admitted nor Denied. Plaintiff leaves Defendant to its proofs. By way of further explanation, Plaintiff objects to this claim as irrelevant to the instant matter. No no-fault PIP benefits have been sought in this matter.

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APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

11. Plaintiff objects to this claim as irrelevant to the instant matter. Nevertheless, Plaintiff Admits. By way of further response, Plaintiff states that Defendant has fabricated whole cloth any duty for Plaintiff to mitigate damages. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers in a manner that benefits the tortfeasor who injured them. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers who accept his medical insurance, even if it is Medicare. A motor vehicle accident victim may even choose to pay out of pocket for medical treatment. The only applicable law regarding this matter is MCL 500.3135(3)(c), which specifically grants *greater* ability to recover allowable expenses if a motor vehicle accident victim 'opts out' of PIP coverage: "Damages for allowable expenses… …**without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c).

12. Denied. Plaintiff states that he is permitted to see "Damages for allowable expenses… …***without limit*** **for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c) through tort.

13. Denied. Sections MCL 500.3107 – MCL 500.3110 apply to Personal Injury Protection benefits through no-fault. No no-fault PIP benefits have been sought in this matter against Defendant.

14. Denied. MCL 500.3157 limits apply only to "…an accidental bodily injury **covered by personal protection insurance**…" No no-fault PIP benefits have been sought in this matter against Defendant.

15. Denied. Plaintiff's providers do not accept Medicare. Defendant has fabricated whole cloth any duty for Plaintiff to mitigate damages. No statute or case law imposes a requirement upon a

motor vehicle accident victim to seek treatment from medical providers in a manner that benefits the tortfeasor who injured them. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers who accept his medical insurance, even if it is Medicare. A motor vehicle accident victim may even choose to pay out of pocket for medical treatment. The only applicable law regarding this matter is MCL 500.3135(3)(c), which specifically grants *greater* ability to recover allowable expenses if a motor vehicle accident victim 'opts out' of PIP coverage: "Damages for allowable expenses… …**without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c).

WHEREFORE, Plaintiff Joseph Canty respectfully requests that this Honorable Court DENY Defendant Michael Mason's Partial Motion For Summary Disposition Pursuant To MCR 2.116(C)(10) in its entirety.

Respectfully Submitted,

APPLEBAUM & STONE, PLC

BY: /s/ Eric M. Noga
ERIK J. STONE (P55304)
ERIC M. NOGA (P83611)
Attorney for Plaintiff
26777 Central Park Blvd, Ste 300
Southfield, MI 48076
(248) 233-5050 / Fax: (248) 359-8539
estone@applebaumstone.com
enoga@applebaumstone.com

Dated: December 16, 2022

APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH CANTY,

Plaintiff,

Case No. 21-004799-NI
Honorable Kathleen M. McCarthy

v.

MICHAEL MASON,

Defendant.
_____/

Erik J. Stone (P55304)
Eric M. Noga (P83611)
APPLEBAUM & STONE, PLC
Attorneys for Plaintiff
26777 Central Park Boulevard, Ste 300
Southfield, Michigan 48076
(248) 233-5050 / FAX: (248) 359-8550
estone@applebaumstone.com
enoga@applebaumstone.com

Angela Esseily (P81816)
KRAMER CORBETT HARDING & DOMBROWSKI
Attorney for Defendant
1450 W. Long Lake Rd, Ste 100
Troy, MI 48098
(248) 712-0590 / FAX: (248) 480-4576
aesseily@acg.aaa.com

_____/

PLAINTIFF'S BRIEF IN SUPPORT OF HIS RESPONSE TO DEFENDANT MICHAEL MASON'S PARTIAL MOTION FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(10)

NOW COMES Plaintiff JOSEPH CANTY, by and through his attorneys, APPLEBAUM & STONE, PLC, and for his Brief In Support Of His Response To Defendant Michael Mason's Partial Motion For Summary Disposition Pursuant To MCR 2.116(C)(10), states as follows:

I. INTRODUCTION AND FACTS

Defendant's Motion is premised upon a fabricated requirement which has never been a part of Michigan law. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers in a manner that benefits the tortfeasor who injured them.

APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

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APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

Plaintiff was injured in February 15, 2021 motor vehicle accident caused by Defendant Mason's negligent operation of a motor vehicle. Plaintiff sought treatment for his injuries with multiple medical providers, including Northland Radiology, Lucid Neurology, Pioneer Labs, and US Rehab & Health Services.

Plaintiff opted out of personal injury protection benefits under his Liberty Mutual auto policy. Plaintiff now seeks payment of outstanding medical billing as allowable expenses through his tort claim against Defendant, as under MCL 500.3135(3)(c).

II. STANDARD OF REVIEW

A motion for summary disposition under MCR 2.116(C)(10) tests whether there is factual support for a claim. In deciding on it, the trial court must give the benefit of reasonable doubt to the nonmoving party. It determines whether a record might be developed which would leave open an issue upon which reasonable minds could differ. *Hutchinson v Allegan Co Bd of Road Comm'rs (On Remand)*, 192 Mich App 472, 480-481; 481 NW2d 807 (1992). A motion for summary judgment grounded on absence of genuine fact issue must set forth with particularity such facts as would be admissible in evidence, not mere opinion, conclusionary denials, unsworn averments, or inadmissible hearsay. *Remes v. Duby*, 87 Mich. App. 534, 274 N.W.2d 64 (1978). Hearsay evidence is insufficient to support motion for summary judgment. *Jones v. Shek*, 48 Mich. App. 530, 210 N.W.2d 808 (1973)

All reasonable inferences are drawn in favor of the nonmoving party. *Perez v KFC Nat'l Management Co, Inc*, 183 Mich App 265, 267-268; 454 NW2d 145 (1990), citing *Dagen v Hastings Mutual Ins Co*, 166 Mich App 225, 229; 420 NW2d 111 (1987).

"A genuine issue of material facts exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds

Canty MOA App'x, p.035a

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might differ." *West v GMC*, 469 Mich. 177, 183; 665 N.W.2d 468 (2003). "This Court is liberal in finding genuine issues of material fact." *Jimkoski v Shupe*, 282 Mich App 1, 5; 763 NW2d 1 (2008). A Court "…may not resolve factual disputes or determine credibility in ruling on a summary disposition motion." *Burkhardt v Bailey*, 260 Mich App 636, 646-647; 680 NW2d 453 (2004). "The court is not permitted to assess credibility, or to determine facts on a motion for summary judgment." *Skinner v Square D Co*, 445 Mich 153, 161; 516 NW2d 475 (1994)

III. LAW AND ARGUMENT

a. Medicare Coverage Is Not A Requirement To Opt Out Of PIP Coverage Under MCL 500.3107d.

"…the applicant or named insured may… …elect to not maintain coverage for personal protection insurance benefits… …if the applicant or named insured… …have qualified health coverage…" MCL 500.3107d(1)

The requirement for PIP coverage opt-out under MCL 500.3107d(1) is "qualified health coverage." While Medicare is considered "qualified health coverage" as under MCL 500.3107d(7)(b)(ii), Medicare coverage is not a *prerequisite* to opt out.

Plaintiff's qualified healthcare coverage in this matter is in fact Medicare, but places no additional requirements upon Plaintiff.

b. MCL 500.3135 places no restriction on a motor vehicle accident victim's choice of medical provider and/or the means by which Plaintiff must seek payment for the same, aside from the affirmative ability to seek allowable expenses through tort without limit if the victim opted out of PIP coverage.

"…tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to: […] Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any

APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

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applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or **without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d** or if an exclusion under section 3109a(2) applies." MCL 500.3135(3), (3)(c) (**emphasis added**)

Defendant has fabricated whole cloth any duty for Plaintiff to mitigate damages. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers in a manner that benefits the tortfeasor who injured them. No statute or case law imposes a requirement upon a motor vehicle accident victim to seek treatment from medical providers who accept his medical insurance, even if it is Medicare. A motor vehicle accident victim may even choose to pay out of pocket for medical treatment. The only applicable published law regarding this issue is MCL 500.3135(3)(c), which specifically grants *greater* ability to recover allowable expenses if a motor vehicle accident victim 'opts out' of PIP coverage: "Damages for allowable expenses… …**without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d**…" MCL 500.3135(3)(c).

WHEREFORE, Plaintiff Joseph Canty respectfully requests that this Honorable Court DENY Defendant Michael Mason's Partial Motion For Summary Disposition Pursuant To MCR 2.116(C)(10) in its entirety.

Respectfully Submitted,

APPLEBAUM & STONE, PLC

BY: /s/ Eric M. Noga

ERIK J. STONE (P55304)
ERIC M. NOGA (P83611)
Attorney for Plaintiff
26777 Central Park Blvd, Ste 300
Southfield, MI 48076
(248) 233-5050 / Fax: (248) 359-8539
estone@applebaumstone.com

APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

enoga@applebaumstone.com

Dated: December 16, 2022

APPLEBAUM & STONE, PLC
Attorneys at Law
26777 Central Park Blvd., Suite 300
Southfield, MI 48076
(248) 233-5050

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MOA App'x 7: Defendant's Motion for Partial Summary Judgment with Appendix

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Appendix
Attachment 6

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH WILLIAM CANTY,

Plaintiff,

CT NO: 21-004799-NI
HON. KATHLEEN M. MCCARTHY

-vs-

MICHAEL CHESTER MASON,

Defendant.
_____/

PROOF OF SERVICE
The Undersigned certifies that the forgoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on this 25th day of October 2022.

☐ US Mail ☐ Fax
☐ Hand Delivered ☐ UPS
☐ Fed.Express ☒ E-Filed
☐ Other

Signature *Kellie F. Klingel*

APPLEBAUM & STONE, PLC
ERIK J. STONE (P55304)
Attorney for Plaintiff
26777 Central Park Blvd Suite 300
Southfield, Michigan 48076
248-233-5050 / 248-359-8524 (Fax)
estone@applebaumstone.com

KRAMER, CORBETT,
HARDING & DOMBROWSKI
BY: ANGELA ESSEILY (P81816)
Attorney for Defendant MICHAEL
CHESTER MASON
PO Box 8084
Royal Oak, Michigan 48068-8084
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com
_____/

DEFENDANT MICHAEL MASON'S PARTIAL MOTION FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(10)

NOW COMES Defendant MICHAEL CHESTER MASON, by and through his Attorneys, KRAMER, CORBETT, HARDING & DOMBROWSKI, and for his Motion for Summary Disposition, states as follows:

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1. Plaintiff filed his third-party Complaint against Defendant Michael Mason on April 15, 2021, alleging both parties were involved in a motor vehicle accident on February 15, 2021.
2. Defendant filed his response to Plaintiff's Complaint on May 25, 2021.
3. Defendant filed his Affirmative Defenses on May 25, 2021, more specifically Paragraph 30, Paragraph 31, and Paragraph 33 of Defendant's Affirmative Defenses. (**Exhibit A**, Answer and Affirmative Defenses).
4. Through the course of discovery, pursuant to this Court's scheduling order and the Michigan Court Rules, it was discovered Plaintiff had an auto insurance Policy with Liberty Mutual. (**Exhibit B,** Policy and Declaration Page).
5. Plaintiff's Liberty Mutual Policy at the time of the subject collision was a Medicare Opt Out pursuant to MCL 500.3107d, which excluded Allowable Expense Coverage to Plaintiff in the event of any alleged injuries sustained as a result of a motor vehicle accident. (**Exhibit B**).
6. Given the requirements to hold Medicare Part A and B in order to qualify for an opt out, Plaintiff had the duty to attempt to mitigate damages by submitting all bills to Medicare prior to making claims against the third-party Defendant.
7. Plaintiff is also a Veteran, who regularly treated with the Veteran's Hospital whenever he required medical attention.
8. However, following this subject collision, Plaintiff chose to seize treatment with the Veteran's Hospital as it relates to the subject collision, and instead began treating with popular no-fault providers such as Northland Radiology, Lucid Neurology, Pioneer Labs, and US Rehab & Health Services.

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9. Despite the Plaintiff and Providers being aware, or becoming aware of Plaintiff's lack of PIP coverage, Plaintiff continued to rack up bills with these providers. (**Exhibit C,** Explanations of Review from Liberty Mutual).
10. Plaintiff was aware of the limitations under his auto insurance policy with Liberty Mutual. (**Exhibit D**, Liberty Mutual Coverage Documentation).
11. Despite being aware of these limitations, Plaintiff chose to treat with Providers that did not accept Medicare and continues to treat with these same providers.
12. Even if this Court finds Plaintiff does not have a duty to mitigate damages or submit his allowable expenses to Medicare, Plaintiff is still limited to recovery for allowable expenses pursuant to the Michigan No-Fault Act.
13. Specifically, Plaintiff is limited to payment of allowable expense limits pursuant to MCL 500.3107 to MCL 500.3110.
14. Consequently, Plaintiff's is limited to payment of allowable expense limits pursuant to MCL 500. 3157.
15. Additionally, Plaintiff's providers would be subject to payment based on the Medicare fee schedule even if MCL 500.3157 was not relevant.

WHEREFORE, Defendant MICHAEL MASON requests this Honorable Court Grant his Motion for Partial Summary Disposition.

Respectfully submitted,

HOM, CORBETT, KRAMER,
HARDING & DOMBROWSKI

/s/Angela Esseily

Angela Esseily (P81816)
Attorney for Defendants Meemic Insurance Company
150 West Jefferson; Suite 1500
Detroit, Michigan 48226
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com

DATED: October 25, 2022

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH WILLIAM CANTY,

Plaintiff,

CT NO: 21-004799-NI
HON. KATHLEEN M. MCCARTHY

-vs-

MICHAEL CHESTER MASON,

Defendant.
_____/

PROOF OF SERVICE
The Undersigned certifies that the forgoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on this 25th day of OCTOBER 2022.

☐ US Mail ☐ Fax
☐ Hand Delivered ☐ UPS
☐ Fed.Express ☒ E-Filed
☐ Other

Signature *Kellie F. Klingel*

APPLEBAUM & STONE, PLC
ERIK J. STONE (P55304)
Attorney for Plaintiff
26777 Central Park Blvd Suite 300
Southfield, Michigan 48076
248-233-5050 / 248-359-8524 (Fax)
estone@applebaumstone.com

KRAMER, CORBETT,
HARDING & DOMBROWSKI
BY: ANGELA ESSEILY (P81816)
Attorney for Defendant MICHAEL
CHESTER MASON
PO Box 8084
Royal Oak, Michigan 48068-8084
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com
_____/

DEFENDANT'S BRIEF IN SUPPORT OF HIS PARTIAL MOTION FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(10)

NOW COMES Defendant Michael Chester Mason, by and through is Attorneys KRAMER, CORBETT, HARDING & DOMBROWSKI, and for his Partial Motion for Summary Disposition, states as follows:

I. FACTS

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Plaintiff alleges he was injured in a motor vehicle accident on February 15, 2021. The subject collision involved Plaintiff improperly changed lanes, striking Defendant's vehicle (Exhibit A, Police Report). Plaintiff now seeks payment for alleged economic damages sustained against the innocent driver.

Plaintiff alleges is a Medicare Part A and B recipient who opted out of Allowable Expense coverage through is auto insurer, Liberty Mutual Insurance Company, pursuant to MCL 500.3107d. Prior to the motor vehicle accident, Plaintiff solely treated at the Veteran's Affair Medical Center anytime he needed to seek treatment with a doctor for any reason. Despite his normal route of treating with the medical center, Plaintiff testified he did not seek treatment with the VA for injuries allegedly sustained as a result of the motor vehicle accident. Rather, after the accident occurred, Plaintiff sought treatment with a slew of popular no-fault providers. The Providers submitted their bills to Liberty Mutual and quickly began receiving EOBs from Liberty denying the claim due to no allowable expense coverage based on the Plaintiff's Medicare Opt-out. Despite this information and knowledge, Plaintiff continued treating with these providers and the providers continued to treat him. Once more, Plaintiff and his providers continued to rack up his medical bills without pause, even while knowing the Providers do not accept Medicare.

II. STANDARD OF REVIEW

A motion for summary disposition brought under MCR 2.116(C)(10) tests the factual support for a claim. "A court must consider the pleadings, affidavits, depositions, admissions, and other documentary evidence then filed in the action or submitted by the parties in the light most favorable to the nonmoving party." *Healing Place at North Oakland Med Ctr v Allstate Ins Co*, 277 Mich App 51, 56; 744 NW2d 174 (2007); MCR 2.116(C)(5). "Summary disposition is appropriate if there is no genuine issue regarding

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any material fact and the moving party is entitled to judgment as a matter of law." *Latham v Barton Malow Co*, 480 Mich 105, 111; 746 NW2d 868 (2008).

In *Maiden v Rozwood*, 461 Mich 109, 121; 597 NW2d 817 (1999), the Court stated, "[t]he court rule plainly requires the adverse party to set forth specific facts at the time of the motion showing a genuine issue for trial." A motion for summary disposition under MCR 2.116(C)(10) tests the factual support of a claim, *Smith v Globe Life Ins Co*, 460 Mich 446, 454; 597 NW2d 28 (1999), and thus, the reviewing court considers affidavits, pleadings, depositions, admissions, and documentary evidence filed in the action or submitted by the parties in the light most favorable to the nonmoving party. *Quinto v Cross & Peters Co*, 451 Mich 358, 362; 547 NW2d 314 (1996).

III. ARGUMENT

A. Plaintiff and His Providers Failed to Mitigate Damages Despite an Obligation to Do So.

Section 3107d of the No-Fault Act allows for complete opt of Allowable Expense Coverage when the insured is a Medicare Part A and B recipient. Contractually, Plaintiff has opted out Allowable Expense Coverage, and chose the specific coverage of Medicare which has obligated Plaintiff to seek payment of any bills incurred from Medicare. (**Exhibit** Section 3107d reads in relevant part:

> i. For an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured may, in a way required under section 3107e and on a form approved by the director, elect to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a) if the applicant or named insured is a qualified person, and if the applicant's or named insured's spouse and any relative of either that resides in the same household have qualified health coverage or have coverage for benefits payable under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

The legislature specifically enumerated a section of the statute addressing potential insureds with other health coverage, including Medicare Part A and B. ***Only when*** a potential

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insured has the proper coverage does the No-Fault Act allow for an opt-out of Allowable Expense Coverage. Defendant anticipates Plaintiff will allege that no portion of the statute requires Plaintiff and/or his Providers to submit bills to Medicare first. However, it is Defendant's position the legislature would not go so far as to require coverage in order to allow a person to opt out of Allowable Expense coverage.

Additionally, despite Plaintiff being well aware of his lack of coverage, he begins treating with popular No-Fault Providers such as Northland Radiology and Lucid Neurology. Prior to this accident Mr. Canty consistently treated at the VA for all medical treatment. He even sought treatment with the VA following the accident; however, only exclusively treated with the no-Fault Providers following that initial treatment. (**Exhibit D**, Plaintiff's Deposition, 43:14-18).

Despite Explanation of Review from Plaintiff's Auto Insurance Carrier, Liberty Mutual, which laid out denials due to no PIP coverage, Plaintiff's providers continued to treat Plaintiff and rack up their bills. Plaintiff continued to treat with these providers without question or concern of how his medical bills would be paid. **(Exhibit C**, Liberty Mutual EOBs).

B. Even if This Court Finds Plaintiff Had No Duty to Mitigate, Plaintiff is Still Limited to Recovery Under Section 3107 and 3157 Based on the Language in Section 3135(c)(3).

Section 3135(c)(3) of the No-Fault Act reads in relevant part:

> (3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:
>
> ***
>
> (c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies. The party liable for damages is entitled to an exemption reducing his or her liability by the

amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

The legislature specifically limits recovering of damages based on what is considered "allowable expenses" pursuant to Sections 3107 to 3110. Allowable expense limits are to be paid if they are **reasonable charges** for reasonably necessary products, services, and accommodations. Consequently, given Plaintiff's own policy of insurance, being Medicare Part A and B, Plaintiff's allowable expenses would only be required to be paid at the Medicare rates provided per CMS. Given, Plaintiff's anticipated insistence this is a regular tort action, the Court is directed to look to

To consider what a reasonable charge is, this Court is directed to MCL 500.3157 of the No-Fault Act. Again, given Section 3135(c)(3)'s reference to allowable expenses pursuant to 3107, it is reasonable to conclude charges would only be payable pursuant to what is reasonable and customary, or what the reasonable amount charged is, as defined by the No-Fault Act. MCL 500.3157 states in relevant part:

(1) Subject to subsections (2) to (14), a physician, hospital, clinic, or other person that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the treatment or training. The charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance.

(2) Subject to subsections (3) to (14), a physician, hospital, clinic, or other person that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is not eligible for payment or reimbursement under this chapter for more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 200% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 195% of the amount payable to the person for the treatment or training under Medicare.

Based on the readings of 3107 and 3135, Plaintiff cannot just claim its provider's full bills and expect payment be made based on whatever the Provider has decided to bill in that instance. By the plain reading of Section 3135(c)(3) of the statute, Plaintiff's bills incurred are

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considered allowable expenses as defined by the Michigan No-Fault Act, which is only payable at a reasonable customary rate, or in the alternative what would have been paid by Medicare considering the contract between Plaintiff and his health insurer.

WHEREFORE, for the aforementioned reasons, Defendant request this Honorable Court Grant his Motion for Partial Summary Disposition.

Respectfully submitted,

HOM, CORBETT, KRAMER,
HARDING & DOMBROWSKI

/s/Angela Esseily

Angela Esseily (P81816)
Attorney for Defendants Meemic Insurance Company
150 West Jefferson; Suite 1500
Detroit, Michigan 48226
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com

DATED: October 25, 2022

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EXHIBIT A

21-004799-NI FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 5/25/2021 9:41 AM Carlita McMiller

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH WILLIAM CANTY,

Plaintiff,

CT NO: 21-004799-NI
HON. LITA MASINI POPKE

-vs-

MICHAEL CHESTER MASON,

Defendant.
_____/

PROOF OF SERVICE
The Undersigned certifies that the forgoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on this 25th day of May 2021.

☐ US Mail ☐ Fax
☐ Hand Delivered ☐ UPS
☐ Fed Express ☒ E-Filed
☐ Other

Signature *s/ Kellie T. Klingel*

APPLEBAUM & STONE, PLC
ERIK J. STONE (P55304)
Attorney for Plaintiff
26777 Central Park Blvd Suite 300
Southfield, Michigan 48076
248-233-5050 / 248-359-8524 (Fax)
estone@applebaumstone.com

KRAMER, CORBETT,
HARDING & DOMBROWSKI
BY: ANGELA ESSEILY (P81816)
Attorney for Defendant MICHAEL CHESTER MASON
150 West Jefferson; Suite 1500
Detroit, Michigan 48226
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com
_____/

DEFENDANT'S ANSWER TO COMPLAINT AND AFFIRMATIVE DEFENSES

NOW COMES Defendant, MICHAEL CHESTER MASON, by and through his attorneys, KRAMER, CORBETT, HARDING & DOMBROWSKI, and in answer to Plaintiff's Complaint says as follows:

PARTIES, JURISDICTION AND VENUE

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1. Answering paragraph 1, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

2. Answering paragraph 2, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

3. Answering paragraph 3, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

4. Answering paragraph 4, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

5. Answering paragraph 5, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

6. Answering paragraph 6, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

7. Answering paragraph 7, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

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8. Answering paragraph 8, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

9. Answering paragraph 9, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

10. Answering paragraph 10, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

11. Answering paragraph 11, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

GENERAL ALLEGATIONS

12. Defendant repeats and realleges each and every answer contained in paragraphs 1 through 11 of PARTIES, JURISDICTION AND VENUE as if set forth word for word and paragraph by paragraph.

13. Answering paragraph 13, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

14. Answering paragraph 14, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

15. Answering paragraph 15, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

16. Answering paragraph 16, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

17. Answering paragraph 17, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

18. Answering paragraph 18, Defendant denies the allegations contained therein since they are untrue.

19. Answering paragraph 19, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

20. Answering paragraph 20, Defendant denies the allegations contained therein since they are untrue.

21. Answering paragraph 21, Defendant denies the allegations contained therein since they are untrue.

22. Answering paragraph 22, Defendant denies the allegations contained therein since they are untrue.

23. Answering paragraph 23, Defendant denies the allegations contained therein since they are untrue.

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24. Answering paragraph 24, Defendant denies the allegations contained therein since they are untrue.

25. Answering paragraph 25, Defendant denies the allegations contained therein since they are untrue.

COUNT I - COUNT TWO (SIC) AUTOMOBILE NEGLIGENCE AGAINST DEFENDANT MICHAEL CHESTER MASON

26. Defendant repeats and realleges each and every answer contained in paragraphs 1 through 11 of PARTIES, JURISDICTION AND VENUE and paragraphs 13 through 25 of GENERAL ALLEGATIONS as if set forth word for word and paragraph by paragraph.

27. Answering paragraph 27, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

28. Answering paragraph 28, Defendant denies the allegations contained therein since they are untrue.

29. Answering paragraph 29, Defendant denies the allegations contained therein since they are untrue.

30. Answering paragraph 30, Defendant denies the allegations contained therein since they are untrue.

31. Answering paragraph 31, Defendant denies the allegations contained therein since they are untrue.

32. Answering paragraph 32, Defendant denies the allegations contained therein since they are untrue.

33. Answering paragraph 33, Defendant denies the allegations contained therein since they are untrue.

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34. Answering paragraph 34, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

35. Answering paragraph 35, Defendant denies the allegations contained therein since they are untrue.

36. Answering paragraph 36, Defendant denies the allegations contained therein since they are untrue.

37. Answering paragraph 37, Defendant denies the allegations contained therein since they are untrue.

38. Answering paragraph 38, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

39. Answering paragraph 39, Defendant neither admits nor denies the allegations contained therein, since he is without knowledge or information sufficient to form a belief as to the truth of these allegations and, therefore, leaves Plaintiff to his proofs.

40. Answering paragraph 40, Defendant denies the allegations contained therein since they are untrue.

41. Answering paragraph 41, Defendant denies the allegations contained therein since they are untrue.

42. Answering paragraph 42, Defendant denies the allegations contained therein since they are untrue.

WHEREFORE, Defendant prays for a judgment of no cause for action or, in the alternative, that this cause be dismissed together with costs and attorney fees.

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KRAMER, CORBETT,
HARDING & DOMBROWSKI

/s/ Angela Esseily
ANGELA ESSEILY (P81816)
Attorney for Defendant MICHAEL CHESTER MASON
150 West Jefferson; Suite 1500
Detroit, Michigan 48226
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com

DATED: May 25, 2021

AFFIRMATIVE DEFENSES

Defendant, MICHAEL CHESTER MASON, through his attorneys, KRAMER, CORBETT, HARDING & DOMBROWSKI, hereby avers by way of Affirmative Defenses as follows:

1. Plaintiff's claims are barred for the reason that the process issued herein is insufficient. MCR 2.116(C)(2).

2. Plaintiff's claims are barred by improper service of process, as there was no service of the Summons or Complaint upon the Defendant. MCR 2.116(C)(3).

3. Plaintiff has failed to state a claim upon which relief can be granted. MCR 2.116(C)(8).

4. Plaintiff's claims are barred for the reason that, except as to the amount of damages, there is no genuine issue as to any material fact, and Defendant is entitled to judgment or partial judgment as a matter of law. MCR 2.116(C)(10) .

5. That Plaintiff failed to use ordinary care to mitigate his damages and may not be compensated for damages which resulted from failure to use such care.

6. That Plaintiff's claims are barred, in whole or in part, by the doctrine(s) of res judicata and/or collateral estoppel.

7. That the benefits claimed by Plaintiff in his action, are not past due, pursuant to MCL 500.3142(1), as such losses have not yet accrued.

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8. That Plaintiff's claims are based upon an assignment of a right to benefits payable in the future and are therefore invalid pursuant to MCL 500.3143.

9. Plaintiff's claims, in whole or in part, are fraudulent or so excessive as to have no reasonable foundation, entitling Defendant to an award representing an attorney fee for the cost of defending this action pursuant to MCL 500.3148(2).

10. That Plaintiff's benefits are not past due, nor did Defendant unreasonably delay or refuse to pay such benefits as there existed a reasonable question of entitlement and/or a reasonable question of law such that Plaintiff is not entitled to an attorney fee pursuant to MCL 500.3148(1).

11. That Plaintiff's claims for benefits are not causally related to any injuries allegedly sustained as a result of the accident complained of by Plaintiff.

12. Plaintiff's claim for personal protection insurance benefits represents unreasonable, unnecessary and/or excessive charges contrary to the Michigan No-Fault Act and the policy provisions. MCL 500.3107 and MCL 500.3157.

13. Plaintiff's entitlement to personal protection insurance benefits under the alleged policy of insurance with Defendant is in dispute, in whole or in part, on the basis that the Plaintiff's claim for allowable expenses is for unreasonable or excessive charges, or were incurred for products and services which were not reasonably necessary or otherwise not causally related to injuries allegedly sustained as a result of the automobile accident complained of by Plaintiff.

14. That Plaintiff and/or those acting in concert with him have misrepresented material facts in connection with the procurement of the policy at issue and/or his claims under said policy, thereby voiding the policy and any applicable coverage there under.

15. That Defendant has complied with all of the applicable statutes and insurance policy provisions in the handling and processing of Plaintiff's claims.

16. That any damages allegedly sustained by Plaintiff were a proximate result of Plaintiff own negligence and/or comparative negligence.

17. That any damages allegedly sustained by Plaintiff were a proximate result of the actions and/or negligence of persons and/or parties not under the control or jurisdiction of Defendant.

18. That any damages recovered by Plaintiff must be reduced in proportion to the fault attributable to him.

19. That any damages claimed by Plaintiff were not a proximate result of the accident at issue herein.

20. That Plaintiff created a sudden emergency thereby denying Defendant an assured clear distance ahead in which to stop.

21. At the time and place alleged Defendant was confronted with a sudden emergency situation not of his own making, and for which Defendant has no liability, in response to which they acted as a reasonable and prudent person would have done under like or similar circumstances.

22. Plaintiff has not suffered death, serious impairment of body function or permanent, serious disfigurement as required by MCL 500.3135 to recover damages in this action.

23. That Plaintiff's claims for economic loss are barred, in whole or in part, by the Michigan No-Fault Act, MCL 500.3135.

24. To the extent Plaintiff is found to have sustained work loss damages in excess of the limits provided for in MCL 500.3107(1)(b), Defendant is entitled to the deduction set forth in MCL 500.3135(3)(c).

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25. Defendant is entitled to all relief and set-offs permitted by the Tort Reform Act, being PA 1986, No. 178; MCL 600.6301 et seq.

26. That Plaintiff is barred from recovering damages because he is more than fifty percent (50%) at fault with regard to the accident herein.

27. That Plaintiff is barred from recovering non-economic damages herein because at the time of the accident in which the injury occurred he was operating his own vehicle which did not have in effect for that motor vehicle security required by Section 3101 of the No Fault Act.

28. Plaintiff is barred from recovering any damages herein because at the time of the accident Plaintiff had an impaired ability to function due to the influence of intoxicating liquor or a controlled substance, and as a result of that impaired ability, Plaintiff fifty percent (50%) or more the cause of the accident or event that resulted in death or injury.

29. Plaintiff has a greater percentage of negligence than Defendant because Plaintiff had the last clear chance to avoid the accident.

30. Plaintiff has failed to provide proof that all PIP has been exhausted.

31. PIP coverage has not been exhausted and as such, any claim for economic damages are barred.

32. Plaintiff holds unlimited PIP coverage, and consequently cannot claim economic damages and/or excess medical.

33. Plaintiff's claim for excess medical is not ripe.

Defendant reserves the right to assert any other Affirmative Defenses, which may become apparent as a result of discovery proceedings.

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KRAMER, CORBETT,
HARDING & DOMBROWSKI

/s/ Angela Esseily
ANGELA ESSEILY (P81816)
Attorney for Defendant MICHAEL CHESTER MASON
150 West Jefferson; Suite 1500
Detroit, Michigan 48226
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com

DATED: May 25, 2021

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EXHIBIT B

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Policy Declarations

A summary of your auto insurance coverage

Liberty Mutual INSURANCE

Reason for this notice:

- Cancellation Non-Payment

Effective date of this change: 03/18/2021

QUESTIONS ABOUT YOUR POLICY?
By Phone
For Service:
1-800-225-7014

Liberty Mutual
PO Box 958416
Lake Mary, FL 32795-9959

Policy Declarations

INSURANCE INFORMATION

Named Insured:	Joseph Canty
Policy Number:	AOV-243-684347-40 0 4
Policy Period:	08/25/2020-03/18/2021 12:01 AM standard time at the address of the Named Insured as stated below.
Mailing Address:	23600 W 7 Mile Rd Apt D210 Apt D210 Detroit MI 48219-5610

Premium Adjustment from 03/18/2021 to 03/18/2021

VEH 1 [redacted]

Total Adjustment [redacted]

Total Adjustment Includes: MCCA and Auto Theft Fee Adjustment Of [redacted]

Assessment Recoupments: $1.00

Total Annual Policy Premium : [redacted]

Your discounts and benefits have been applied. Includes state sales tax and local surcharge where applicable.

Endorsements - Changes to Your Policy

Amendment of Policy Provisions - Michigan AS2281 07 20
Automobile Amendatory Endorsement AS3742 05 16
Amendatory Endorsement AS3905MI 10 17
Personal Injury Protection Coverage - Michigan AS2141 07 20
Amendment of Policy Definitions AS3647 03 10
Property Protection Coverage - Michigan PP 05 91 11 94
Nuclear, Bio-Chemical & Mold Exclusion Endorsement AS3660 03 10
Split Liability Limits PP 03 09 04 86
Coverage For Damage To Your Auto Exclusion Endorsement PP 13 01 12 99
Mutual Holding Company 2340e

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Liberty Mutual INSURANCE

LibertyGuard Auto Policy Declaration provided and underwritten by
Liberty Mutual Personal Insurance Company, Boston, MA.

This policy, including endorsements listed above,
is countersigned by:

Authorized Representative

President

Secretary

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Questions about your Policy?
Call 1-800-225-7014

Policy Number:
AOV-243-684347-40 0 4

Report a Claim:
1-800-2CLAIMS

Liberty Mutual INSURANCE

ACTION REQUIRED:
PLEASE REVIEW AND KEEP FOR YOUR RECORDS.

Policy Declarations

Total Annual Costs:* [redacted]

(Including Recoupments)

Save an estimated $24 annually by switching to Paid-in-Full

Policy Declarations

Bill Frequency: Monthly Installment Fee Per Payment: $2.00
*Total Annual policy premium above does not include installment fees.

All eligible discounts and benefits have been applied. Includes state sales tax and local surcharge where applicable.

Insurance Information

Named Insured:	Joseph Canty	Policy Number:	AOV-243-684347-40 0 4
Mailing Address:	23600 W 7 Mile Rd Apt D210 Apt D210 Detroit MI 48219-5610	Policy Period:	Coverage begins at the later of: (1) 12:01 AM on 08/25/2020, or (2) The time that the application for insurance is submitted and the policy is bound. No coverage is provided prior to the policy being bound. Coverage will expire at 12:01 AM on 08/25/2021
		Declarations Effective:	08/25/2020
		Affinity Affiliation:	Public Service Credit Union

Vehicles Covered by Your Auto Policy

	YEAR	MAKE	MODEL	VEHICLE ID NUMBER
1	2015	CHEVROLET	MALIBU	1G11C5SLXFF342067

Driver Information

	NAME	STATE	NAME	STATE
1	Joseph Canty	MI		

To ensure proper coverage, please contact us to add drivers not listed above.

DISCOUNTS AND BENEFITS SECTION

Your discounts and benefits have been applied to your Total Annual Policy Premium.

Policy Discounts

- Early Shopper Discount
- Claims Free Discount
- Good Payer Discount
- Military Discount
- Multi-Policy Discount
- Paperless Discount
- Preferred Payment Discount
- Violation Free Discount

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DISCOUNTS AND BENEFITS SECTION continued

Policy Benefits

Accident Forgiveness:
This policy is not eligible for Accident Forgiveness

New Car Replacement:
New Car Replacement is not included with this policy

Coverage Information

Your total annual policy premium for all covered vehicles is shown below. A premium is shown for each type of coverage you have purchased for each vehicle. Where no premium is shown, you have not purchased the indicated coverage for that vehicle.

COVERAGE	LIMITS	PREMIUM PER VEHICLE
		VEH 1 2015 CHEVROL MALIBU
A. Liability		
Bodily Injury	$ 50,000 Each Person	[redacted]
	$ 100,000 Each Accident	
Property Damage	$ 50,000 Each Accident	
C. Uninsured Motorists Has Been Rejected		
Personal Injury Protection (PIP)		
No PIP Medical		
$500 Deductible		
Work Loss Exclusion Applies		
Add'l Property Damage Liability Cov - $3,000		
Property Protection Coverage $1,000,000		
Annual Premium Per Vehicle:		

Total Annual Policy Premium: [redacted]

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Coverage Information continued

Programs Required by State Law

	VEH 1
MI Catastrophic Claims Association Deficit	$0.00
MI Auto Theft Prevention Authority	$1.00

Total Programs Required by State Law: $1.00

Total Annual Policy Costs (including Recoupments) [redacted]

Additional Coverages and Products Available*

We've reviewed your policy and have identified additional optional coverages and products that can add valuable protection. Talk to your agent about purchasing the following coverages and products and whether they meet your needs.

- Multi-Policy Discounts: Having more than one insurance policy with Liberty Mutual can save you time and money. Learn more about how you can bundle your auto, home, renters, condo, or umbrella insurance.

*These optional coverages are subject to policy provisions, limitations, and exclusions. Daily limits or a deductible may apply. For a complete explanation, please consult your agent today.

Financial Stability Score: 414

Policy Forms and Endorsements: The following forms and endorsements are applicable to your policy.

Amendment of Policy Provisions - Michigan AS2281 07 20
Amendatory Endorsement AS3905MI 10 17
Amendment of Policy Definitions AS3647 03 10
Nuclear, Bio-Chemical & Mold Exclusion Endorsement AS3660 03 10
Coverage For Damage To Your Auto Exclusion Endorsement PP 13 01 12 99
Automobile Amendatory Endorsement AS3742 05 16
Personal Injury Protection Coverage - Michigan AS2141 07 20
Property Protection Coverage - Michigan PP 05 91 11 94
Split Liability Limits PP 03 09 04 86
Mutual Holding Company 2340e

Special State Provisions

YOU HAVE QUALIFIED FOR THE FOLLOWING POTENTIAL SAVINGS BASED ON YOUR PERSONAL INJURY PROTECTION SELECTION(S):

$13.00 for the selected PIP Deductible

WARNING

ONE OR MORE OF THE INSUREDS UNDER THIS POLICY HAVE BEEN EXCLUDED FROM PERSONAL INJURY PROTECTION BENEFITS BASED ON THE AVAILABILITY OF QUALIFIED HEALTH COVERAGE. IF YOUR AVAILABLE QUALIFIED HEALTH COVERAGE CHANGES YOU MUST ADVISE US WITHIN 30 DAYS. YOU MUST OBTAIN COVERAGE FOR PERSONAL INJURY PROTECTION MEDICAL BENEFITS FOR SUCH PERSON(S) WITHIN 30 DAYS AFTER THE EFFECTIVE DATE OF THE TERMINATION OF QUALIFIED HEALTH COVERAGE OR THE PERSON(S) WILL NOT BE ENTITLED TO ANY PIP MEDICAL BENEFITS UNDER THIS POLICY AS PER MCL 500.3107d(6) AND MCL 500.3109a(2)(d)(i).

Canty MOA App'x, p.067a

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LibertyGuard Auto Policy Declaration provided and underwritten by Liberty Mutual Personal Insurance Company (a stock insurance company), Boston, MA.

President

Secretary

This policy, including endorsements listed above, is countersigned by:

Authorized Representative

Canty MOA App'x, p.068a

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Liberty Mutual INSURANCE

LibertyGuard Auto Policy

Please read your policy and each endorsement carefully.

To serve you best...

Liberty Mutual has over 300 offices throughout the United States. Please contact your service office shown on your Declarations Page to report losses, or for any changes or questions about your insurance. Payments should be sent to the office indicated on your bill.

THIS POLICY IS NONASSESSABLE

Liberty Mutual Insurance Group

AUTO 3422 Ed. 6-94 R1

[redacted]

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Liberty Mutual INSURANCE

LIBERTYGUARD AUTO POLICY
QUICK REFERENCE
DECLARATIONS PAGE

Your Name and Address
Your Auto or Trailer
Policy Period
Coverages and Amounts of Insurance

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*These conditions apply only if Liberty Mutual Fire Insurance Company is shown in the Declarations as the insurer.

[redacted]

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Liberty Mutual INSURANCE

AUTO POLICY

AGREEMENT

In return for payment of the premium and subject to all the terms of this policy, we agree with you as follows:

DEFINITIONS

A. Throughout this policy, "you" and "your" refer to:

1. The "named insured" shown in the Declarations; and
2. The spouse if a resident of the same household.

B. "We," "us" and "our" refer to the Company providing this insurance.

C. For purposes of this policy, a private passenger type auto shall be deemed to be owned by a person if leased:

1. Under a written agreement to that person; and
2. For a continuous period of at least 6 months.

Other words and phrases are defined. They are in quotation marks when used.

D. "Bodily injury" means bodily harm, sickness or disease, including death that results.

E. "Business" includes trade, profession or occupation.

F. "Family member" means a person related to you by blood, marriage or adoption who is a resident of your household. This includes a ward or foster child.

G. "Occupying" means in, upon, getting in, on, out or off.

H. "Property damage" means physical injury to, destruction of or loss of use of tangible property.

I. "Trailer" means a vehicle designed to be pulled by a:

1. Private passenger auto; or
2. Pickup or van.

It also means a farm wagon or farm implement while towed by a vehicle listed in 1. or 2. above.

J. "Your covered auto" means:

1. Any vehicle shown in the Declarations.
2. Any of the following types of vehicles on the date you become the owner:

   a. a private passenger auto; or

   b. a pickup or van that:

      (1) has a Gross Vehicle Weight of less than 10,000 lbs.; and

      (2) is not used for the delivery or transportation of goods and materials unless such use is:

         (a) incidental to your "business" of installing, maintaining or repairing furnishings or equipment; or

         (b) for farming or ranching.

   This provision (J.2.) applies only if:

   a. you acquire the vehicle during the policy period;

   b. you ask us to insure it within 30 days after you become the owner; and

   c. with respect to a pickup or van, no other insurance policy provides coverage for that vehicle.

   If the vehicle you acquire replaces one shown in the Declarations, it will have the same coverage as the vehicle it replaced. You must ask us to insure a replacement vehicle within 30 days only if you wish to add or continue Coverage for Damage to Your Auto.

   If the vehicle you acquire is in addition to any shown in the Declarations, it will have the broadest coverage we now provide for any vehicle shown in the Declarations.

3. Any "trailer" you own.

4. Any auto or "trailer" you do not own while used as a temporary substitute for any other vehicle described in this definition which is out of normal use because of its:

   a. breakdown; d. loss; or
   b. repair; e. destruction.
   c. servicing;

   This provision (J.4.) does not apply to Coverage for Damage to Your Auto.

Canty MOA App'x, p.071a

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Liberty Mutual INSURANCE

PART A - LIABILITY COVERAGE

INSURING AGREEMENT

A. We will pay damages for "bodily injury" or "property damage" for which any "insured" becomes legally responsible because of an auto accident. Damages include pre-judgment interest awarded against the "insured." We will settle or defend, as we consider appropriate, any claim or suit asking for these damages. In addition to our limit of liability, we will pay all defense costs we incur. Our duty to settle or defend ends when our limit of liability for this coverage has been exhausted. We have no duty to defend any suit or settle any claim for "bodily injury" or "property damage" not covered under this policy.

B. "Insured" as used in this Part means:

1. You or any "family member" for the ownership, maintenance or use of any auto or "trailer."
2. Any person using "your covered auto."
3. For "your covered auto," any person or organization but only with respect to legal responsibility for acts or omissions of a person for whom coverage is afforded under this Part.
4. For any auto or "trailer," other than "your covered auto," any other person or organization but only with respect to legal responsibility for acts or omissions of you or any "family member" for whom coverage is afforded under this Part. This provision (B.4.) applies only if the person or organization does not own or hire the auto or "trailer."

SUPPLEMENTARY PAYMENTS

In addition to our limit of liability, we will pay on behalf of an "insured":

1. Up to $250 for the cost of bail bonds required because of an accident, including related traffic law violations. The accident must result in "bodily injury" or "property damage" covered under this policy.
2. Premiums on appeal bonds and bonds to release attachments in any suit we defend.
3. Interest accruing after a judgment is entered in any suit we defend. Our duty to pay interest ends when we offer to pay that part of the judgment which does not exceed our limit of liability for this coverage.
4. Up to $50 a day for loss of earnings, but not other income, because of attendance at hearings or trials at our request.
5. Other reasonable expenses incurred at our request.

EXCLUSIONS

A. We do not provide Liability Coverage for any "insured":

1. Who intentionally causes "bodily injury" or "property damage."
2. For "property damage" to property owned or being transported by that "insured."
3. For "property damage" to property:
   a. rented to;
   b. used by; or
   c. in the care of;
   that "insured."
   This exclusion (A.3.) does not apply to "property damage" to a residence or private garage.
4. For "bodily injury" to an employee of that "insured" during the course of employment. This exclusion (A.4.) does not apply to "bodily injury" to a domestic employee unless workers' compensation benefits are required or available for that domestic employee.
5. For that "insured's" liability arising out of the ownership or operation of a vehicle while it is being used as a public or livery conveyance. This exclusion (A.5.) does not apply to a share-the-expense car pool.
6. While employed or otherwise engaged in the "business" of:
   a. selling; d. storing; or
   b. repairing; e. parking;
   c. servicing;
   vehicles designed for use mainly on public highways. This includes road testing and delivery. This exclusion (A.6.) does not apply to the ownership, maintenance or use of "your covered auto" by:
   a. you;
   b. any "family member;" or
   c. any partner, agent or employee of you or any "family member."
7. Maintaining or using any vehicle while that "insured" is employed or otherwise engaged in any "business" (other than farming or ranching) not described in exclusion A.6.
   This exclusion (A.7.) does not apply to

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the maintenance or use of a:

a. Private passenger auto;

b. Pickup or van that:

(1) You own; or

(2) You do not own while used as a temporary substitute for "your covered auto" which is out of normal use because of its:

a. breakdown; d. loss; or
b. repair; e. destruction; or
c. servicing;

c. "Trailer" used with a vehicle described in a. or b. above.

8. Using a vehicle without a reasonable belief that that "insured" is entitled to do so.

9. For "bodily injury" or "property damage" for which that "insured:"

a. is an insured under a nuclear energy liability policy; or

b. would be an insured under a nuclear energy liability policy but for its termination upon exhaustion of its limit of liability.

A nuclear energy liability policy is a policy issued by any of the following or their successors:

a. American Nuclear Insurers;

b. Mutual Atomic Energy Liability Underwriters; or

c. Nuclear Insurance Association of Canada.

B. We do not provide Liability Coverage for the ownership, maintenance or use of:

1. Any vehicle which:

a. Has fewer than four wheels; or

b. Is designed mainly for use off public roads.

This exclusion (B.1.) does not apply:

a. While such vehicle is being used by an "insured" in a medical emergency; or

b. To any "trailer."

2. Any vehicle, other than "your covered auto," which is:

a. owned by you; or

b. furnished or available for your regular use.

3. Any vehicle, other than "your covered auto," which is:

a. owned by any "family member;" or

b. furnished or available for the regular use of any "family member."

However, this exclusion (B.3.) does not apply to you while you are maintaining or "occupying" any vehicle which is:

a. owned by a "family member;" or

b. furnished or available for the regular use of a "family member."

4. Any vehicle, located inside a facility designed for racing, for the purpose of:

a. Competing in; or

b. Practicing or preparing for;

any prearranged or organized racing or speed contest.

LIMIT OF LIABILITY

A. The limit of liability shown in the Declarations for this coverage is our maximum limit of liability for all damages resulting from any one auto accident. This is the most we will pay regardless of the number of:

1. "Insureds;"
2. Claims made;
3. Vehicles or premiums shown in the Declarations; or
4. Vehicles involved in the auto accident.

B. We will apply the limit of liability to provide any separate limits required by law for bodily injury and property damage liability. However, this provision (B.) will not change our total limit of liability.

C. No one will be entitled to receive duplicate payments for the same elements of loss under this coverage and:

1. Part B or Part C of this policy; or
2. Any Underinsured Motorists Coverage provided by this policy.

OUT OF STATE COVERAGE

If an auto accident to which this policy applies occurs in any state or province other than the one in which "your covered auto" is principally garaged, we will interpret your policy for that accident as follows:

A. If the state or province has:

1. A financial responsibility or similar law specifying limits of liability for "bodily injury" or "property damage" higher than the limit shown in the Declarations, your policy will provide the higher specified limit.

2. A compulsory insurance or similar law requiring a nonresident to maintain insurance whenever the nonresident uses a vehicle in that state or province, your policy will provide at least the required minimum amounts and types of coverage.

B. No one will be entitled to duplicate payments for the same elements of loss.

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Liberty Mutual INSURANCE

FINANCIAL RESPONSIBILITY

When this policy is certified as future proof of financial responsibility, this policy shall comply with the law to the extent required.

OTHER INSURANCE

If there is other applicable liability insurance we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide for a vehicle you do not own shall be excess over any other collectible insurance.

PART B - MEDICAL PAYMENTS COVERAGE

INSURING AGREEMENT

A. We will pay reasonable expenses incurred for necessary medical and funeral services because of "bodily injury:"

1. Caused by accident; and

2. Sustained by an "insured."

We will pay only those expenses incurred for services rendered within 3 years from the date of the accident.

B. "Insured" as used in this Part means:

1. You or any "family member:"

a. while "occupying;" or

b. as a pedestrian when struck by;

a motor vehicle designed for use mainly on public roads or a trailer of any type.

2. Any other person while "occupying" "your covered auto."

EXCLUSIONS

We do not provide Medical Payments Coverage for any "insured" for "bodily injury:"

1. Sustained while "occupying" any motorized vehicle having fewer than four wheels.

2. Sustained while "occupying" "your covered auto" when it is being used as a public or livery conveyance. This exclusion (2.) does not apply to a share-the-expense car pool.

3. Sustained while "occupying" any vehicle located for use as a residence or premises.

4. Occurring during the course of employment if workers' compensation benefits are required or available for the "bodily injury."

5. Sustained while "occupying," or when struck by, any vehicle (other than "your covered auto") which is:

a. owned by you; or

b. furnished or available for your regular use.

6. Sustained while "occupying," or when struck by, any vehicle (other than "your covered auto") which is:

a. owned by any "family member;" or

b. furnished or available for the regular use of any "family member."

However, this exclusion (6.) does not apply to you.

7. Sustained while "occupying" a vehicle without a reasonable belief that that "insured" is entitled to do so.

8. Sustained while "occupying" a vehicle when it is being used in the "business" of an "insured." This exclusion (8.) does not apply to "bodily injury" sustained while "occupying" a:

a. private passenger auto;

b. pickup or van that you own; or

c. "trailer" used with a vehicle described in a. or b. above.

9. Caused by or as a consequence of:

a. discharge of a nuclear weapon (even if accidental);

b. war (declared or undeclared);

c. civil war;

d. insurrection; or

e. rebellion or revolution.

10. From or as a consequence of the following, whether controlled or uncontrolled or however caused:

a. nuclear reaction;

b. radiation; or

c. radioactive contamination.

11. Sustained while "occupying" any vehicle located inside a facility designed for racing, for the purpose of:

a. competing in; or

b. practicing or preparing for;

any prearranged or organized racing or speed contest.

LIMIT OF LIABILITY

A. The limit of liability shown in the Declarations for this coverage is our maximum limit of liability for each person injured in any one accident. This is the most we will pay regardless of the number of:

1. "Insureds;"

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2. Claims made;
3. Vehicles or premiums shown in the Declarations; or
4. Vehicles involved in the accident.

B. No one will be entitled to receive duplicate payments for the same elements of loss under this coverage and:
1. Part A or Part C of this policy; or
2. Any Underinsured Motorists Coverage provided by this policy.

OTHER INSURANCE

If there is other applicable auto medical payments insurance we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide with respect to a vehicle you do not own shall be excess over any other collectible auto insurance providing payments for medical or funeral expenses.

PART C - UNINSURED MOTORISTS COVERAGE

INSURING AGREEMENT

A. We will pay compensatory damages which an "insured" is legally entitled to recover from the owner or operator of an "uninsured motor vehicle" because of "bodily injury:"
1. Sustained by an "insured;" and
2. Caused by an accident.

The owner's or operator's liability for these damages must arise out of the ownership, maintenance or use of the "uninsured motor vehicle."

Any judgment for damages arising out of a suit brought without our written consent is not binding on us.

B. "Insured" as used in this Part means:
1. You or any "family member."
2. Any other person "occupying" "your covered auto."
3. Any person for damages that person is entitled to recover because of "bodily injury" to which this coverage applies sustained by a person described in 1. or 2. above.

C. "Uninsured motor vehicle" means a land motor vehicle or trailer of any type:
1. To which no bodily injury liability bond or policy applies at the time of the accident.
2. To which a bodily injury liability bond or policy applies at the time of the accident. In this case its limit for bodily injury liability must be less than the minimum limit for bodily injury liability specified by the financial responsibility law of the state in which "your covered auto" is principally garaged.
3. Which is a hit-and-run vehicle whose operator or owner cannot be identified and which hits:
   a. you or any "family member;"
   b. a vehicle which you or any "family member" are "occupying;" or
   c. "your covered auto."
4. To which a bodily injury liability bond or policy applies at the time of the accident but the bonding or insuring company:
   a. denies coverage; or
   b. is or becomes insolvent.

However, "uninsured motor vehicle" does not include any vehicle or equipment:
1. Owned by or furnished or available for the regular use of you or any "family member."
2. Owned or operated by a self-insurer under any applicable motor vehicle law, except a self-insurer which is or becomes insolvent.
3. Owned by any governmental unit or agency.
4. Operated on rails or crawler treads.
5. Designed mainly for use off public roads while not on public roads.
6. While located for use as a residence or premises.

EXCLUSIONS

A. We do not provide Uninsured Motorists Coverage for "bodily injury" sustained:
1. By an "insured" while "occupying," or when struck by, any motor vehicle owned by that "insured" which is not insured for this coverage under this policy. This includes a trailer of any type used with that vehicle.
2. By any "family member" while "occupying," or when struck by, any motor vehicle you own which is insured for this coverage on a primary basis under any other policy.

B. We do not provide Uninsured Motorists Coverage for "bodily injury" sustained by any "insured:"
1. If that "insured" or the legal

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representative settles the "bodily injury" claim without our consent.

2. While "occupying" "your covered auto" when it is being used as a public or livery conveyance. This exclusion (B.2.) does not apply to a share-the-expense car pool.
3. Using a vehicle without a reasonable belief that that "insured" is entitled to do so.

C. This coverage shall not apply directly or indirectly to benefit any insurer or self-insurer under any of the following or similar law:
1. Workers' compensation law; or
2. Disability benefits law.

D. We do not provide Uninsured Motorists Coverage for punitive or exemplary damages.

LIMIT OF LIABILITY

A. The limit of liability shown in the Declarations for this coverage is our maximum limit of liability for all damages resulting from any one accident. This is the most we will pay regardless of the number of:
1. "Insureds;"
2. Claims made;
3. Vehicles or premiums shown in the Declarations; or
4. Vehicles involved in the accident.

B. No one will be entitled to receive duplicate payments for the same elements of loss under this coverage and:
1. Part A or Part B of this policy; or
2. Any Underinsured Motorists Coverage provided by this policy.

C. We will not make a duplicate payment under this coverage for any element of loss for which payment has been made by or on behalf of persons or organizations who may be legally responsible.

D. We will not pay for any element of loss if a person is entitled to receive payment for the same element of loss under any of the following or similar law:
1. Workers' compensation law; or
2. Disability benefits law.

OTHER INSURANCE

If there is other applicable insurance available under one or more policies or provisions of coverage:

1. Any recovery for damages under all such policies or provisions of coverage may equal but not exceed the highest applicable limit for any one vehicle under any insurance providing coverage on either a primary or excess basis.
2. Any insurance we provide with respect to a vehicle you do not own shall be excess over any collectible insurance providing coverage on a primary basis.
3. If the coverage under this policy is provided:
   a. On a primary basis, we will pay only our share of the loss that must be paid under insurance providing coverage on a primary basis. Our share is the proportion that our limit of liability bears to the total of all applicable limits of liability for coverage provided on a primary basis.
   b. On an excess basis, we will pay only our share of the loss that must be paid under insurance providing coverage on an excess basis. Our share is the proportion that our limit of liability bears to the total of all applicable limits of liability for coverage provided on an excess basis.

ARBITRATION

A. If we and an "insured" do not agree:
1. Whether that "insured" is legally entitled to recover damages; or
2. As to the amount of damages which are recoverable by that "insured;"

from the owner or operator of an "uninsured motor vehicle," then the matter may be arbitrated. However, disputes concerning coverage under this Part may not be arbitrated.

Both parties must agree to arbitration. If so agreed, each party will select an arbitrator. The two arbitrators will select a third. If they cannot agree within 30 days, either may request that selection be made by a judge of a court having jurisdiction.

B. Each party will:
1. Pay the expenses it incurs; and
2. Bear the expenses of the third arbitrator equally.

C. Unless both parties agree otherwise, arbitration will take place in the county in which the "insured" lives. Local rules of law as to procedure and evidence will apply. A decision agreed to by two of the arbitrators will be binding as to:
1. Whether the "insured" is legally entitled to recover damages; and
2. The amount of damages. This applies only if the amount does not exceed the

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minimum limit for bodily injury liability specified by the financial responsibility law of the state in which "your covered auto" is principally garaged. If the amount exceeds that limit, either party may demand the right to a trial. This demand must be made within 60 days of the arbitrators' decision. If this demand is not made, the amount of damages agreed to by the arbitrators will be binding.

PART D - COVERAGE FOR DAMAGE TO YOUR AUTO

INSURING AGREEMENT

A. We will pay for direct and accidental loss to "your covered auto" or any "non-owned auto," including their equipment, minus any applicable deductible shown in the Declarations. If loss to more than one "your covered auto" or "non-owned auto" results from the same "collision," only the highest applicable deductible will apply. We will pay for loss to "your covered auto" caused by:

1. Other than "collision" only if the Declarations indicate that Other Than Collision Coverage is provided for that auto.
2. "Collision" only if the Declarations indicate that Collision Coverage is provide d for that auto.

If there is a loss to a "non-owned auto," we will provide the broadest coverage applicable to any "your covered auto" shown in the Declarations.

B. "Collision" means the upset of "your covered auto" or a "non-owned auto" or their impact with another vehicle or object.

Loss caused by the following is considered other than "collision:"

1. Missiles or falling objects;
2. Fire;
3. Theft or larceny;
4. Explosion or earthquake;
5. Windstorm;
6. Hail. Water or flood;
7. Malicious mischief or vandalism
8. Riot or civil commotion;
9. Contact with bird or animal; or
10. Breakage of glass.

If breakage of glass is caused by a "collision," you may elect to have it considered a loss caused by "collision."

C. "Non-owned auto" means:

1. Any private passenger auto, pickup, van or "trailer" not owned by or furnished or available for the regular use of you or any "family member" while in the custody of or being operated by you or any "family member;" or
2. Any auto or "trailer" you do not own while used as a temporary substitute for "your covered auto" which is out of normal use because of its:
   a. breakdown;
   b. repair;
   c. servicing;
   d. loss; or
   e. destruction.

TRANSPORTATION EXPENSES

In addition, we will pay, without application of a deductible, up to $15 per day, to a maximum of $450, for:

1. Temporary transportation expenses incurred by you in the event of a loss to "your covered auto." We will pay for such expenses if the loss is caused by:
   a. Other than "collision" only if the Declarations indicate that Other Than Collision Coverage is provided for that auto.
   b. "Collision" only if the Declarations indicate that Collision Coverage is provided for that auto.
2. Loss of use expenses for which you become legally responsible in the event of loss to a "non-owned auto." We will pay for loss of use expenses if the loss is caused by:
   a. Other than "collision" only if the Delcarations indicate that Other Than Collision Coverage is provided for any "your covered auto."
   b. "Collision" only if the Declarations indicate that Collision Coverage is provided for any "your covered auto."

If the loss is caused by a total theft of "your covered auto" or a "non-owned auto," we will pay only expenses incurred during the period:

1. Beginning 48 hours after the theft; and
2. Ending when "your covered auto" or the "non-owned auto" is returned to use or we pay for its loss.

If the loss is caused by other than theft of a "your covered auto" or a "non-owned auto," we will pay only expenses beginning when the auto is withdrawn from use for more than 24 hours.

Our payment will be limited to that period of time reasonably required to repair or replace the "your covered auto" or the "non-owned auto."

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EXCLUSIONS

We will not pay for:

1. Loss to "your covered auto" or any "non-owned auto" which occurs while it is being used as a public or livery conveyance. This exclusion (1.) does not apply to a share-the-expense car pool.
2. Damage due and confined to:
   a. wear and tear;
   b. freezing;
   c. mechanical or electrical breakdown or failure; or
   d. road damage to tires.

   This exclusion (2.) does not apply if the damage results from the total theft of "your covered auto" or any "non-owned auto."
3. Loss due to or as a consequence of:
   a. radioactive contamination;
   b. discharge of any nuclear weapon (even if accidental);
   c. war (declared or undeclared);
   d. civil war;
   e. insurrection; or
   f. rebellion or revolution.
4. Loss to:
   a. Any electronic equipment designed for the reproduction of sound, including, but not limited to:
      (1) radios and stereos;
      (2) tape decks; or
      (3) compact disc players;
   b. Any other electronic equipment that receives or transmits audio, visual or data signals, including, but not limited to:
      (1) citizens band radios;
      (2) telephones;
      (3) two-way mobile radios;
      (4) scanning monitor receivers;
      (5) television monitor receivers;
      (6) video cassette recorders;
      (7) audio cassette recorders; or
      (8) personal computers;
   c. tapes, records, discs, or other media used with equipment described in a. or b.; or
   d. any other accessories used with equipment described in a. or b.

   This exclusion (4.) does not apply to:
   a. equipment designed solely for the reproduction of sound and accessories used with such equipment, provided:
      (1) The equipment is permanently installed in "your covered auto" or any "non-owned auto;" or
      (2) The equipment is:
         (a) Removable from a housing unit which is permanently installed in the auto;
         (b) Designed to be solely operated by use of the power from the auto's electrical system; and
         (c) In or upon "your covered auto" or any "non-owned auto;"

         at the time of the loss.
   b. any other electronic equipment that is:
      (1) necessary for the normal operation of the auto or the monitoring of the auto's operating systems; or
      (2) an integral part of the same unit housing any sound reproducing equipment described in a. and permanently installed in the opening of the dash or console of "your covered auto" or any "non-owned auto" normally used by the manufacturer for installation of a radio.
5. A total loss to "your covered auto" or any "non-owned auto" due to destruction or confiscation by governmental or civil authorities.

   This exclusion (5.) does not apply to the interests of Loss Payees in "your covered auto."
6. Loss to a camper body or "trailer" you own which is not shown in the Declarations. This exclusion (6.) does not apply to a camper body or "trailer" you:
   a. acquire during the policy period; and
   b. ask us to insure within 30 days after you become the owner.
7. Loss to any "non-owned auto" when used by you or any "family member" without a reasonable belief that you or that "family member" are entitled to do so.
8. Loss to:
   a. awnings or cabanas; or
   b. equipment designed to create additional living facilities.
9. Loss to equipment designed or used for the detection or location of radar or laser.

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10. Loss to any custom furnishings or equipment in or upon any pickup or van. Custom furnishings or equipment include but are not limited to:
    a. special carpeting and insulation, furniture or bars;
    b. facilities for cooking and sleeping;
    c. height-extending roofs; or
    d. custom murals, paintings or other decals or graphics.
11. Loss to any "non-owned auto" being maintained or used by any person while employed or otherwise engaged in the "business" of:
    a. selling; d. storing; or
    b. repairing; e. parking;
    c. servicing;

    vehicles designed for use on public highways. This includes road testing and delivery.
12. Loss to any "non-owned auto" being maintained or used by any person while employed or otherwise engaged in any "business" not described in exclusion 11. This exclusion (12.) does not apply to the maintenance or use by you or any "family member" of a "non-owned auto" which is a private passenger auto or "trailer."
13. Loss to "your covered auto" or any "non-owned auto," located inside a facility designed for racing, for the purpose of:
    a. competing in; or
    b. practicing or preparing for;

    any prearranged or organized racing or speed contest.
14. Loss to, or loss of use of, a "non-owned auto" rented by:
    a. you; or
    b. any "family member;"

    if a rental vehicle company is precluded from recovering such loss or loss of use, from you or that "family member," pursuant to the provisions of any applicable rental agreement or state law.

LIMIT OF LIABILITY

A. Our limit of liability for loss will be the lesser of the:
1. Actual cash value of the stolen or damaged property;
2. Amount necessary to repair or replace the property with other property of like kind and quality.

However, the most we will pay for loss to any "non-owned auto" which is a trailer is $500.

B. An adjustment for depreciation and physical condition will be made in determining actual cash value in the event of a total loss.

C. If a repair or replacement results in better than like kind or quality, we will not pay for the amount of the betterment.

PAYMENT OF LOSS

We may pay for loss in money or repair or replace the damaged or stolen property. We may, at our expense, return any stolen property to:
1. You; or
2. The address shown in this policy.

If we return stolen property we will pay for any damage resulting from the theft. We may keep all or part of the property at an agreed or appraised value.

If we pay for loss in money, our payment will include the applicable sales tax for the damaged or stolen property.

NO BENEFIT TO BAILEE

This insurance shall not directly or indirectly benefit any carrier or other bailee for hire.

OTHER SOURCES OF RECOVERY

If other sources of recovery also cover the loss, we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide with respect to a "non-owned auto" shall be excess over any other collectible source of recovery including, but not limited to:
1. Any coverage provided by the owner of the "non-owned auto;"
2. Any other applicable physical damage insurance;
3. Any other source of recovery applicable to the loss.

APPRAISAL

A. If we and you do not agree on the amount of loss, either may demand an appraisal of the loss. In this event, each party will select a competent appraiser. The two appraisers will select an umpire. The appraisers will state separately the actual cash value and the amount of loss. If they fail to agree, they will submit their differences to the umpire. A decision agreed to by any two will be binding. Each party will:

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1. Pay its chosen appraiser; and
2. Bear the expenses of the appraisal and umpire equally.

B. We do not waive any of our rights under this policy by agreeing to an appraisal.

PART E - DUTIES AFTER AN ACCIDENT OR LOSS

We have no duty to provide coverage under this policy unless there has been full compliance with the following duties:

A. We must be notified promptly of how, when and where the accident or loss happened. Notice should also include the names and addresses of any injured persons and of any witnesses.

B. A person seeking any coverage must:

1. Cooperate with us in the investigation, settlement or defense of any claim or suit.
2. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
3. Submit, as often as we reasonably require:
   a. to physical exams by physicians we select. We will pay for these exams.
   b. to examination under oath and subscribe the same.
4. Authorize us to obtain:
   a. medical reports; and
   b. other pertinent records.
5. Submit a proof of loss when required by us.

C. A person seeking Uninsured Motorists Coverage must also:

1. Promptly notify the police if a hit-and-run driver is involved.
2. Promptly send us copies of the legal papers if a suit is brought.

D. A person seeking Coverage for Damage to Your Auto must also:

1. Take reasonable steps after loss to protect "your covered auto" or any "non-owned auto" and their equipment from further loss. We will pay reasonable expenses incurred to do this.
2. Promptly notify the police if "your covered auto" or any "non-owned auto" is stolen.
3. Permit us to inspect and appraise the damaged property before its repair or disposal.

PART F - GENERAL PROVISIONS

BANKRUPTCY

Bankruptcy or insolvency of the "insured" shall not relieve us of any obligations under this policy.

CHANGES

A. This policy contains all the agreements between you and us. Its terms may not be changed or waived except by endorsement issued by us.

B. If there is a change to the information used to develop the policy premium, we may adjust your premium. Changes during the policy term that may result in a premium increase or decrease include, but are not limited to, changes in:

1. The number, type or use classification of insured vehicles;
2. Operators using insured vehicles;
3. The place of principal garaging of insured vehicles;
4. Coverage, deductible or limits.

If a change resulting from A. or B. requires a premium adjustment, we will make the premium adjustment in accordance with our manual rules.

C. If we make a change which broadens coverage under this edition of your policy without additional premium charge, that change will automatically apply to your policy as of the date we implement the change in your state. This paragraph (C.) does not apply to changes implemented with a general program revision that includes both broadenings and restrictions in coverage, whether that general program revision is implemented through introduction of:

1. A subsequent edition of your policy; or
2. An Amendatory Endorsement.

FRAUD

We do not provide coverage for any "insured" who has made fraudulent statements or engaged in fraudulent conduct in connection with any accident or loss for which coverage is sought under this policy.

LEGAL ACTION AGAINST US

A. No legal action may be brought against us until there has been full compliance with all

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the terms of this policy. In addition, under Part A, no legal action may be brought against us until:

1. We agree in writing that the "insured" has an obligation to pay; or
2. The amount of that obligation has been finally determined by judgment after trial.

B. No person or organization has any right under this policy to bring us into any action to determine the liability of an "insured."

OUR RIGHT TO RECOVER PAYMENT

A. If we make a payment under this policy and the person to or for whom payment was made has a right to recover damages from another we shall be subrogated to that right. That person shall do:

1. Whatever is necessary to enable us to exercise our rights; and
2. Nothing after loss to prejudice them.

However, our rights in this paragraph (A.) do not apply under Part D, against any person using "your covered auto" with a reasonable belief that that person is entitled to do so.

B. If we make a payment under this policy and the person to or for whom payment is made recovers damages from another, that person shall:

1. Hold in trust for us the proceeds of the recovery; and
2. Reimburse us to the extent of our payment.

POLICY PERIOD AND TERRITORY

A. This policy applies only to accidents and losses which occur:

1. During the policy period as shown in the Declarations; and
2. Within the policy territory.

B. The policy territory is:

1. The United States of America, its territories or possessions;
2. Puerto Rico; or
3. Canada.

This policy also applies to loss to, or accidents involving, "your covered auto" while being transported between their ports.

TERMINATION

A. Cancellation. This policy may be cancelled during the policy period as follows:

1. The named insured shown in the Declarations may cancel by:
   a. returning this policy to us; or
   b. giving us advance written notice of the date cancellation is to take effect.
2. We may cancel by mailing to the named insured shown in the Declarations at the address shown in this policy:
   a. at least 10 days notice:
      (1) if cancellation is for nonpayment of premium; or
      (2) if notice is mailed during the first 60 days this policy is in effect and this is not a renewal or continuation policy; or
   b. at least 20 days notice in all other cases.
3. After this policy is in effect for 60 days, or if this is a renewal or continuation policy, we will cancel only:
   a. for nonpayment of premium; or
   b. if your driver's license or that of:
      (1) any driver who lives with you; or
      (2) any driver who customarily uses "your covered auto;"

   has been suspended or revoked. This must have occurred:
      (1) during the policy period; or
      (2) since the last anniversary of the original effective date if the policy period is other than 1 year; or
   c. if the policy was obtained through material misrepresentation.

B. Nonrenewal. If we decide not to renew or continue this policy, we will mail notice to the named insured shown in the Declarations at the address shown in this policy. Notice will be mailed at least 20 days before the end of the policy period. If the policy period is:

1. Less than 6 months, we will have the right not to renew or continue this policy every 6 months, beginning 6 months after its original effective date.
2. 1 year or longer, we will have the right not to renew or continue this policy at each anniversary of its original effective date.

C. Automatic Termination. If we offer to renew or continue and you or your representative do not accept, this policy will automatically terminate at the end of the current policy period. Failure to pay the required renewal or continuation premium when due shall mean that you have not accepted our offer.

If you obtain other insurance on "your covered auto," any similar insurance provided by

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this policy will terminate as to that auto on the effective date of the other insurance.

D. Other Termination Provisions.

1. We may deliver any notice instead of mailing it. Proof of mailing of any notice shall be sufficient proof of notice.
2. If this policy is cancelled, you may be entitled to a premium refund. If so, we will send you the refund. The premium refund, if any, will be computed according to our manuals. However, making or offering to make the refund is not a condition of cancellation.
3. The effective date of cancellation stated in the notice shall become the end of the policy period.

TRANSFER OF YOUR INTEREST IN THIS POLICY

A. Your rights and duties under this policy may not be assigned without our written consent. However, if a named insured shown in the Declarations dies, coverage will be provided for:

1. The surviving spouse if resident in the same household at the time of death. Coverage applies to the spouse as if a named insured shown in the Declarations; and
2. The legal representative of the deceased person as if a named insured shown in the Declarations. This applies only with respect to the representative's legal responsibility to maintain or use "your covered auto."

B. Coverage will only be provided until the end of the policy period.

TWO OR MORE AUTO POLICIES

If this policy and any other auto insurance policy issued to you by us apply to the same accident, the maximum limit of our liability under all the policies shall not exceed the highest applicable limit of liability under any one policy.

***MUTUAL POLICY CONDITIONS**

You are a member of the Liberty Mutual Fire Insurance Company while this policy is in force. Membership entitles you to vote in person or by proxy at meetings of the company. The Annual Meeting is in Boston, Massachusetts, on the second Wednesday in April each year at 11 o'clock in the morning.

Also, as a member, you will receive any dividends declared on this policy by the Directors.

This policy is classified in Dividend Class IV-Automobile.

This policy has been signed by our President and Secretary at Boston, Massachusetts, and countersigned on the Declarations Page by an authorized representative.

*These conditions apply only if Liberty Mutual Fire Insurance Company is shown in the Declarations as the insurer.

PRESIDENT

SECRETARY

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POLICY NUMBER:

Liberty Mutual INSURANCE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDMENT OF POLICY PROVISIONS - MICHIGAN

PERSONAL AUTO
AS 2281 07 20

I. Definitions

The following are added to the **Definitions** Section:

K. Throughout the policy, "minimum limits" refers to the following limits of liability as required by Michigan law, to be provided under a policy of automobile liability insurance:

1. $50,000 for each person, subject to $100,000 for each accident, with respect to "bodily injury"; and

2. $10,000 for each accident with respect to "property damage".

L. "Personal vehicle sharing program" means a legal entity qualified to do "business" in this state and engaged in the "business" of facilitating the sharing of private passenger motor vehicles for noncommercial use by individuals within this state. Private passenger motor vehicle as it relates to "personal vehicle sharing program" means a four wheel passenger or station wagon type motor vehicle insured under an automobile liability insurance policy covering any individuals residing in your household.

M. "Transportation network platform" means an online-enabled application or digital network used to connect passengers with drivers using vehicles for the purpose of providing prearranged transportation services for compensation.

II. Part A - Liability Coverage

SCHEDULE

☐	Additional Property Damage Liability Coverage applies.

Part **A** is amended as follows:

A. Paragraph **A.** of the **Insuring Agreement** is replaced by the following:

INSURING AGREEMENT

We will pay damages for "bodily injury" or "property damage" for which any "insured" becomes legally responsible because of an auto accident. We will settle or defend, as we consider appropriate, any claim or suit asking for these damages. In addition to our limit of liability, we will pay all defense costs we incur. Our duty to settle or defend ends when our limit of liability for this coverage has been exhausted by payment. We have no duty to defend any suit or settle any claim for "bodily injury" or "property damage" not covered under this policy.

B. Item **B.2.** of the Insuring Agreement is replaced by the following:

2. Any person using "your covered auto" with your express or implied permission. The actual use must be within the scope of that permission.

C. The following is added to Item **B.** of the Insuring Agreement:

However, for the purposes of this coverage, "insured" does not mean any person who is using "your covered auto" under a "personal vehicle sharing program".

D. The following paragraph is added to the **Supplementary Payments** Provision:

We will pay on behalf of an "insured":

6. Prejudgment interest awarded against the "insured" on that part of the judgment we pay.

E. Exclusion **A.1.** is replaced by the following:

We do not provide Liability Coverage for any "insured":

1. Who intentionally causes "bodily injury" or "property damage" to the extent that the limits of liability for this coverage exceed the minimum limits of liability required by the Michigan Financial Responsibility Act.

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F. Exclusion **A.5.** is replaced by the following:

We do not provide Liability Coverage for any "insured":

5. For that "insured's" liability arising out of the ownership or operation of a vehicle while it is being used as a public or livery conveyance. This includes but is not limited to any period of time a vehicle is being used by any "insured" who is logged into a "transportation network platform" as a driver, whether or not a passenger is "occupying" the vehicle.

This Exclusion (**A.5.**) does not apply:

a. To a share-the-expense car pool; or

b. To the ownership or operation of a vehicle while it is being used for volunteer or charitable purposes; or

c. When reimbursement for normal operating expenses is received.

G. Exclusion **B.4.** is replaced by the following:

We do not provide Liability Coverage for the ownership, maintenance or use of:

4. Any vehicle while it is:

a. Operating on a surface designed or used for racing, except for an organized and controlled event that is not a speed, performance, stunt or demolition event;

b. Participating in a high performance driving or racing instruction course or school; or

c. Preparing for, practicing for, used in, or competing in any prearranged or organized:

(1) race activity; or

(2) speed, performance, stunt, or demolition contest or exhibition

This Exclusion (**B.4.**) only applies to the extent that the limits of liability for this coverage exceed the "minimum limits" required by the Michigan Financial Responsibility Act.

H. The following exclusion is added with respect to vehicles subject to Section 500.3101 of the Michigan Insurance Code:

We do not provide Liability Coverage for any "insured" for damage to a motor vehicle as a result of an auto accident occurring in Michigan.

I. The following provision is added:

ADDITIONAL PROPERTY DAMAGE LIABILITY COVERAGE

If the Schedule or the Declarations indicates that Additional Property Damage Liability Coverage applies, we will pay:

1. Up to $3,000 for damage to a motor vehicle for which an "insured" becomes legally responsible because of an auto accident occurring in Michigan and arising out of the use of "your covered auto". This coverage applies only if "your covered auto" is subject to Section 500.3101 of the Michigan Insurance Code.

2. Only to the extent that there is no insurance available, except for the insurance provided by this endorsement, to pay for the damage to the motor vehicle for which the "insured" is legally responsible.

J. The Other Insurance section is replaced by the following:

OTHER INSURANCE

If there is other applicable liability insurance available any insurance we provide shall be excess over any other applicable liability insurance. If more than one policy applies on an excess basis, we will bear our proportionate share with other collectible liability insurance. However, we will share on a pro rata basis with other valid and collectible insurance of the same type that is purchased by you to apply on a primary basis. Our share will be the proportionate amount that this insurance bears to the total amount of all applicable limits.

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III. **Part B - Medical Payments Coverage**

Part **B** is amended as follows:

A. Item **A.** of the Insuring Agreement is replaced by the following:

A. We will pay "usual and customary charges" incurred for necessary medical and funeral services because of "bodily injury":

1. Caused by accident; and

2. Sustained by an "insured".

We will pay only those expenses incurred for services rendered within 3 years from the date of the accident.

B. Item **B.2.** of the Insuring Agreement is replaced by the following:

2. Any other person while occupying your covered auto with your express or implied permission. The actual occupation must be within the scope of that permission.

3. Any other person while occupying, as a guest, an automobile not owned by you or a family member, while being operated by you or a family member.

C. The following is added to Item **B.** of the Insuring Agreement:

However, for the purposes of this coverage, "insured" does not mean any person who is "occupying" or using "your covered auto" under a "personal vehicle sharing program".

D. The following item is added to the Insuring Agreement:

"Usual and customary charges" as used in this Part means:

The lowest of the following:

1. The charge billed by the medical provider for covered treatment;

2. The eightieth percentile charge for that covered treatment in the geozip area where the provider is located, as determined through the use of a FAIRHealth or similar database;

3. The amount authorized by a state or by another law or regulation; or

4. The amount authorized by a written PPN or PPO agreement to which the Medical Provider is a party.

The "insured" shall not be responsible for payment of any reduction applied by us. If a medical provider disputes an amount paid by us, we will be responsible for resolving such disputes.

E. Exclusion **2.** is replaced by the following:

We do not provide Medical Payments Coverage for any "insured" for "bodily injury":

2. Sustained while "occupying" "your covered auto" when it is being used as a public or livery conveyance. This includes but is not limited to any period of time "your covered auto" is being used by any "insured" who is logged into a "transportation network platform" as a driver, whether or not a passenger is "occupying" the vehicle. This Exclusion (2.) does not apply:

a. To a share-the-expense car pool; or

b. While "your covered auto" is being used for volunteer or charitable purposes; or

c. When reimbursement for normal operating expenses is received.

F. Exclusion **11.** is replaced by the following:

11. Sustained while "occupying" any vehicle while it is:

a. operating on a surface designed or used for racing except for an organized and controlled event that is not a speed, performance, stunt or demolition event;

b. participating in a high performance driving or racing instruction course or school; or

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c. preparing for, practicing for, used in, or competing in any prearranged or organized:

(1) race activity; or

(2) speed, performance, stunt, or demolition contest or exhibition.

G. The Other Insurance section is replaced by the following:

OTHER INSURANCE

If there is other applicable auto medical payments insurance available any insurance we provide shall be excess over any other applicable auto medical payments insurance. If more than one policy applies on an excess basis, we will bear our proportionate share with other collectible auto medical payments insurance.

IV. Part C - Uninsured Motorists Coverage

A. The following is added to Part A of the Insuring Agreement:

You are not forbidden from filing a lawsuit against us within the statute of limitations to have any dispute settled by a court of proper jurisdiction if you believe that we have not appropriately responded to your requests concerning such proceedings.

B. Item **B.2.** of the Insuring Agreement is replaced by the following:

2. Any other person "occupying":

a. "Your covered auto" with your express or implied permission. The actual occupation must be within the scope of that permission; or

b. Any other auto operated by you.

C. The following is added to Item **B.** of the Insuring Agreement:

However, for the purposes of this coverage, "insured" does not mean any person who is occupying or using "your covered auto" under a "personal vehicle sharing program".

D. Paragraph **3.** of the definition of "uninsured motor vehicle" of Part **C** is replaced by the following:

3. Which is a hit-and-run vehicle whose operator or owner cannot be identified and which hits or causes an object to hit

a. You or any "family member";

b. A vehicle which you or any "family member" are "occupying"; or

c. "Your covered auto".

If there is no direct physical contact with the hit-and-run vehicle the facts of the accident must be proved. We will only accept competent evidence other than the testimony of a person making a claim under this or any similar coverage.

E. The following is added to Exclusion **B.1**:

You are not forbidden from filing a lawsuit against us within the statute of limitations to have any dispute settled by a court of proper jurisdiction if you believe that we have not appropriately responded to your requests concerning such proceedings.

F. Exclusion **B.2.** is replaced by the following:

We do not provide Uninsured Motorists Coverage for "bodily injury" sustained by any "insured":

2. While "occupying" "your covered auto" when it is being used as a public or livery conveyance. This includes but is not limited to any period of time "your covered auto" is being used by any "insured" who is logged into a "transportation network platform" as a driver, whether or not a passenger is "occupying" the vehicle. This Exclusion (**B.2.**) does not apply:

a. To a share-the-expense car pool; or

b. While "your covered auto" is being used for volunteer or charitable purposes; or

c. When reimbursement for normal operating expenses is received.

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G. The following exclusion is added to item B.

4. While using any vehicle while it is:

a. operating on a surface designed or used for racing except for an organized and controlled event that is not a speed, performance, stunt or demolition event;

b. participating in a high performance driving or racing instruction course or school; or

c. preparing for, practicing for, used in, or competing in any prearranged or organized:

(1) race activity; or

(2) speed, performance, stunt, or demolition contest or exhibition.

H. The Other Insurance section is replaced by the following:

OTHER INSURANCE

If there is other applicable insurance available under one or more policies or provisions of coverage that is similar to the insurance provided under this Part of the policy:

1. Any recovery for damages under all such policies or provisions of coverage may equal but not exceed the highest applicable limit for any one vehicle under any insurance providing coverage on either a primary or excess basis.

2. Any insurance we provide with respect to a vehicle you do not own, including any vehicle while used as a temporary substitute for "your covered auto", shall be excess over any collectible insurance

3. If the coverage under this policy is provided:

a. On a primary basis, we will pay only our share of the loss that must be paid under insurance providing coverage on a primary basis. Our share is the proportion that our limit of liability bears to the total of all applicable limits of liability for coverage provided on a primary basis.

b. On an excess basis, we will pay only our share of the loss that must be paid under insurance providing coverage on an excess basis. Our share is the proportion that our limit of liability bears to the total of all applicable limits of liability for coverage provided on an excess basis.

V. **Part D - Coverage for Damage to Your Auto**

Part D is amended as follows:

A. Exclusion 1. is replaced by the following:

We will not pay for:

1. Loss to "your covered auto" or any "non-owned auto" which occurs while it is being used as a public or livery conveyance. This includes but is not limited to any period of time "your covered auto" or any "non-owned auto" is being used by any person who is logged into a "transportation network platform" as a driver, whether or not a passenger is "occupying" the vehicle. This Exclusion (1.) does not apply:

a. To a share-the-expense car pool; or

b. While "your covered auto" or any "non-owned auto" is being used for volunteer or charitable purposes; or

c. When reimbursement for normal operating expenses is received.

B. Exclusion 13. is replaced by the following:

13. Loss to "your covered auto" or any "non-owned auto" while it is:

a. operating on a surface designed or used for racing. This does not apply to an organized and controlled event that is not a speed, performance, stunt or demolition event;

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b. participating in a high performance driving or racing instruction course or school; or

c. preparing for, practicing for, used in, or competing in any prearranged or organized:

(1) race activity; or

(2) speed, performance, stunt, or demolition contest or exhibition.

C. The following Exclusion is added:

15. Loss to "your covered auto" or "non-owned auto" while being used in a "personal vehicle sharing program".

D. Item **A.** of the Limit of Liability is replaced by the following:

A. At our option, our limit of liability for loss will be the lowest of:

1. The actual cash value of the stolen or damaged property;

2. **a.** The amount necessary to repair or replace the property;

b. Determination of the cost of repair or replacement will be based upon one of the following:

(1) the cost of repair or replacement agreed upon by you and us;

(2) a competitive bid approved by us; or

(3) an estimate written based upon the prevailing competitive price. You agree with us that we may include in the estimate parts furnished by the original vehicle manufacturer or parts from other sources including non-original equipment manufacturers. The prevailing competitive price means prices charged by a majority of the repair market in the area where the vehicle is to be repaired as determined by us; or

3. The limit of liability shown in the Declarations.

However, the most we will pay for loss to any "non-owned auto" which is a "trailer" is $500.

VI. Part E - Duties After An Accident Or Loss

The following is added to Paragraph **A.** of Part E:

Notice to our authorized representative is any considered notice to us. Failure to give any notice required by this policy shall not invalidate any claim made by a person seeking coverage if it shall be shown not to have been reasonably possible to give such notice promptly and that notice was given as soon as was reasonably possible.

VII. Part F - General Provisions

Part F is amended as follows:

A. Items **A.** and **B.** of the Changes provision are replaced by the following:

A. This policy, your Declarations page and endorsements issued by us to this policy contain all the agreements between you and us. Its terms may not be changed or waived except by endorsement issued by us.

B. The premium for your policy is based on information we have received from you or other sources. You agree to cooperate with us in determining if this information is correct and complete and you will notify us if it changes. If this information is incorrect, incomplete, or changes, we will adjust your premium during the policy term or take other appropriate action based upon the corrected, completed or changed information. Changes during the policy term that will result in a premium increase or decrease during the policy term

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include, but are not limited to, changes in:

1. The number, type or use classification of insured vehicles;
2. Operators using insured vehicles, including newly licensed "family member" drivers and any household members that have licenses.
3. The location where your vehicle is principally garaged.
4. Customized equipment or parts.
5. The persons who regularly operate a covered auto.

   You also agree to disclose all licensed drivers residing in your household.

B. The **Fraud** provision is replaced by the following:

FRAUD

This policy was issued in reliance upon the information provided on your application. Any changes we make at your request to this policy after inception will be made in reliance upon information you provide. We may rescind this policy if you or an "insured" have concealed or misrepresented any material fact or circumstance, or engaged in fraudulent conduct, at the time application was made, at the time changes were requested, or any time during the policy period.

We may deny coverage for an accident or loss if you or an "insured" have concealed or misrepresented any material fact or circumstance, or engaged in fraudulent conduct, in connection with the presentation or settlement of a claim.

We may deny coverage for fraud or material misrepresentation even after the occurrence of an accident or loss. This means we will not be liable for any claims or damages which would otherwise be covered. If we make a payment, we may request that you reimburse us. If so requested, you must reimburse us for any payments we may have already made.

C. Section **A.1** of the **Legal Action Against Us** Provision is revised as follows:

1. We agree in writing that the "insured" has an obligation to pay. You are not forbidden from filing a lawsuit against us within the statute of limitations to have any dispute settled by a court of proper jurisdiction if you believe that we have not appropriately responded to your requests concerning such proceedings; or

D. The following is added to the **Our Right To Recover Payment** Provision with respect to Uninsured Motorists Coverage:

OUR RIGHT TO RECOVER PAYMENT

We shall be entitled to recovery under Paragraph **B.** only after the person has been fully compensated for damages by another party.

E. The **Termination** Provision is replaced by the following:

TERMINATION

A. Cancellation

This policy may be cancelled during the policy period as follows:

1. The named insured shown in the Declarations may cancel by giving us notice of the date cancellation is to take effect. You must notify us no later than the day you want cancellation to occur.
2. We may cancel by mailing to the named insured shown in the Declarations at the address last known by us or our agent:

   a. At least 10 days notice by first class mail, if cancellation is for nonpayment of premium; or

   b. At least 20 days notice by first class mail, if notice is mailed during the first 55 days this policy is in effect and this is not a renewal or continuation policy; or

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c. At least 30 days notice by certified mail, return receipt requested, in all other cases.

3. After this policy is in effect for 55 days, or if this is a renewal or continuation policy, we will cancel only:

   a. For nonpayment of premium; or

   b. If during the first 55 days after the original issuance of this policy, we determine that the risk is unacceptable to us; or

   c. If your driver's license or that of:

      (1) Any driver who lives with you; or

      (2) Any driver who customarily uses "your covered auto";

      has been suspended or revoked and the suspension or revocation has become final. This must have occurred:

      (1) During the policy period; or

      (2) Since the last anniversary of the original effective date if the policy period is other than 1 year.

   d. For material misrepresentation or fraud by you with respect to any material fact in obtaining, changing, renewing this policy or with submitting any claim.

B. Nonrenewal

If we decide not to renew or continue this policy, we will mail notice, by first class mail, to the named insured shown in the Declarations at the address last known to us or our agent. Notice will be mailed at least 30 days before the end of the policy period. Subject to this notice requirement, if the policy period is:

1. Less than 6 months, we will have the right not to renew or continue this policy every 6 months, beginning 6 months after its original effective date.

2. 6 months or longer, but less than one year, we will have the right not to renew or continue this policy at the end of the policy period.

3. 1 year or longer, we will have the right not to renew or continue this policy at each anniversary of its original effective date.

C. Other Termination Provisions

1. We may deliver any notice instead of mailing it. Proof of mailing of any notice shall be sufficient proof of notice.

2. If this policy is cancelled, you may be entitled to a premium refund. If you cancel, the refund will be computed in accordance with Michigan Law. However, making or offering to make the refund is not a condition of cancellation.

3. The effective date of cancellation stated in the notice shall become the end of the policy period.

TRANSFER OF YOUR INTEREST IN THIS POLICY

Paragraph **A.1** is added to the following:

1. The spouse is considered to be a resident of the household when there is a legitimate marital covenant, shared economic and non-economic burdens, and legitimate reasons for the spouses to be staying in another home or location; and

F. The following provisions are added:

DUTY TO REPORT CHANGES

You must promptly report to us all changes, including additions and deletions, in policy information. Further, you must report to us certain changes no later than 30 days after the change occurs. These are changes to:

1. your residence address;

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2. operators using insured vehicles, including newly licensed "family member" drivers and any household members that have licenses;
3. the location where your vehicle is principally garaged;
4. the persons who regularly operate a covered auto;
5. the driver's license or operator's permit status of you, a relative, or a resident of your household.

STORAGE COSTS

If you give us your consent, we may move the damaged property, at our expense, to reduce storage costs during the claims process. If you do not give us your consent, we will pay only the storage costs which would have resulted if we had moved the damaged property.

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Liberty Mutual INSURANCE

AUTOMOBILE AMENDATORY ENDORSEMENT

AS 3742 05 16

I. DEFINITIONS

The **Definitions** section is revised as follows:

A. The definition of "Your Covered Auto" is replaced with the following:

"Your Covered Auto" means:

1. Any vehicle shown in the Declarations.

2. A "newly acquired auto".

3. Any "trailer" you own.

4. Any auto or "trailer" you do not own while used as a temporary substitute for any other vehicle described in this definition which is out of normal use because of its:

a. Breakdown;

b. Repair;

c. Servicing;

d. Loss; or

e. Destruction.

This provision **(4.)** does not apply to Coverage For Damage To Your Auto.

B. The definition of "Newly Acquired Auto" is added as follows:

"Newly acquired auto":

1. "Newly acquired auto" means any of the following types of vehicles you become the owner of during the policy period:

a. A private passenger auto; or

b. A pickup or van, for which no other insurance policy provides coverage, that:

(1) Has a Gross Vehicle Weight of less than 10,000 lbs.; and

(2) Is not used for the delivery or transportation of goods and materials unless such use is:

(a) Incidental to your "business" of installing, maintaining or repairing furnishings or equipment; or

(b) For farming or ranching.

For this definition to apply to a "newly acquired auto", which is in addition to the vehicles listed in the Declarations, we must insure all other vehicles owned by you.

2. Coverage for a "newly acquired auto" is provided as described below. If you ask us to insure a "newly acquired auto" after a specified time period described below has elapsed, any coverage we provide for a "newly acquired auto" will begin at the time you request the coverage.

a. For any coverage provided in this policy except Coverage For Damage To Your Auto, a "newly acquired auto" will have the broadest coverage we now provide for any vehicle shown in the Declarations. Coverage begins on the date you become the owner.

However, for this coverage to apply to a "newly acquired auto" that is in addition to any vehicle shown in the Declarations, you must ask us to insure it within 30 days after you become the owner.

If a "newly acquired auto" replaces a vehicle shown in the Declarations, coverage is provided for this vehicle without your having to ask us to insure it.

b. Collision Coverage for a "newly acquired auto" begins on the date you become the owner. However, for this coverage to apply, you must ask us to insure it within:

(1) 30 days after you become the owner if the Declarations indicate that Collision Coverage applies to at least one auto. In this case, the "newly acquired auto" will have the broadest coverage we now provide for any auto shown in the Declarations.

(2) Five days after you become the owner if the Declarations do not indicate that Collision Coverage applies to at least one auto. If you comply with the 5 day requirement and a loss occurred before you asked us to insure the "newly acquired auto", a Collision deductible of $500 will apply.

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c. Other Than Collision Coverage for a "newly acquired auto" begins on the date you become the owner. However, for this coverage to apply, you must ask us to insure it within:

(1) 30 days after you become the owner if the Declarations indicate that Other Than Collision Coverage applies to at least one auto. In this case, the "newly acquired auto" will have the broadest coverage we now provide for any auto shown in the Declarations.

(2) Five days after you become the owner if the Declarations do not indicate that Other Than Collision Coverage applies to at least one auto. If you comply with the 5 day requirement and a loss occurred before you asked us to insure the "newly acquired auto", an Other Than Collision deductible of $500 will apply.

II. **PART B - MEDICAL PAYMENTS COVERAGE**

Part B is revised as follows:

A. The following are added to the Insuring Agreement:

"Reasonable Expenses" means services or supplies provided by a licensed hospital, licensed physician, or other licensed medical provider that, as determined by us or someone on our behalf, are:

1. Required to identify or treat an injury caused by an accident covered by this policy;
2. Consistent with symptoms, diagnosis, and treatment of the covered person's injury and appropriately documented in the covered person's medical records;
3. Provided in accordance with recognized standards of care for the covered person's injury at the time the charge is incurred;
4. Consistent with published practice guidelines and technology, and assessment standards of national organizations or multi-disciplinary medical groups;
5. Not primarily for the convenience of the covered person, or his or her physician, hospital, or other health care provider;
6. The most appropriate supply or level of service that can be safely provided to the covered person; and
7. Not excessive in terms of scope, duration, or intensity of care needed to provide safe, adequate, and appropriate diagnosis and treatment.
8. Reasonable in terms of the charge for the service or supply provided.

However, "reasonable expenses" do not include expenses for any of the following:

1. Nutritional supplements or over-the-counter drugs unless prescribed by a licensed physician;
2. Experimental services or supplies, which means services or supplies that we determine have not been accepted by the majority of the relevant medical specialty as safe and effective for treatment of the condition for which its use is proposed.
3. Inpatient services or supplies provided to the covered person when these could safely have been provided to the covered person as an outpatient.

"Reasonable" - When applied to the charge for the service or supply provided means the least of:

1. The actual charge;
2. The charge negotiated with a provider; or
3. The charge determined by us based on a methodology using a database designed to reflect amounts charged by providers of medical services or supplies within the same or similar geographic region in which you receive your medical services or supplies. The database will reflect (a) service charge data regardless of the provider's specialty and (b) in the case of new procedures, services or supplies, or existing procedures, services or supplies for which there is little or no charge data, a comparison to commonly used procedures, services or supplies.

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II. PART D - COVERAGE FOR DAMAGE TO YOUR AUTO

A. Paragraph **A.** of the **Insuring Agreement** is replaced by the following:

INSURING AGREEMENT

A. We will pay for direct and accidental loss to "your covered auto" or any "non owned auto", including their equipment, subject to **Customized Equipment Coverage**, minus any applicable deductible shown in the Declarations. If loss to more than one "your covered auto" or "non owned auto" results from the same collision, only the highest applicable deductible will apply. We will pay for loss to "your covered auto" caused by:

1. Other than **collision** only if the Declarations indicate that Other Than Collision Coverage is provided for that auto.
2. **Collision** only if the Declarations indicate that Collision Coverage is provided for that auto.

If there is a loss to a "non owned auto" we will provide the broadest coverage applicable to any "your covered auto" shown in the Declarations.

B. The following **Customized Equipment Coverage** provision is added under **Part D:**

CUSTOMIZED EQUIPMENT COVERAGE

A. We will pay up to $500 for theft or damage to "customized equipment" if the loss is caused by:

1. Other than **collision** only if the Declarations indicate that Other Than Collision Coverage is provided for that auto.
2. **Collision** only if the Declarations indicate that Collision Coverage is provided for that auto.

Payments shall be reduced by the applicable deductible. However, only one deductible will be applied for any one loss. If you or the owner of a "non owned auto" keeps salvaged material, payments will also be reduced by the salvage value. In no way shall this coverage increase the limit of liability for "your covered auto" or any "non owned auto".

B. "Customized equipment" means any parts, equipment and accessories including devices, extensions, furnishings, fixtures, finishings, and other alterations that:

1. are permanently installed or attached by bolts or brackets;
2. are removable from a housing unit that is permanently installed inside the auto;
3. are permanently bonded to the vehicle by an adhesive or welding procedure; or
4. change the appearance or performance of the vehicle including but not limited to any additions or alterations to the chassis, engine, exterior or interior of the auto.

This includes but is not limited to ground effects, specialty rims, performance tires, specialty paint or dye, roll bars, running boards, spoilers, special interior or exterior lighting, roof/trunk racks, and high performance engine components. However, such parts, equipment and accessories that were installed by the automobile manufacturer or licensed auto dealer are not considered "customized equipment". This also includes any electronic equipment that is not necessary for the normal operation of the auto or the monitoring of the auto's operating system that is used solely for the reproduction of recorded material or used for transmitting or receiving audio, visual or data signals. However, such parts, equipment and accessories that were installed by the automobile manufacturer or licensed auto dealer or in a location the automobile manufacturer intended for such equipment, are not considered "customized equipment".

C. If you have purchased additional coverage for "customized equipment" we will pay up to the amount of coverage you have purchased in addition to the $500 limit provided by the policy. This additional coverage must be shown in the Declarations.

D. The most we will pay for parts, equipment and accessories that are:

a. not installed by the auto manufacturer or dealer and

b. permanently installed in or upon the auto is the actual cash value

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of the vehicle not including such parts, equipment and accessories.

C. The **Transportation Expenses** provision is replaced by the following:

TRANSPORTATION EXPENSES

In addition, we will pay up to $30 per day to a maximum of 30 days for any temporary transportation expenses incurred by you. This applies in the event of the theft of your covered auto.

We will pay only transportation expenses incurred during the period:

1. Beginning 48 hours after the theft; and
2. Ending when your covered auto is returned to use or we pay for its loss.

D. Exclusion **4.** is replaced by the following:

4. We will not pay for loss to equipment that is not permanently installed in or upon "your covered auto" or any "non owned auto". This consists of any equipment that is either designed for the reproduction of sound or receives or transmits audio, visual or data signals. This includes but is not limited to:
   a. radios and stereos;
   b. tape decks;
   c. compact disc players and burners;
   d. digital video disc (DVD) players and burners;
   e. citizens band radios;
   f. scanning monitor receivers;
   g. television monitor receivers;
   h. global positioning system (GPS) receivers and/or components;
   i. video cassette players and recorders;
   j. audio cassette recorders; or
   k. personal computers, which includes laptops, desktops, and personal digital assistants (PDA) or any other handheld device.

   All accessories used with the above or similar equipment are also excluded.

F. Exclusion **15.** is added as follows:

15. We will not pay for loss to "customized coverage" in excess of what is provided under Customized Equipment Coverage unless additional coverage has been purchased by endorsement and is shown in the Declarations.

G. Exclusion **16.** is added as follows:

16. We will not pay for loss to tapes, records, discs or other media used with any sound reproducing or other electronic equipment.

H. Paragraph B of the **Limit of Liability** provision of **Part D** is added as follows:

B. An adjustment for depreciation and physical condition will be made in determining actual cash value in the event of a total loss. In this case, the actual cash value consists of the value of the vehicle not including any "customized equipment".

IV. PART E - DUTIES AFTER AN ACCIDENT OR LOSS

Part E is amended as follows:

A. Paragraph **B.** of **Part E** is replaced by the following:

B. A person seeking any coverage must:
   1. Cooperate with us in the investigation, settlement or defense of any claim or suit. This includes, but is not limited to, allowing us to inspect damage to a vehicle covered by this policy.
   2. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
   3. Submit, as often as we reasonably require, within 30 days of our request:
      a. To physical and mental exams by physicians we select under terms we require. We will pay for these exams.
      b. To interviews and recorded statements without the need for us to conduct an examination under oath.
      c. To examination under oath and subscribe the same.
   4. Authorize us to obtain, within 30 days of our request:
      a. Medical reports; and
      b. Other pertinent records, including but not limited to, information contained in or transmitted by any device located in or on the motor vehicle.
   5. Submit a proof of loss when required by us within 30 days of our request.

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AMENDATORY ENDORSEMENT

It is agreed that the policy is amended as follows:

PART D - COVERAGE FOR DAMAGE TO YOUR AUTO

The following is added to the Exclusions:

We will not pay for damage resulting from a "collision" involving "your covered auto" or attached "trailer" if at the time of the accident "your covered auto" was operated by a driver residing in your household longer than 90 days and not listed on your policy.

This exclusion does not apply if the driver operating "your covered auto":

1. Became:
   a. a resident of your household;
   b. a guest temporarily staying as a resident of your household; or
   c. a licensed driver;

   no more than 90 days prior to the loss;
2. Was listed as an insured or rated driver under another automobile insurance policy; or
3. Was operating "your covered auto":
   a. For the purpose of obtaining emergency medical treatment for a passenger in "your covered auto"; or
   b. Because all other licensed drivers in "your covered auto" were intoxicated and the driver was not legally intoxicated. Coverage will not apply unless a police accident report is obtained at the scene of the accident or, if a police accident report is not available at the scene of the accident, as soon as possible afterwards.

All other provisions of the policy apply.

POLICY NUMBER:

Liberty Mutual INSURANCE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PERSONAL INJURY PROTECTION COVERAGE - MICHIGAN **AS 2141 07 20**

With respect to the coverage provided by this endorsement, the provisions of the policy apply unless modified by the endorsement.

SCHEDULE

Benefits	**Limit Of Liability**
Medical Expenses	per person
Funeral Expenses	Up to << PIP.FUNERAL.EXP >> per person
Work Loss	Up to << PIP.WORK.LOSS >> * for any 30 day period
Replacement Services	<< PIP.REPL.SERV >> per day maximum
Survivor's loss consisting of income loss and replacement services	Up to << LOSS >> * for any 30 day period subject to a << MAX >> per day maximum for replacement services

*Or whatever amount is established under the Michigan Insurance Code for accidents occurring on or after the date of the change in the maximum.

The following options apply as indicated in your Policy Declarations or by an X in the box below:

COORDINATION OF BENEFITS

☐ Coordination of medical expenses (excluding Medicare or Medicaid benefits provided by the Federal Government) applies to you or any "family member".

☐ Coordination of work loss applies to you or any "family member".

REJECTION OF MEDICAL EXPENSES

Medical Expenses Coverage does not apply to you or any "family member".

REJECTION OF WORK LOSS

☐ Work loss does not apply to an "insured" age 60 or older who has signed a form rejecting the work loss benefit.

DEDUCTIBLE

☐ A deductible of $ applies to you or any "family member".

EXCESS ATTENDANT CARE

☐ Excess Attendant Care Coverage Limit $ per person/per accident.

QUALIFIED HEALTH COVERAGE APPLICABLE TO THE $250,000 LIMIT FOR MEDICAL EXPENSES

☐ Qualified Health Coverage applies to individuals.

I. Definitions

The Definitions Section is amended as follows:

A. The definition of "your covered auto" is replaced by the following:

"Your covered auto" means an "auto":

1. For which you are required to maintain security under the Michigan Insurance Code; and
2. To which the bodily injury liability coverage of this policy applies.

B. The following definitions are added:

1. "Auto" means a motor vehicle or trailer operated or designed for use on public roads. It does not include:
   a. A motorcycle or moped;
   b. A farm tractor or other implement of husbandry which is not subject to the registration requirements of the Michigan Vehicle Code; or
   c. A vehicle operated by muscular power or with fewer than three wheels.
2. "Auto accident" means a loss involving the ownership, operation, maintenance, or use of an "auto" as an "auto" regardless of whether the accident also involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle.

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C. "Insured" as used in this endorsement means:

1. You or any "family member" injured in an "auto accident", or
2. Anyone else injured in an "auto accident" who is a **resident** of Michigan and is entitled to Michigan no-fault benefits as a named insured, named insured's spouse or "family member" under another policy:
   a. While "occupying" "your covered auto";
   b. While "occupying" any other "auto";
      (1) Which is operated by you or any "family member"; and
      (2) To which Part **A** of this policy applies.
3. Anyone else injured in an "auto accident" while "occupying" a motorcycle if the accident involves "your covered auto".

However, for the purposes of this coverage, "insured" does not mean any person who is "occupying" or using "your covered auto" under a "personal vehicle sharing program".

D. "Medical expenses" means all reasonable fees for reasonably necessary products and services and accommodations for a covered person's care, recovery, or rehabilitation.

E. "Medical Provider" means a person licensed, certified, or registered under Section 550.52(d) of the Michigan Prudent Purchaser Act.

F. "**Qualified health coverage**" means either of the following:

1. Other health or accident coverage in which:
   a. Such coverage does not exclude or limit coverage for "bodily injury" sustained in an "auto accident"; and
   b. The annual deductible for such coverage is $6,000 or less per individual or the amount as annually adjusted by the Director of the Department of Insurance and Financial Services; or
2. Coverage provided under Parts A and B of Medicare.

G. "Reside", "resides" or "residing" means to currently live in a place permanently or for any extended period of time as a primary and legal domicile.

H. "Usual and customary charges" as used in this endorsement means:

The lowest of the following:

1. The charge billed by the medical provider for covered treatment;
2. The eightieth percentile charge for that covered treatment in the geozip area where the provider is located, as determined through the use of a FAIRHealth or similar database;
3. The amount authorized by a state or by another law or regulation; or
4. The amount authorized by a written PPN or PPO agreement to which the "Medical Provider" is a party.

The "insured" shall not be responsible for payment of any reduction applied by us. If a medical provider disputes an amount paid by us, we will be responsible for resolving such disputes.

II. **Personal Injury Protection Coverage**

INSURING AGREEMENT

A. We will pay personal injury protection benefits to or for an "insured" who sustains "bodily injury". The "bodily injury" must:

1. Be caused by accident; and
2. Result from the ownership, maintenance or use of an "auto" as an "auto".

B. These benefits are subject to the provisions of the Michigan Insurance Code. Subject to the limits shown in the Schedule or your Policy Declarations, personal injury protection benefits consist of the following:

1. "**Medical Expenses**"

   "Usual and customary charges" incurred for reasonable and necessary services rendered for an "insured's":

   a. Care;
   b. Recovery; or
   c. Rehabilitation.

   This includes attendant care.

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Only semi-private room charges will be paid unless special or intensive care is required.

2. **Funeral Expenses**

   Reasonable expenses, up to the scheduled limits, for professional funeral and burial services.

3. **Work Loss**

   Up to 85% of an "insured's" actual loss of income from work. We will pay a higher percentage if the "insured" gives us reasonable proof that net income is more than 85% of gross income. The most we will pay in any 30 day period for this benefit is the amount shown in the Schedule or your Policy Declarations unless another amount is established by law. Any income an "insured" earns during the 30 day period is included in determining the income benefit we will pay. This benefit is payable for loss sustained during the 3 years after the accident. It does not apply after an "insured" dies. We will prorate this benefit for any period less than 30 days.

4. **Replacement Services**

   Reasonable expenses for obtaining services to replace those an "insured" would have done:

   a. Without pay; and

   b. For the benefit of that "insured" or that "insured's" dependents.

   This benefit is payable for loss sustained during the 3 years after the accident. It does not apply after an "insured" dies.

5. **Survivor's Loss**

   a. Income Loss

   The contributions a deceased "insured's" spouse and dependents would have received as dependents, if the "insured" had not died. The contributions must be tangible things of economic value, not including services.

   b. Replacement Services

   Reasonable expenses incurred for obtaining services to replace those a deceased "insured" would have done for that "insured's" spouse and dependents.

   The most we will pay in any 30 day period for the total of these benefits is the amount shown in the Schedule or your Policy Declarations unless another amount is established by law. These benefits are payable for loss sustained during the 3 years after the accident. A deceased "insured's" spouse must have either:

   a. **Resided** with; or

   b. Been dependent on;

   the "insured" at the time of death. The benefits end for a spouse at remarriage or death.

   Any other person who was dependent upon the deceased "insured" at the time of death qualifies for benefits if, and as long as that dependent is:

   a. Under age 18; or

   b. Physically or mentally unable to earn a living; or

   c. In a full time formal program of academic or vocational education or training.

6. **Coordination of Benefits**

   a. If coordination of medical expenses is applicable as shown in the schedule and you do not have other medical insurance applicable to the "bodily injury" at the time of the accident, any amount payable for medical expenses or work loss shall be subject to a $500 penalty deductible per accident.

   b. If coordination of work loss is applicable as shown in the schedule and you do not have other disability insurance applicable to the "bodily injury" at the time of the accident, any amount payable for medical expenses or work loss shall be subject to a $500 penalty deductible per accident.

   c. If **6.a.** and **6.b.** are applicable as shown in the schedule and you do not have other medical or disability insurance applicable to

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the "bodily injury" at the time of the accident, any amount payable for medical expenses or work loss shall be subject to a $500 penalty deductible per accident. This $500 penalty deductible is in addition to the personal injury protection deductible you elect as shown in your Policy Declarations.

EXCLUSIONS

A. We do not provide Personal Injury Protection Coverage for "bodily injury":

1. To any "insured" who intentionally caused the "bodily injury".
2. Sustained by any "insured" using an "auto" which that "insured" had taken unlawfully. This Exclusion (**A.2.**) does not apply if the "insured" had a reasonable belief that he or she was entitled to use the "auto".
3. Sustained by any person while not "occupying" an "auto" if the accident takes place outside Michigan. However, this Exclusion (**A.3.**) does not apply to:
   a. You;
   b. Any "family member".
4. To you while "occupying", or struck by while not "occupying", any "auto":
   a. Owned or registered by you; and
   b. Which is not "your covered auto".
5. Sustained by the owner or registrant of an "auto" involved in the accident and for which the security required under the Michigan Insurance Code is not in effect.
6. Sustained by any "family member" entitled to Michigan no-fault benefits as a named insured under another policy providing similar coverage except while an operator or passenger of a motorcycle involved in the accident.
7. Sustained while "occupying", or struck by while not "occupying", an "auto" (other than "your covered auto") if:
   a. Operated by you or any "family member"; and
   b. The owner or registrant has the security required under the Michigan Insurance Code.

   This Exclusion (**A.7.**) does not apply to:
   a. You;
   b. Any "family member".
8. Sustained while "occupying" an "auto" located for use as a residence or premises.
9. Sustained while "occupying" a public auto for which the security required under the Michigan Insurance Code is in effect. This Exclusion (**A.9.**) does not apply to "bodily injury" to you or a "family member" while a passenger in a:
   a. School bus;
   b. Certified common carrier;
   c. Bus operated under government sponsored transportation program;
   d. Bus operated by or servicing a non-profit organization;
   e. Bus operated by a watercraft, bicycle, or horse livery used only to transport passengers to or from a destination point; or
   f. Taxicab; or
   g. a transportation network platform vehicle.
   h. Motor vehicle insured under a policy for which the person named on the policy has elected not to maintain personal injury protection coverage or to which exclusion related to "qualified health coverage" applies under such policy.
10. Sustained by you or any "family member" while "occupying" an "auto" which is owned or registered by:
    a. Your employer;
    b. Any "family member's" employer;

    for which the security required under the Michigan Insurance Code is in effect.

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11. Sustained by any person other than you or any "family member" while "occupying" an "auto" other than "your covered auto":

    a. For which the owner or registrant is not required to provide security under the Michigan Insurance Code; and

    b. Which is being operated by you or a "family member" outside Michigan.

    This Exclusion (**A.11.**) does not apply to:

    a. You or any "family member"; or

    b. Medical or funeral expense benefits.

12. Arising out of the ownership, operation, maintenance or use of a parked "auto". This Exclusion (**A.12.**) does not apply if:

    a. The "auto" was parked in such a way as to cause unreasonable risk of the "bodily injury"; or

    b. The "bodily injury" resulted from physical contact with:

        (1) Equipment permanently mounted on the "auto" while the equipment was being used; or

        (2) Property being lifted onto or lowered from the "auto"; or

    c. The "bodily injury" was sustained while "occupying" the "auto".

    However, Exceptions **b.** and **c.** to this Exclusion (**A.12.**) do not apply to any employee that has Michigan workers' disability compensation benefits available and who sustains "bodily injury" in the course of employment while loading, unloading, or doing mechanical work on an auto, unless the injury arises from the use or operation of another vehicle.

13. Sustained in an "auto accident" by you or any "family member" while an operator or passenger of a motorcycle, if the owner, registrant or operator of the "auto" has provided security for that "auto" as required under the Michigan Insurance Code.

14. Sustained while "occupying" any vehicle while it is:

    a. operating on a surface designed or used for racing except for an organized and controlled event that is not a speed, performance, stunt or demolition event;

    b. participating in a high performance driving or racing instruction course or school; or

    c. preparing for, practicing for, used in, or competing in any prearranged or organized:

        (1) race activity; or

        (2) speed, performance, stunt, or demolition contest or exhibition.

15. Caused by the actual, alleged or threatened presence, growth, proliferation or spread of "fungi" or bacteria.

16. Sustained while "occupying your covered auto" when it is being used as a public or livery conveyance. This includes but is not limited to any period of time while it is being used by any person who is logged into a "transportation network platform" as a driver, whether or not a passenger is "occupying" the vehicle. This exclusion (**A.16.**) does not apply to a share-the-expense car pool.

17. Sustained in an "auto accident" by you, a "family member" or any other person while operating an "auto" or "motorcycle" in a manner that results in a felony driving conviction.

    This exclusion applies even if:

    c. such "bodily injury" is of a different kind or degree than intended or reasonably expected; or

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d. such "bodily injury" is sustained by a different person than intended or reasonably expected.

18. Sustained by anyone who is not a **resident** of Michigan unless, at the time of the accident, such person is the owner of a motor vehicle which is registered in Michigan and for which the security required under the Michigan Insurance Code is in effect.

B. We do not provide Personal Injury Protection Coverage for:

1. Medical expenses for you or any "family member":

a. to the extent that similar benefits are paid or payable in accordance with prescribed guidelines of any "medical provider" or accident coverage provider, under any other insurance, service, benefit or reimbursement plan. This includes but is not limited to any:

(1) individual, blanket or group accident disability or hospitalization insurance;

(2) medical or surgical reimbursement plan;

(3) automobile no-fault benefits or medical expense benefits, or premises insurance affording medical expense benefits;

(4) HMOs, PPOs, or other medical plans, excluding Medicare or Medicaid benefits provided by the Federal Government; and

b. If Coordination of Benefits for medical expenses is indicated in the Schedule or your Policy Declarations.

2. Work loss for you or any "family member":

a. to the extent that similar benefits are paid or payable in accordance with prescribed guidelines of any "medical provider" or accident coverage provider, under any other insurance, service, benefit or reimbursement plan. This includes any valid and collectible:

(1) individual, blanket or group accident or disability insurance;

(2) salary or wage continuation program, including sick pay programs;

(3) workers' compensation law, or similar disability law, or any state or federal government laws, except Social Security Retirement Benefits; and

b. If Coordination of Benefits for work loss is indicated in the Schedule or your Policy Declarations.

3. Work loss for an "insured" age 60 or older if:

a. Rejection of Work Loss is indicated in the Schedule or your Policy Declarations; and

b. That "insured" has signed a form rejecting the work loss benefit.

4. Medical expenses for you if you:

a. are covered under **qualified health coverage** as defined in Paragraph **E.1.** of the Definitions section; and

b. if the Policy Declarations indicate that you:

(1) have **qualified health coverage**; and

(2) are excluded from Personal Injury Protection Medical coverage.

5. Medical expenses for any **family member** if such person:

a. is covered under **qualified health coverage** as defined in Paragraph **E.1.** or **E.2.** of the Definitions section; and

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b. if the Policy Declarations indicate that you:

(1) have **qualified health coverage**; and

(2) are excluded from Personal Injury Protection Medical coverage.

6. Medical expenses for you or any **family member** if:

a. rejection of medical expenses is indicated in your Policy Declarations; and

b. the named insured has signed a form rejecting coverage for medical expenses.

LIMIT OF LIABILITY

A. The limits of liability shown in the Schedule or your Policy Declarations for Personal Injury Protection Coverage are the most we will pay for each "insured" injured in any one accident, regardless of the number of:

1. "Insureds";
2. Claims made;
3. Vehicles or premiums shown in your Policy Declarations;
4. Vehicles involved in the accident; or
5. Insurers providing no-fault benefits.

Any amount payable under this insurance shall be reduced by:

a. Any amounts paid, payable or required to be provided by state or federal law except any amounts paid, payable or required to be provided by Medicare, or Medicaid provided that the benefits:

(1) Serve the same purpose as personal injury protection benefits paid or payable to an "insured" under this policy; and

(2) Are provided or required to be provided as a result of the same accident for which this insurance is payable. However, this insurance shall not be reduced by any amount of workers' compensation benefits if workers' compensation benefits that are required to be provided are not available to an "insured".

b. Any deductible you elect. However, the deductible applies only to you and any "family member".

B. **Excess Attendant Care**

If Excess Attendant Care is indicated in your Policy Declarations, we will pay up to the limits shown in your Policy Declarations. The Excess Attendant Care Coverage limit shown in your Policy Declarations is in addition to the Limit Of Liability shown in your Policy Declarations for medical expenses.

III. **Part E - Duties After An Accident Or Loss**

Part E is amended as follows:

A. Duties **B.1.** and **B.5.** are replaced by the following:

A person seeking coverage must:

1. Cooperate with us in the investigation or settlement of any claim.
2. Submit a written proof of claim when required by us.

B. Duty **B.2.** does not apply.

C. The following duty is added:

A person seeking coverage must promptly send us copies of the legal papers if a suit is brought.

D. Paragraph B.3.b. does not apply.

IV. **Part F - General Provisions**

Part F is amended as follows:

A. The **Legal Action Against Us** Provision is replaced by the following:

LEGAL ACTION AGAINST US

No legal action may be brought against us until there has been full compliance with the terms of this coverage. In addition, no legal action may be brought against us after one year from the date of accident causing the injury unless:

1. Written notice of the injury has been given to us within one year from the date of the accident; or

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2. We have already paid any personal injury protection benefits for the injury.

If either **1.** or **2.** apply, you may bring action against us. Action must be brought within one year from the date the most recent medical or funeral expense or work or survivor's loss was incurred.

The commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of personal injury protection benefits until the date we formally deny the claim. Such tolling does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence.

No one may recover benefits for any portion of the loss incurred more than one year before the date on which the action was begun.

B. The **Our Right To Recover Payment** Provision is amended as follows:

OUR RIGHT TO RECOVER PAYMENT

1. Paragraph **A.** of the provision is replaced by the following:

   If we make a payment under this coverage and the person to or for whom payment was made has a right to recover damages from the owner or operator of a motor vehicle, and that owner or operator is an uninsured motorist, we shall be subrogated to that right. That person shall do:

   1. Whatever is necessary to enable us to exercise our rights; and
   2. Nothing after loss to prejudice them.

2. The following is added to Paragraph **B.** of the provision:

Our right is subject to any applicable limitations stated in the Michigan Insurance Code.

C. The following provisions are added:

DUPLICATION OF BENEFITS

No one will be entitled to duplicate payments for the same elements of loss under this coverage regardless of the number of:

1. Vehicles covered; or
2. Insurers (including self-insurers) providing coverage in accordance with the Michigan Insurance Code or any other similar law.

If there is any other insurance plan providing coverage for expenses or loss covered under Personal Injury Protection Coordination of Benefits or primary Benefits, the coverage provided under this Personal Injury Protection Coordination of Benefits or Primary Benefits shall be coordinated with the coverage available under all such policies and plans so that up to, but no more than, one hundred percent (100%) of any such expenses or loss shall be recoverable under this and all such policies and plans combined.

An "insured" who sustains "bodily injury" resulting from an "auto accident" which shows evidence of the involvement of an "auto" while an operator or passenger of a motorcycle shall claim insurance benefits in the following order of priority:

1. The insurer of the owner or registrant of the "auto" involved in the accident.
2. The insurer of the operator of the "auto" involved in the accident.
3. The "auto" insurer of the operator of the motorcycle involved in the accident.
4. The "auto" insurer of the owner or registrant of the motorcycle involved in the accident.

If personal injury protection benefits are payable under two or more policies in the same order of priority, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any one of the policies.

Other Insurance

If Medical Expenses are payable under two or more policies, benefits are only payable up to an aggregate coverage

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limit that equals the highest available coverage limit under any one of the policies.

If an "insured" is a named insured under this Policy and that "insured" is insured as a "family member" under another policy providing similar coverage, Medical Expenses benefits for such named insured are only payable up to the Limit Of Liability shown in your Policy Declarations for each person under this Policy.

PREMIUM RECOMPUTATION

The Michigan Insurance Code places certain limitations on a person's right to sue for damages. The premium for this policy reflects these limitations. A court from which there is no appeal can declare any of these limitations unenforceable. If this occurs, we will have the right to recompute the premium. You can choose to delete any coverage as the result of the court's decision. If you do, we will compute any refund of premium on a pro rata basis.

Qualified Health Coverage Ineligibility

The named insured shall notify us when "qualified health coverage" has been terminated for you or any "family member" if your Policy Declarations indicates that coverage for medical expenses is excluded for you or any "family member". In such case, the named insured shall obtain coverage for personal injury protection benefits within 30 days after the effective date of the termination of "qualified health coverage".

If it is determined that:

1. The named insured did not have a "qualified health coverage" as defined in Paragraph **D.1.** of the Definitions section; or
2. Any "family member" did not have "qualified health coverage" as defined in Paragraph **D.1.** or **D.2.** of the Definitions section;

in effect at the time an accident occurred which resulted in "bodily injury" to that named insured, "family member" after the 30-day period in which the "qualified health coverage" has elapsed and the named insured did not obtain personal injury protection coverage within such period, such injured person is not entitled to medical expenses benefits under this Policy.

Canty MOA App'x, p.105a

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Liberty Mutual INSURANCE

AMENDMENT OF POLICY DEFINITIONS - MICHIGAN

THIS ENDORSEMENT CHANGES YOUR POLICY - PLEASE READ IT CAREFULLY

THIS ENDORSEMENT SUPERCEDES ALL OTHER ENDORSEMENTS WHICH HAVE BEEN MADE PART OF YOUR POLICY AND REFERENCE THESE SAME PROVISIONS.

It is agreed that item **A.** under the **DEFINITIONS** provisions of the contract is deleted and replaced with the following:

A. Throughout this policy, "you" and "your" refer to:
1. the "named insured" shown in the declarations, and the spouse of the "named insured," if a resident of the same household; or
2. the partner in a civil union, registered domestic partnership or other similar union or partnership, with the "named insured" shown in the Declarations, if a resident of the same household.

Section **2.** above, only applies if the civil union, registered domestic partnership or other similar union or partnership is validly entered into under the law of any state, territory or possession of the United States of America, any territory or province of Canada, or the equivalent of a state or province of any other country.

The spouse or partner is considered a resident of the household when there is a legitimate marital covenant or lawfully recognized partnership, shared economic and non-economic burdens, and legitimate reasons for the spouse or partner to be staying in another home or location.

It is further agreed that paragraph **A.** of the **TRANSFER OF YOUR INTEREST IN THIS POLICY** is deleted and replaced with the following:

A. Your rights and duties under this policy may not be assigned without our written consent. However, if a named insured shown in the Declarations dies, coverage will be provided for:

1. the surviving spouse or partner in a civil union, registered domestic partnership or other similar union or partnership. Coverage applies to the spouse or partner in a civil union, registered domestic partnership or other similar union or partnership as if a named insured shown in the declarations; and
2. the legal representative of the deceased person as if a named insured shown in the Declarations. This applies only with respect to the representative's legal responsibility to maintain or use "your covered auto."

All other terms and conditions of this policy remain unchanged.

[redacted]

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Liberty Mutual INSURANCE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PERSONAL AUTO
PP 05 91 11 94

PROPERTY PROTECTION COVERAGE - MICHIGAN

With respect to coverage provided by this endorsement, the provisions of the policy apply unless modified by the endorsement.

SCHEDULE

Benefit	Limit of Liability
Property Protection Coverage	$1,000,000

I. DEFINITIONS

The Definitions section is amended as follows:

A. The definition of "your covered auto" is replaced by the following:

"Your covered auto" means an "auto":

1. Which you own;
2. For which you are required to maintain security under the Michigan Insurance Code; and
3. To which the property damage liability coverage of this policy applies.

B. The following definition is added:

"Auto" means a motor vehicle or trailer operated or designed for use on public roads. However, "auto" does not include:

1. A motorcycle or moped;
2. A farm tractor or other implement of husbandry which is not subject to the registration requirements of the Michigan Vehicle Code; or
3. A vehicle operated by muscular power or with fewer than three wheels.

C. "Insured" as used in this endorsement means:

1. You or any "family member" for the ownership, maintenance or use of any "auto". This applies only if Part **A** of this policy applies to that "auto".
2. Any person using "your covered auto" which is owned by you.

II. PROPERTY PROTECTION COVERAGE

INSURING AGREEMENT

We will pay, for an "insured", "property damage":

1. Caused by an accident; and
2. Resulting from the ownership, maintenance or use of an "auto" as an "auto".

This coverage is subject to the provisions of the Michigan Insurance Code. Property protection benefits apply only to accidents which happen in Michigan.

EXCLUSIONS

We do not provide Property Protection Coverage for "property damage":

1. Intentionally caused by any claimant.
2. To the property of any "insured" using "your covered auto" without your expressed or implied consent.
3. To "your covered auto" or its contents.
4. To any vehicle which is not "your covered auto" or its contents. This exclusion (**4.**) does not apply if the vehicle was:
   a. Damaged by "your covered auto"; and
   b. Parked in such a way as not to cause unreasonable risk of the "property damage".
5. To property owned by either:
   a. You; or
   b. Any "family member";
   if you or any "family member" were the:
   a. Owner;
   b. Operator; or
   c. Registrant;
   of an "auto" involved in the accident which caused the "property damage".
6. Resulting from an accident involving an "auto" not owned by, but used by:
   a. You; or
   b. Any "family member";
   to the extent the owner or registrant has the security required under the Michigan Insurance Code.
7. To any property while an "auto" is located for use as a residence or premises.
8. Occurring within the course of the business of:
   a. Repairing;
   b. Servicing; or
   c. Otherwise maintaining;
   motor vehicles.

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Canty MOA App'x, p.107a

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Liberty Mutual INSURANCE

LIMIT OF LIABILITY

Our maximum limit of liability for property protection insurance for all "property damage" resulting from any one auto accident is $1,000,000. This is the most we will pay regardless of the number of:

1. "Insureds";
2. Claims made;
3. Vehicles or premiums shown in the Declarations;
4. Vehicles involved in the accident; or
5. Insurers providing property protection insurance.

However, we will pay the lesser of:

1. Reasonable repair costs; or
2. Replacement costs minus depreciation.

We will also pay, where applicable, the value of loss of use.

III. **PART E - DUTIES AFTER AN ACCIDENT OR LOSS**

Part E is amended as follows:

A. Duty **B.1.** is replaced by the following:

A person seeking coverage must cooperate with us in the investigation or settlement of any claim.

B. The following duties are added:

A person seeking payment must:

1. Take reasonable steps after an accident, at our expense, to protect the damaged property. Any "property damage" due to failure to protect the property will not be paid under this insurance.
2. Permit us to inspect and appraise the damaged property before its repair or disposal.

IV. **PART F - GENERAL PROVISIONS**

Part F is amended as follows:

A. The Legal Action Against Us provision is replaced by the following:

LEGAL ACTION AGAINST US

No legal action may be brought against us until there has been full compliance with the terms of this coverage. In addition, no legal action may be brought against us later than one year from the date of the accident causing the "property damage".

B. The Our Right to Recover Payment provision is amended as follows:

OUR RIGHT TO RECOVER PAYMENT

1. Paragraph **A.** of the provision does not apply.
2. The following is added to Paragraph **B.**:

   Our right is subject to any applicable limitations stated in the Michigan Insurance Code.

C. The following provisions are added:

DUPLICATION OF BENEFITS

No one will be entitled to duplicate payments for the same elements of loss under this coverage regardless of the number of:

1. Vehicles covered; or
2. Insurers (including self-insurers) providing security in accordance with the Michigan Insurance Code or any other similar law.

PREMIUM RECOMPUTATION

The Michigan Insurance Code places certain limitations on a person's right to sue for damages. The premium for the policy reflects these limitations. A court from which there is no appeal can declare any of these limitations unenforceable. If this occurs, we will have the right to recompute the premium. You may choose to delete any coverage as the result of the court's decision. In that event, we will compute any refund of premium on a pro rata basis.

This endorsement must be attached to the Change Endorsement when issued after the policy is written.

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Liberty Mutual INSURANCE

NUCLEAR, BIOLOGICAL, CHEMICAL & MOLD EXCLUSION ENDORSEMENT **AS 3660 03 10**

THIS EXCLUSION APPLIES TO ALL COVERAGES PROVIDED BY THIS POLICY INCLUDING ANY AND ALL ENDORSEMENTS

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

We **do not** provide coverage for loss, damage, injury, liability, cost or expense, due to or as a consequence of, whether controlled or uncontrolled or however caused:

a. Nuclear exposure, reaction or explosion including resulting fire, smoke, radiation or contamination; and/or

b. Biological or chemical attack or exposure to biological or chemical agents, or combination of such agents, including resulting contamination or pollution.

We **do not** provide coverage for loss, damage, injury, liability, cost or expense arising out of or aggravated by, in whole or in part, "mold, fungus, wet rot, dry rot, bacteria or virus."

"Mold, fungus, wet rot, dry rot, bacteria or virus" means any type or form of fungus, rot, virus or bacteria. This includes mold, mildew and any mycotoxins, other microbes, spores, scents or byproducts produced or released by mold, mildew, fungus, rot, bacteria, or virus.

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Liberty Mutual INSURANCE

SPLIT LIABILITY LIMITS

PP 03 09 04 86

SCHEDULE

Bodily Injury Liability	$	**each person**
	$	**each accident**
Property Damage Liability	$	**each accident**

The first paragraph of the Limit of Liability provision in Part A is replaced by the following:

LIMIT OF LIABILITY

The limit of liability shown in the Schedule or in the Declarations for each person for Bodily Injury Liability is our maximum limit of liability for all damages, including damages for care, loss of services or death, arising out of "bodily injury" sustained by any one person in any one auto accident. Subject to this limit for each person, the limit of liability shown in the Schedule or in the Declarations for each accident for Bodily Injury Liability is our maximum limit of liability for all damages for "bodily injury" resulting from any one auto accident. The limit of liability shown in the Schedule or in the Declarations for each accident for Property Damage Liability is our maximum limit of liability for all "property damage" resulting from any one auto accident. This is the most we will pay regardless of the number of:

1. "Insureds;"
2. Claims made;
3. Vehicles or premiums shown in the Declarations; or
4. Vehicles involved in the auto accident.

This endorsement must be attached to the Change Endorsement when issued after the policy is written.

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Liberty Mutual INSURANCE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

COVERAGE FOR DAMAGE TO YOUR AUTO EXCLUSION ENDORSEMENT

PERSONAL AUTO
PP 13 01 12 99

With respect to the coverage provided by this endorsement, the provisions of the policy apply unless modified by the endorsement.

I. Definitions

The following definition is added:

"Diminution in value" means the actual or perceived loss in market or resale value which results from a direct and accidental loss.

II. Part D - Coverage For Damage To Your Auto

The following exclusion is added:

We will not pay for:

Loss to "your covered auto" or any "non-owned auto" due to "diminution in value".

This endorsement must be attached to the Change Endorsement when issued after the policy is written.

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Liberty Mutual INSURANCE

Notice of Membership in Liberty Mutual Holding Company Inc.

While this policy is in effect, the named insured first named in the Declarations is a member of Liberty Mutual Holding Company Inc. and is entitled to vote either in person or by proxy at any and all meetings of the members of said company. The Annual Meeting of Liberty Mutual Holding Company Inc. is in Boston, Massachusetts, on the second Wednesday in April each year at ten o'clock in the morning.

The named insured first named in the Declarations shall participate in the distribution of any dividends declared by us for this Policy. The amount of such Named Insured's participation is determined by the decision of our Board of Directors in compliance with any laws that apply.

Any provisions in the policy relating to:

1. Membership in Liberty Mutual Insurance Company or Liberty Mutual Fire Insurance Company; or
2. Entitlement to dividends as a member of Liberty Mutual Insurance Company or Liberty Mutual Fire Insurance Company

are deleted and replaced by the preceding paragraphs.

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[redacted]

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EXHIBIT C

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Explanation of Review
*** * * * THIS IS NOT A BILL * * * ***

Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Bill: L01-N474-200376

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022

Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319
CR Seq: 0520220103000008705024308033

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description					Explanation Code(s)
				Charges	BR	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Allow.
1	02-26-2021	81	80349	BC	1	CANNABINOIDS NATURAL					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 1 DOS: 02-26-2021 Reviewed: 01-07-2022											
2	02-26-2021	81	80369	BC	1	SKELETAL MUSCLE RELAXANT					224, B41
				250.00	250.00						0.00
Duplicate Reference ID: N474-197523 Line 2 DOS: 02-26-2021 Reviewed: 01-07-2022											
3	02-26-2021	81	80373	BC	1	DRUG SCREENING TRAMADOL					224, B41
				375.00	375.00						0.00
Duplicate Reference ID: N474-197523 Line 3 DOS: 02-26-2021 Reviewed: 01-07-2022											
4	02-26-2021	81	82575	A	1	CREATININE CLEARANCE TES					224, B41
				150.00	150.00						0.00
Duplicate Reference ID: N474-197523 Line 4 DOS: 02-26-2021 Reviewed: 01-07-2022											
5	02-26-2021	81	83986-59	BC	1	ASSAY PH BODY FLUID NOS					224, B41
				100.00	100.00						0.00
Duplicate Reference ID: N474-197523 Line 5 DOS: 02-26-2021 Reviewed: 01-07-2022											
6	02-26-2021	81	80307	A	1	DRUG TEST PRSMV CHEM ANL					224, B41
				1,000.00	1,000.00						0.00
Duplicate Reference ID: N474-197523 Line 6 DOS: 02-26-2021 Reviewed: 01-07-2022											

IF PAYMENT IS DUE, CHECK WILL BE SENT UNDER SEPARATE COVER. APPEALS MUST BE SUBMITTED IN WRITING WITH COPY OF THIS EOR AND SUPPORTING DOCUMENTATION TO

PO BOX 5014, SCRANTON, PA 18505-5014. FOR QUESTIONS CALL: 888-288-7218

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DCN Number: 20220105 0520220103000008705024308033

Explanation of Review
*** * * * THIS IS NOT A BILL * * * ***

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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022

Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319

CR Seq: 0520220103000008705024308033

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BR	Description	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Explanation Code(s) Allow.
7	02-26-2021	81	80323	BC	200.00	1	200.00	ALKALOIDS NOS						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 7 DOS: 02-26-2021 Reviewed: 01-07-2022														
8	02-26-2021	81	80324	BC	300.00	1	300.00	DRUG SCREEN AMPHETAMINES						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 8 DOS: 02-26-2021 Reviewed: 01-07-2022														
9	02-26-2021	81	80345	BC	162.50	1	162.50	DRUG SCREENING BARBITURA						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 9 DOS: 02-26-2021 Reviewed: 01-07-2022														
10	02-26-2021	81	80346	BC	325.00	1	325.00	BENZODIAZEPINES1 12						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 10 DOS: 02-26-2021 Reviewed: 01-07-2022														
11	02-26-2021	81	80348	BC	325.00	1	325.00	DRUG SCREENING BUPRENORP						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 11 DOS: 02-26-2021 Reviewed: 01-07-2022														
12	03-25-2021	81	80349	BC	350.00	1	306.00	CANNABINOIDS NATURAL		44.00				975, B41 0.00
13	03-25-2021	81	80369	BC	250.00	1	250.00	SKELETAL MUSCLE RELAXANT						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 13 DOS: 03-25-2021 Reviewed: 01-07-2022														

IF PAYMENT IS DUE, CHECK WILL BE SENT UNDER SEPARATE COVER. APPEALS MUST BE SUBMITTED IN WRITING WITH COPY OF THIS EOR AND SUPPORTING DOCUMENTATION TO

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DCN Number: 20220105 0520220103000008705024308033

Explanation of Review
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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022

Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319
CR Seq: 052022010300000870502430803 3

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description					Explanation Code(s)
				Charges	BR	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Allow.
14	03-25-2021	81	80373	BC	1	DRUG SCREENING TRAMADOL					224, B41
				375.00	375.00						0.00
Duplicate Reference ID: N474-197523 Line 14 DOS: 03-25-2021 Reviewed: 01-07-2022											
15	03-25-2021	81	82575	A	1	CREATININE CLEARANCE TES					224, B41
				150.00	150.00						0.00
Duplicate Reference ID: N474-197523 Line 15 DOS: 03-25-2021 Reviewed: 01-07-2022											
16	03-25-2021	81	83986-59	BC	1	ASSAY PH BODY FLUID NOS					224, B41
				100.00	100.00						0.00
Duplicate Reference ID: N474-197523 Line 16 DOS: 03-25-2021 Reviewed: 01-07-2022											
17	03-25-2021	81	80307	A	1	DRUG TEST PRSMV CHEM ANL					224, B41
				1,000.00	1,000.00						0.00
Duplicate Reference ID: N474-197523 Line 17 DOS: 03-25-2021 Reviewed: 01-07-2022											
18	03-25-2021	81	80323	BC	1	ALKALOIDS NOS					224, B41
				200.00	200.00						0.00
Duplicate Reference ID: N474-197523 Line 18 DOS: 03-25-2021 Reviewed: 01-07-2022											
19	03-25-2021	81	80324	BC	1	DRUG SCREEN AMPHETAMINES					224, B41
				300.00	300.00						0.00
Duplicate Reference ID: N474-197523 Line 19 DOS: 03-25-2021 Reviewed: 01-07-2022											
20	03-25-2021	81	80345	BC	1	DRUG SCREENING BARBITURA					224, B41
				162.50	162.50						0.00
Duplicate Reference ID: N474-197523 Line 20 DOS: 03-25-2021 Reviewed: 01-07-2022											

IF PAYMENT IS DUE, CHECK WILL BE SENT UNDER SEPARATE COVER. APPEALS MUST BE SUBMITTED IN WRITING WITH COPY OF THIS EOR AND SUPPORTING DOCUMENTATION TO

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DCN Number: 20220105 052022010300000870 5024308033

Explanation of Review
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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

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Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
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Bill Details

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Post Date: 01-14-2022

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Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319
CR Seq: 0520220103000008705024308033

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description					Explanation Code(s)
				Charges	BR	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Allow.
21	03-25-2021	81	80346	BC	1	BENZODIAZEPINES1 12					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 21 DOS: 03-25-2021 Reviewed: 01-07-2022											
22	03-25-2021	81	80348	BC	1	DRUG SCREENING BUPRENORP					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 22 DOS: 03-25-2021 Reviewed: 01-07-2022											
23	05-06-2021	81	80349	ABC	1	CANNABINOIDS NATURAL					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 29 DOS: 05-06-2021 Reviewed: 01-07-2022											
24	05-06-2021	81	80369	ABC	1	SKELETAL MUSCLE RELAXANT					224, B41
				250.00	250.00						0.00
Duplicate Reference ID: N474-197523 Line 30 DOS: 05-06-2021 Reviewed: 01-07-2022											
25	05-06-2021	81	80373	ABC	1	DRUG SCREENING TRAMADOL					224, B41
				375.00	375.00						0.00
Duplicate Reference ID: N474-197523 Line 31 DOS: 05-06-2021 Reviewed: 01-07-2022											
26	05-06-2021	81	80307	ABC	1	DRUG TEST PRSMV CHEM ANL					224, B41
				1,000.00	1,000.00						0.00
Duplicate Reference ID: N474-197523 Line 23 DOS: 05-06-2021 Reviewed: 01-07-2022											
27	05-06-2021	81	80323	ABC	1	ALKALOIDS NOS					224, B41
				200.00	200.00						0.00
Duplicate Reference ID: N474-197523 Line 24 DOS: 05-06-2021 Reviewed: 01-07-2022											

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DCN Number: 20220105 0520220103000008705024308033

Explanation of Review
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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022

Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319
CR Seq: 052022010300000870502430803 3

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description					Explanation Code(s)
				Charges	BR	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Allow.
28	05-06-2021	81	80324	ABC	1	DRUG SCREEN AMPHETAMINES					224, B41
				300.00	300.00						0.00
Duplicate Reference ID: N474-197523 Line 25 DOS: 05-06-2021 Reviewed: 01-07-2022											
29	05-06-2021	81	80345	ABC	1	DRUG SCREENING BARBITURA					224, B41
				162.50	162.50						0.00
Duplicate Reference ID: N474-197523 Line 26 DOS: 05-06-2021 Reviewed: 01-07-2022											
30	05-06-2021	81	80346	ABC	1	BENZODIAZEPINES1 12					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 27 DOS: 05-06-2021 Reviewed: 01-07-2022											
31	05-06-2021	81	80348	ABC	1	DRUG SCREENING BUPRENORP					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 28 DOS: 05-06-2021 Reviewed: 01-07-2022											
32	05-06-2021	81	82575	ABC	1	CREATININE CLEARANCE TES					224, B41
				150.00	150.00						0.00
Duplicate Reference ID: N474-197523 Line 32 DOS: 05-06-2021 Reviewed: 01-07-2022											
33	05-06-2021	81	83986-QW	ABC	1	ASSAY PH BODY FLUID NOS					224, B41
				100.00	100.00						0.00
Duplicate Reference ID: N474-197523 Line 33 DOS: 05-06-2021 Reviewed: 01-07-2022											
34	06-03-2021	81	80349	ABC	1	CANNABINOIDS NATURAL					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 40 DOS: 06-03-2021 Reviewed: 01-07-2022											

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DCN Number: 20220105 052022010300000870 5024308033

Explanation of Review
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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022

Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319
CR Seq: 0520220103000008705024308033

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BR	Description	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Explanation Code(s) Allow.
35	06-03-2021	81	80369	ABC	250.00	1	250.00	SKELETAL MUSCLE RELAXANT						224, B41
														0.00
Duplicate Reference ID: N474-197523 Line 41 DOS: 06-03-2021 Reviewed: 01-07-2022														
36	06-03-2021	81	80373	ABC	375.00	1	375.00	DRUG SCREENING TRAMADOL						224, B41
														0.00
Duplicate Reference ID: N474-197523 Line 42 DOS: 06-03-2021 Reviewed: 01-07-2022														
37	06-03-2021	81	82575	ABC	150.00	1	150.00	CREATININE CLEARANCE TES						224, B41
														0.00
Duplicate Reference ID: N474-197523 Line 43 DOS: 06-03-2021 Reviewed: 01-07-2022														
38	06-03-2021	81	83986-QW-59	ABC	100.00	1	91.75	ASSAY PH BODY FLUID NOS		8.25				975, B41
														0.00
39	06-03-2021	81	80307	ABC	1,000.00	1	1,000.00	DRUG TEST PRSMV CHEM ANL						224, B41
														0.00
Duplicate Reference ID: N474-197523 Line 34 DOS: 06-03-2021 Reviewed: 01-07-2022														
40	06-03-2021	81	80323	ABC	200.00	1	200.00	ALKALOIDS NOS						224, B41
														0.00
Duplicate Reference ID: N474-197523 Line 35 DOS: 06-03-2021 Reviewed: 01-07-2022														
41	06-03-2021	81	80324	ABC	300.00	1	300.00	DRUG SCREEN AMPHETAMINES						224, B41
														0.00
Duplicate Reference ID: N474-197523 Line 36 DOS: 06-03-2021 Reviewed: 01-07-2022														

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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022

Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319
CR Seq: 052022010300000870502430803 3

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description					Explanation Code(s)
				Charges	BR	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Allow.
42	06-03-2021	81	80345	ABC	1	DRUG SCREENING BARBITURA					224, B41
				162.50	162.50						0.00
Duplicate Reference ID: N474-197523 Line 37 DOS: 06-03-2021 Reviewed: 01-07-2022											
43	06-03-2021	81	80346	ABC	1	BENZODIAZEPINES1 12					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 38 DOS: 06-03-2021 Reviewed: 01-07-2022											
44	06-03-2021	81	80348	ABC	1	DRUG SCREENING BUPRENORP					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 39 DOS: 06-03-2021 Reviewed: 01-07-2022											
45	06-17-2021	81	80349	ABC	1	CANNABINOIDS NATURAL					224, B41
				325.00	325.00						0.00
Duplicate Reference ID: N474-197523 Line 45 DOS: 06-17-2021 Reviewed: 01-07-2022											
46	06-17-2021	81	80369	ABC	1	SKELETAL MUSCLE RELAXANT					224, B41
				250.00	250.00						0.00
Duplicate Reference ID: N474-197523 Line 46 DOS: 06-17-2021 Reviewed: 01-07-2022											
47	06-17-2021	81	80373	ABC	1	DRUG SCREENING TRAMADOL					224, B41
				375.00	375.00						0.00
Duplicate Reference ID: N474-197523 Line 47 DOS: 06-17-2021 Reviewed: 01-07-2022											
48	06-17-2021	81	82575	ABC	1	CREATININE CLEARANCE TES					224, B41
				150.00	150.00						0.00
Duplicate Reference ID: N474-197523 Line 48 DOS: 06-17-2021 Reviewed: 01-07-2022											

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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 **Type:** LA **Specialty (1):** CL
Specialty (2): CL

Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022

Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
Adjuster: n1542319
CR Seq: 0520220103000008705024308033

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BR	Description	UR	ADJ	PPO/NEG	CPY/DED	POLICY	Explanation Code(s) Allow.
49	06-17-2021	81	83986-QW-59	ABC	100.00	1	91.75	ASSAY PH BODY FLUID NOS		8.25				975, B41 0.00
50	06-17-2021	81	80307	ABC	1,000.00	1	1,000.00	DRUG TEST PRSMV CHEM ANL						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 50 DOS: 06-17-2021 Reviewed: 01-07-2022														
51	06-17-2021	81	80323	ABC	200.00	1	200.00	ALKALOIDS NOS						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 51 DOS: 06-17-2021 Reviewed: 01-07-2022														
52	06-17-2021	81	80324	ABC	300.00	1	300.00	DRUG SCREEN AMPHETAMINES						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 52 DOS: 06-17-2021 Reviewed: 01-07-2022														
53	06-17-2021	81	80345	ABC	162.50	1	162.50	DRUG SCREENING BARBITURA						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 53 DOS: 06-17-2021 Reviewed: 01-07-2022														
54	06-17-2021	81	80346	ABC	325.00	1	325.00	BENZODIAZEPINES1 12						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 54 DOS: 06-17-2021 Reviewed: 01-07-2022														
55	06-17-2021	81	80348	ABC	325.00	1	325.00	DRUG SCREENING BUPRENORP						224, B41 0.00
Duplicate Reference ID: N474-197523 Line 55 DOS: 06-17-2021 Reviewed: 01-07-2022														

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DCN Number: 20220105 0520220103000008705024308033

Explanation of Review
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Insurance Co

LIBERTY MUTUAL | SAFECO - MI -
Insurance Co: LIBERTY MUTUAL PERSONAL INS CO
PO BOX 5014
SCRANTON, PA 18505-5014

Bill: L01-N474-200376

Provider

PIONEER LAB HOUSTON
1650 W BAKER RD STE B
BAYTOWN, TX 77521-2284

Patient

CANTY, JOSEPH
23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Tax ID: 471677831 Type: LA Specialty (1): CL
Specialty (2): CL
Rendering Provider: PIONEER LAB HOUSTON, LP
External ID: 1347510
Invoice No: 10520Z73950

Claim Number: 0447867440001
DOI/DOL: 02-15-2021
CR Date / BR Date: 01-03-2022 01-05-2022

Policyholder/Insured: JOSEPH CANTY
Policyholder/Insured Address: 23600 W 7 MILE RD APT D210
DETROIT, MI 48219-5610

Bill Details

Dates of Service: 02-26-2021 to 06-17-2021
Post Date: 01-14-2022
Reviewer: SD HJ
Pay Auth: 99
Client Type of Bill: 48
CR Seq: 052022010300000870502430803 3
Adjuster: n1542319

Bill ICD Version: 10

Dx A: Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY
Dx B: Z02.89 ENCOUNTER FOR OTHER ADMINISTRATIVE EXAMINATIONS
Dx C: G89.21 CHRONIC PAIN DUE TO TRAUMA

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BR	Description	UR	ADJ	PPO/NEG	CPY/DED	Explanation Code(s) POLICY	Allow.

Totals

Total Charges:	17,587.50
Bill Review Reductions:	17,527.00
Bill Review Allowance:	60.50
Adjuster Reductions:	60.50
Recommended Allowance:	0.00

Messages

224 A CHARGE WAS MADE FOR A DUPLICATE PROCEDURE AND OR SUPPLY.
975 THIS LINE ITEM WAS REVIEWED USING THE FAIR HEALTH CHARGE BENCHMARK DATABASE MODULE BASED ON THE PROVIDER GEOGRAPHIC AREA.
B41 PAYMENT OF YOUR BILL IS DENIED BECAUSE THERE IS NO FIRST PARTY MEDICAL COVERAGE ON THE POLICY.

Notes

* Unless otherwise noted, this bill has been reviewed according to rules and guidelines established under the Michigan Insurance Code Chapter 500, section 500.3157 for dates of service on or after 7 2 2021. Unless otherwise noted, bill review reductions for dates prior to 7 2 2021 are in accordance with PPO contract guidelines, or negotiated contract guidelines, or due to charges exceeding amounts that would appear reasonable for the provider's geographical region, and or policy limits.

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EXHIBIT D

FORM C

Michigan Selection of Personal Injury Protection (PIP) Medical Coverage

Liberty Mutual INSURANCE

AGENCY:	APPLICANT/NAMED INSURED: Joseph Canty	
	INSURANCE COMPANY: Liberty Mutual Personal Insurance Company	
	POLICY/QUOTE NO.: AOV-243-684347-40	EFFECTIVE DATE: 08/25/2020

READ THIS ENTIRE FORM CAREFULLY

THE PURPOSE OF THIS FORM

The purpose of this form is to explain the choice you have regarding your **Personal Injury Protection (PIP) medical** coverage and to assist you in making that choice. Read this form carefully because the choice you make will have financial consequences.

Personal Injury Protection (PIP) Medical Coverage Explained

Personal Injury Protection (PIP) pays allowable expenses for your care, recovery, rehabilitation, wage loss and replacement services. PIP coverage also includes some funeral expense benefits and survivor's benefits which are paid to your dependents if injuries from an auto accident result in your death. This form allows you to select the level of **PIP medical** coverage you want included with your auto policy.

This form is divided into three sections, which are described below.

- Section A will review your **PIP medical** coverage options and the risks and benefits of each option.
- Section B will ask you to choose ONE coverage option.
- Section C will ask you to certify your choice and acknowledge the information within this form.

NOTICE

You must choose the level of **PIP medical** coverage you wish to have under your auto policy. If you do not make a selection from the options listed:

- Your policy will be issued with unlimited **PIP medical** coverage; AND
- You will be charged the appropriate premium for this coverage.

Definitions

The terms in bold letters throughout this form are defined below for informational purposes only and are not intended to limit or expand coverage that may be available in a particular policy.

Applicant means a person who has submitted an application for insurance but is not yet insured under a policy.

Attendant care means services to assist an injured person with tasks they would normally do for themselves (e.g., eating, bathing, dressing, grooming, and medication administration). It may also involve supervision or other types of support.

Excess attendant care means additional coverage purchased for **attendant care** above the **PIP medical** coverage limit selected for your policy.

Michigan Assigned Claims Plan is a program that may pay benefits to people injured in an accident involving a motor vehicle when there is no applicable auto insurance policy.

Named insured means the individual(s) named in an insurance policy.

Personal Injury Protection (PIP) Medical is coverage under an auto insurance policy issued in Michigan that pays allowable expenses for medical care, recovery, rehabilitation, and some funeral expenses.

Qualified health coverage means either of the following:

- Health and accident coverage that does not exclude or limit coverage for injuries related to auto accidents and has an annual individual deductible of $6,000 or less; OR

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Sign & Return
Canty MOA App'x, p.124a

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- Coverage under both Medicare Parts A and B.

Medicaid and health care sharing ministries are examples of coverages that are NOT considered **qualified health coverage**.

Family member means a person related to you by blood, marriage, civil union, domestic partnership or adoption who is a resident of your household. This includes a ward or foster child who is a resident of your household.

Section A: Your PIP Medical Choices and the Risks and Benefits of Each

Option 1: Unlimited Coverage

This option provides the most coverage. It will pay for **all** allowable expenses for your care, recovery, and rehabilitation if you are injured in an auto accident.

Risks	The premiums for this option are higher than premiums for other options.
Benefits	**PIP medical** will cover costs that may not be covered by health insurance, such as rehabilitation and **attendant care**. This choice will significantly limit the risk that you will have out-of-pocket costs for your care.

Option 2: Limited Coverage of $500,000 or Option 3: Limited Coverage of $250,000

If you choose one of these limits, this amount is the most your auto insurance company will pay per person per accident for an injured person's expenses under **PIP medical** coverage.

Risks	Limited **PIP medical** coverages may not be enough to cover your medical expenses. If your **PIP medical** limit is reached, you may need to rely on other health coverage, which may not cover all medical, rehabilitation or **attendant care** costs. If you do not have other health coverage, you may be personally responsible for paying these expenses. NOTE: Your insurance company must offer **excess attendant care** coverage, which you may purchase for an additional premium. Check with your agent or company for additional information.
Benefits	Lower coverage limits have less expensive premiums than plans with higher or unlimited **PIP medical** coverage. Up to the limit chosen, **PIP medical** will cover the cost of products and services that may not be covered by health insurance, such as rehabilitation and **attendant care**.

Option 4: Limited Coverage of $250,000, with some or all persons excluded from **PIP medical**

This option is only available if you choose the $250,000 **PIP medical** limit.

- A **named insured** who wishes to exclude **PIP medical** must have **qualified health coverage** that is not Medicare.
- Any **family member** who wishes to exclude **PIP medical** must have **qualified health coverage**.

Anyone who is excluded **will** have no **PIP medical** coverage. Anyone who is not excluded will have $250,000 in **PIP medical** coverage.

Risks	ANYONE YOU EXCLUDE WILL NOT HAVE **PIP MEDICAL** COVERAGE. In addition: • Persons relying on **qualified health coverage** to pay for auto accident injuries should be aware that, unlike auto insurance, health insurance stops paying when the policy ends or is canceled. • If any excluded person loses **qualified health coverage**, you must notify your insurer within 30 days of loss of coverage.

Liberty Mutual INSURANCE

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Section A (Continued)

	• Within 30 days of losing **qualified health coverage**, if an excluded person is injured in an auto accident, coverage will be provided by the **Michigan Assigned Claims Plan** up to $2,000,000 if they have no other **qualified health coverage** or **PIP medical** coverage. • A person who has not obtained **qualified health coverage** or **PIP medical** coverage within 30 days of the loss of coverage will not be entitled to any **PIP medical** benefits. NOTE: Your insurance company must offer **excess attendant care**, which you may purchase for an additional premium. This coverage is only available to those who are not excluded from **PIP medical** coverage. Check with your agent or company for additional information.
Benefits	You will pay a reduced premium because you will not be charged a premium for **PIP medical** coverage for anyone who is excluded.

Option 5: Limited Coverage of $50,000

If you choose this limit, $50,000 is the most your auto insurance company will pay per person per accident for an injured person's expenses under **PIP medical** coverage.

You may select this option if:

- The **applicant** or **named insured** is enrolled in Medicaid; AND
- All **family members** have one of the following:
  - **a)** **qualified health coverage**;
  - **b)** Medicaid enrollment, or
  - **c)** coverage under another auto policy with **PIP medical** coverage.

Risks	Limited **PIP medical** coverages may not be enough to cover the cost of your medical care. If your **PIP medical** limit is reached, you may need to rely on other health coverage, which may not cover all medical, rehabilitation or **attendant care** costs. If you do not have other health coverage, you may be personally responsible for paying these expenses. NOTE: Your insurance company must offer **excess attendant care** coverage, which you may purchase for an additional premium. Check with your agent or company for additional information.
Benefits	Lower coverage limits have less expensive premiums than plans with higher or unlimited **PIP medical** coverage. Up to the limit chosen, **PIP medical** will cover the cost of products and services that may not be covered by health insurance, such as rehabilitation and **attendant care**.

Option 6: No **PIP medical** coverage for anyone covered by this policy

You may select this option if:

- The **applicant** or **named insured** has coverage under both Medicare Parts A and B, AND
- All **family members** covered by the policy have **qualified health coverage** or are covered under another auto policy with **PIP medical** coverage.

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Section A (Continued)

Risks	NO **PIP MEDICAL** COVERAGE WILL BE PROVIDED UNDER YOUR POLICY. You and any other persons covered by this policy will not have **PIP medical** coverage. You and those persons may have to rely on other health coverage to pay for medical expenses resulting from an auto accident, which may not cover all products and services that **PIP medical** provides. • Persons relying on **qualified health coverage** to pay for auto accident injuries should be aware that, unlike auto insurance, health insurance stops paying when the policy ends or is canceled. • If anyone covered by the policy loses **qualified health coverage**, you must notify your insurer within 30 days of loss of the coverage. • Within the 30 days of losing **qualified health coverage**, if anyone covered by the policy is injured in an auto accident, coverage will be provided by the **Michigan Assigned Claims Plan** up to $2,000,000 if they have no other **qualified health coverage** or **PIP medical** coverage. • A person who has not obtained **qualified health coverage** or **PIP medical** coverage within 30 days of the loss of coverage will not be entitled to any **PIP medical** benefits.
Benefits	You will pay a reduced premium because your policy will not be charged a premium for **PIP medical** coverage.

Section B: PIP Medical Coverage Options and Certification

Make your selection carefully because the choice you make will have financial consequences. If you choose more than one option, your insurer will provide you with the option that has the highest level of benefits and will charge the appropriate premium for that option.

If not already marked, please indicate your PIP Medical Coverage selection:

☐ Option 1: Unlimited coverage **OR**

☐ Option 2: $500,000 per person per accident **OR**

☐ Option 3: $250,000 per person per accident **OR**

☐ Option 4: $250,000 per person per accident with exclusions **OR**

By selecting Option 4, you certify that one or both of the following are true:

- A **named insured** who is excluding **PIP medical** has **qualified health coverage** that is not Medicare.
- Any **family member** who is excluding **PIP medical** has **qualified health coverage.**

Full Name of Excluded Named Insured(s) and/or Family Member(s)	Date of Birth

Canty MOA App'x, p.127a

Liberty Mutual INSURANCE

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Section B (Continued)

Full Name of Excluded Named Insured(s) and/or Family Member(s)	Date of Birth

☐ Option 5: $50,000 per person per accident **OR**

By selecting Option 5, you certify that both of the following are true:

- The **applicant** or **named insured** is enrolled in Medicaid; AND
- All **family members** have **qualified health coverage**, is enrolled in Medicaid, or are covered under another auto policy with **PIP medical** coverage.

☒ Option 6: No **PIP medical** coverage.

By selecting Option 6, you certify that both of the following are true:

- The **applicant** or **named insured** has coverage under both Medicare Parts A and B; AND
- All **family members** have **qualified health coverage** or are covered under another auto policy with **PIP medical** coverage.

Section C: Certification

You must initial each line and sign and date this form.

J.C. (Initial) — I have read this form. I understand the **PIP medical** options available to me and the benefits and risks associated with those options.

J.C. (Initial) — I have made a coverage selection and I understand that the selection I have made applies to me and any other person claiming benefits under this policy.

J.C. (Initial) — I understand that if I have not made a selection my policy will be issued with unlimited **PIP medical** coverage and I will be charged the premium for this option.

J.C. (Initial) — I understand that if I have chosen Option 4 or Option 6, I must notify my insurer within 30 days if a person who has **qualified health coverage** loses their **qualified health coverage**. A person who has not obtained **qualified health coverage** or **PIP medical** coverage within 30 days of the loss of coverage will not be entitled to any **PIP medical** benefits.

e-Signed by Joseph Canty on 2020-08-28

Signature of Applicant/Named Insured — Date

Canty MOA App'x, p.128a

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MOA App'x 8: February 7, 2023 Hearing Transcript 11-24

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH WILLIAM CANTY,

Plaintiff, Case No. 21-004799-NI

vs.

MICHAEL CHESTER MASON,

Defendant.

ZOOM Proceedings taken in the above-entitled matter before **HONORABLE KATHLEEN McCARTHY**, Third Judicial Circuit Court Judge, Detroit, Michigan, on February 7, 2023.

APPEARANCES:

On behalf of Plaintiff: MR. ERIK STONE (P55304)
26777 Central Pk. Blvd #300
Southfield, MI 48076

On behalf of Defendant: MS. ANGELA ESSEILY (P81816)
P.O. Box 8084
Royal Oak, MI 48068

Shelee Beard, CSR-5493
Official Court Reporter

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Detroit, Michigan

February 7, 2023

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THE COURT: I'm on the record on case number 2021-004799-NI. Counsel for Plaintiff, your appearance.

MR. STONE: Erik Stone appearing on behalf of plaintiff.

THE COURT: Counsel for Defense.

MS. ESSEILY: Angela Esseily appearing on behalf of defendant.

THE COURT: I know there's an issue regarding the hearing; it was a motion for summary. I had made a ruling. There's a dispute about the 7 day orders. Frankly, that got me researching this issue a little bit more, and I believe my ruling is incorrect. So in looking at this issue further because Medicare and Medicaid are exempt from the no fault statute, there is no duty to mitigate. Medicare is normally rejected if there's an auto accident because it's exempt under the federal court. So Mr. Stone, I believe, argued that and is correct in that ruling.

This is a third party case. Was there

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a -- There wasn't a first party because he opted out.

MR. STONE: Correct.

THE COURT: Under the third party case he just has to show what ever was charged by his providers was reasonable and necessary.

MS. ESSEILY: Judge if I could make a clear record on this based on the previous -- I mean, we were only here to clarify this order. It's still defendant's position the legislature intent was very clear here. They even quantified there would be increase in payment Medicare and Medicaid would be making on these no fault cases. At the end of the day, the whole point of the opt out was for the intent that people can take a deduction. He didn't have to do this opt out, and he chose to do it anyway. To penalize everyone around hundred him, we believe that's not the intent. He opted out the first party benefits here. There need to be a duty to mitigate based off that --

THE COURT: Here's your problem; if it had been a qualified health insurance plan, I agree with you, but Medicare is not a qualified health insurance plan, and the federal law has

specifically exempted it. So you can disagree with me; I'm not going to argue with you. I have a right to revisit my opinions on my own motions; I have chosen to do that. And I found my previous ruling is in error, and there is no duty to mitigate. He couldn't even collect Medicare. If a bill went to Medicare, he had a duty to inform them that this was an auto accident. It's an affirmative duty so they can lien the file to the extent they paid for Medicare. His only duty is to make sure the bills are reasonable and necessary.

MS. ESSEILY: Judge, if you could allow me to make a full record for purposes of appeal. Plaintiff made a decision to accept a discounted rate by opting out of allowable expense coverage based on Medicaid part A and B coverage. I know this is going to be redundant, but the opt out as the legislature addresses would shift cost of certain medical expenses. Because plaintiff chose not to rely on the no fault system, he cannot just throw up his hand and assume alleged tortfeasor will absorb the cost.

The court of appeals previously ruled that you would still be able to mitigate despite

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it not be a codified -- it doesn't have to be codified in No-Fault Act, but there would still be a duty. That was in Bazzi V Citizens. Plaintiff can't just rack up medical cost and assume payment from an alleged tortfeasor when there could have been -- could have been a way to minimize those damages.

In this case, despite receiving an EOB denying claims from his auto carrier which is Liberty, they continue to bill and bill and bill without any intentional recourse. There was actually no attempt to mitigate. We have a bill that's been racked up with Northland nearly $200,000. Plaintiff's allegations that the right of plaintiff to treat wherever he wants, or the notion to treat no matter that benefits the tortfeasor entirely is missing the point. The duty to mitigate is not to benefit the tortfeasor rather to prevent needless accumulation of economic loss that could otherwise be avoided.

As far as the second issue relating to 3135 argument despite plaintiff's claiming no obligation to submit these bills, the legislature predicated opt out in insurance that the insureds had other means of coverage. I'm repeating that

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over and over. I think it worthy to be noted. If your Honor does not believe there's a duty to mitigate, I would like your Honor to still consider that the No-Fault Act has to be read as a whole and as such 3135 refers to a potential claimant allowable expenses. Plaintiff should still have those limits listed in 3107 to 3110, allowable expenses also includes. Allowable expenses means as well the fee schedule that was also written out in the statute 3157 subsection 2 of the statute

The plaintiff made the decision to disregard submissions to Medicare despite the election and despite asking over and over again, recover of allowable expenses should still be required to be mitigated. And there was a failure to do so here.

THE COURT: Thank you. You've made your record. I will add to my ruling that he is subject to the fee schedule under 3157. It specifically references Medicare. I don't know the dates of service of ur client. Go ahead.

MR. STONE: In the third party case he's not limited to fee schedule, that's only in the first party. That needs be clarified because

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that was Ms. Esseily's intention. She believed the fee schedule applies to all bills in the third-party case. The statute says anything but not limited to. There is no limit on third party. As far as him having a duty to mitigate, he opted out. This tortfeasor could very well have $50,000 policy. And then he would be stuck with all the automobile bills, or the accident bill, or the medical bills.

MS. ESSEILY: Your Honor, to Mr. Stone's point, if that were the case, plaintiff would have likely submitted all those bills to Medicare. As far as my 3157 argument, 3135 refers to allowable expenses. I believe that plaintiff would be subject to the fee schedule pursuant to the No-Fault Act that is provided. I understand this is a third-party case, but the legislature didn't abandon the notion of allowable expenses. It didn't abandon the way that it was intended to be, or the way it was written in the no-fault act. In fact, they refer, to -- If there was no intent for a third party and to base it off of the No-Fault Act, they would have never referred to allowable expenses.

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MR. STONE: One more thing, your Honor, if I may. If this were the case, we have a fee schedule that's 200 percent on. Therefore if you bill Medicare you would get Medicare rates where the fee scheduled is a heck of a lot more than Medicare rates. We went through Medicare to get an amount when no fault is 200 times that amount.

THE COURT: That's my point. What 3157 says she wants a fee schedule, then it's probably the same as what they're billing.

MR. STONE: The fee schedule is nowhere mentioned in 3135. There's no referenced statute that fee schedule applies in the third party case. This gentleman had a severe knee injury and went to Canada to have it operated on.

THE COURT: Hold on a second. 500.3157 says charges for treatment or training for injured person. It doesn't say it's limited to first-party cases.

MR. STONE: 3135 is the statute under the first party. Once you opt out, there's no PIP benefits. The fee schedule can't apply because there's no PIP benefits. That's the whole point of opting out.

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THE COURT: Give me a second. I've got to read 3135. Thank you. I just reviewed 500.3135. Again, I agree with plaintiff's position there's nothing in the statute that indicates that the fee schedule 3157 would apply on a third-party claim.

MS. ESSEILY: Your Honor, If I can just briefly respond to that, the -- I'm not arguing 3157 isn't noted in the statute. I don't think it necessarily makes sense to read 3135(3)(c) on its own. The entire No-Fault Act has to be read. It still says damages are allowable expenses and references 3157. It's not completely abandoning the notion that still following the No-Fault Act and still following the 3157 which is how we're now considering payments of bills. I don't think that was the legislature's intent.

THE COURT: I believe their intent was to help people of lower means to have affordable car insurance. People of lower means are identified by either being on Medicare, which means they're retired, and/or Medicaid, which means they're income eligible. In looking at the automobile code in conjunction with this makes perfect sense to me that this does not apply.

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The law is clear that Medicare is a separate government policy that does not get invoked when there's an auto policy in place.

That's my ruling. He obviously has an obligation to make sure his bills are reasonable and necessary. That's where we're at. I need an order, Mr. Stone, from you today indicating that the Court has revisited the issue on its own motion. And that's my ruling. And then you two have a final settlement conference, correct?

MS. ESSEILY: Yes. In considering the ruling, respectfully, your Honor --

THE COURT: It's not personal to me.

MS. ESSEILY: We're likely going to file a motion for reconsideration. I know the trial is less than a month. I -- my client may want to even appeal this. I think it's a good idea to adjourn the trial concerning the facts of bills. We have to be sure what bills should be included at trial. I think we'll benefit interest of judicial economy.

THE COURT: What is the amount of the policy in this case?

MS. ESSEILY: 250,000.

THE COURT: What are the amount of

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bills? Mr. Stone has a point; if the whole policy is used up paying medical providers then the client doesn't get anything for pain and suffering.

MS. ESSEILY: Your Honor, if reasonable and customary still applies, we can have some discussion about exactly what's been paid out on bill. It's a decent policy.

MR. STONE: Your Honor, that's to be determined by a jury.

THE COURT: Okay. Sure.

MR. STONE: For this bill I believe he should get 10,000 versus --

THE COURT: What are at amount of him current bills?

MR. STONE: I don't know. They're pretty extensive.

MS. ESSEILY: I think they're over 200.

MR. STONE: 250.

THE COURT: You're indicating you'll leave it to the jury to apportion.

MR. STONE: Correct.

THE COURT: That is the hazard of somebody not taking PIP coverage.

MR. STONE: Correct.

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MS. ESSEILY: Your Honor, what ever happens with this ruling maybe it's prevalent to see what happens before trial on this ruling in general.

THE COURT: You're free to file a motion for reconsideration. I need to know whether you filing an appeal. If it's filed, I'll cancel the trial. If it's not filed, I'm proceeding with the trial.

MS. ESSEILY: Okay.

THE COURT: All right.

(Whereupon proceedings concluded.)

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STATE OF MICHIGAN)
) SS
COUNTY OF WAYNE)

R E P O R T E R' S C E R T I F I C A T E

I, Shelee Beard, CSR-5493, do hereby certify that I have transcribed the **VIDEO** proceedings had in the above-entitled matter at the time and place hereinbefore set forth and that the foregoing is a true and correct transcript of proceedings.

/s/ Shelee Beard

Shelee D. Beard, CSR-5493
921 Coleman A. Young Municipal Center
Detroit, MI 48226
stenobeard@ymail.com

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MOA App'x 9: January 4, 2023 Hearing Transcript

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STATE OF MICHIGAN
IN THE THIRD CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH WILLIAM CANTY,

Plaintiff,

-vs-

MICHAEL CHESTER MASON,

Defendant.
_____/

Case No. 21-004799-NI

Honorable Kathleen McCarthy

DEFENDANT'S MOTION FOR PAYMENT OF MEDICAL BILLS

BEFORE THE HONORABLE Kathleen McCarthy,

Third Circuit Court, Civil Division

Detroit, Michigan on

Wednesday, January 4, 2023

APPEARANCES:

On Behalf of Plaintiff: **ERIK J. STONE** (P-55304)
26777 Central Park Blvd, #300
Southfield, MI 48076
(248) 233-5050

On Behalf of Defendant: **ANGELA ESSEILY** (P-81816)
P.O. Box 8084
Royal Oak, MI 48068
(313) 237-5636

REPORTED BY: SHELEE BEARD, CSR 5493
Official Court Reporter

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I N D E X

WITNESSES: **PAGE**

None

E X H I B I T S:

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None Offered		

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Detroit, Michigan

Wednesday, January 4, 2023

- - -

THE COURT: We're on the record on case number 2021-004799-NI.

Counsel for Plaintiff, your appearance, please.

MR. STONE: Erik Stone appearing on behalf of the Plaintiff.

THE COURT: Counsel for Defendant.

MS. ESSEILY: Angela Esseily appearing on behalf of Defendant.

THE COURT: Okay. So Defendant has filed a motion in this third party auto neg case because the Plaintiff in this case opted out of first party benefits.

In opting out of first party, he opted out of first party benefits, period. He then began treating with various providers and has not submitted the bill to Medicare.

Defendant maintains that all of these providers, except Medicare and ultimately in their final response indicate that Plaintiff does have a duty to mitigate.

Anything else for the record, Counsel

for Defendant?

MS. ESSEILY: Yes, Judge, if I could just briefly.

I know you've read through all the briefs and gotten through everything. But I just want to emphasize that it has been ruled in the Court of Appeals that the duty to mitigate is not something that needs to be abrogated. It doesn't have to be written out into the law.

THE COURT: Common law duty.

MS. ESSEILY: Yeah. And the person wronged cannot recover for any damages as it relates to the failure to mitigate.

Additionally, even if this Court dos not find that mitigation is pertinent here, which I believe it absolutely is, at the end of the day, the Plaintiff must comply with 3135(C) which requires them to limit the pricing based on 3107 and 3157.

THE COURT: Okay. So those are two different issues.

MS. ESSEILY: Yes.

THE COURT: So let's break them down.

I agree with you that Plaintiff has a duty to mitigate. The whole purpose of the

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insurance reform in allowing someone to opt out was to guarantee that they had underlying insurance and/or that they were a qualified Medicare or Medicaid recipient.

And so even if it doesn't plainly state in the statute, it would defy common sense to indicate you have to have insurance or you have to have Medicare but you don't have to bill them.

Anything to add on that issue, Mr. Stone?

MR. STONE: Yes. I could like to counter the point --

THE COURT: Sure.

MR. STONE: That Medicare is not responsible for any no-fault or any damages arising out of an automobile motor vehicle accident.

I don't know who, I've even provided the Court rejections from Medicare on this saying they're not paying it because it arose out of a motor vehicle accident. Medicare is not responsible for this, Your Honor. You cannot --

THE COURT: I know your argument. And your argument is that if you're -- I don't know that's the case if you opt out because the

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insurance information that one of you provided, I think it was Ms. Esseily, clearly anticipated that Medicare costs were going to go up with this new opt out in auto insurance.

MR. STONE: But we provided this Court with documentation that it's been rejected by Medicare. That proves my point.

THE COURT: Okay. Hold on. I didn't see that.

MR. STONE: Lucid's billing which is 24,000 has been rejected by Medicare.

THE COURT: Only, what exhibit that is?

MR. STONE: I can't tell.

THE COURT: Hold on, don't over talk him. I just want to see what he's talking about first.

MS. ESSEILY: I apologize.

MR. STONE: And if I could continue my argument with regards to the Medicare.

THE COURT: Well, I think it makes a difference. I think you have to submit them to Medicare. And if Medicare rejects, then Medicare rejects. I think that's a different argument.

But I think you have an obligation to

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submit to his, either health insurance or Medicare with anticipated with the opt out.

MR. STONE: But if you don't, under the No-Fault law, you don't have to treat with anyone. You don't have to treat with Medicare. You don't have to treat with Medicaid. You could treat in Saudi Arabia if you wanted. Okay.

Why is there -- why would you be putting a bigger protection on someone who is not at fault, who opted out of no-fault? No fault does not even apply here. The word --

THE COURT: Because it's anticipated to be qualified to opt out, otherwise prior to the changes, you had to.

MR. STONE: But you don't have to go to someone who treats Medicare.

THE COURT: Well, in this case they did. And if they did, they have to submit them to Medicare.

MR. STONE: And only one of the places did, treats Medicare.

THE COURT: Go ahead and make a record. I'm not going to argue the point. Go ahead and make a record.

MR. STONE: Well, I'd like to know

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what your ruling is first, Your Honor.

THE COURT: My ruling is that you have, there's a common law duty to mitigate. You have an obligation to mitigate that the changes in the No-Fault law anticipated you could only opt out if you had qualified health insurance or you were a Medicare recipient.

Obviously that anticipation was that your health insurance or Medicare was going to be primary. And so that is my ruling.

You have a duty to mitigate. You must submit all of your bills in good faith to Medicare in this case.

MR. STONE: May I clarify?

What if the provider does accept or bill Medicare?

THE COURT: That's a secondary issue that Ms. Esseily, is it Esseily?

MS. ESSEILY: Esseily.

THE COURT: And her second argument is that he is then subject to a Medicare fee schedule; correct, that's your second argument, Ms. Esseily?

MS. ESSEILY: Yes, Judge. You'd still be required to submit the bills based on the

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statute of limitations, 3107, 3157.

THE COURT: In that case I disagree with you on that second part because I don't see anywhere in the statute that does require, as Mr. Stone said, to treat with a Medicare provider, unfortunately. It seems like it's a loophole in this new statute.

But I don't see any cases or anything in the statute that indicates that requirement.

So I have to deny that request. I think he has -- I'm ruling that it's granted in part and denied in part. He has to submit all of these bills in good faith to Medicare for payment. And anything above and beyond is the responsibility of the insurance company.

MR. STONE: Your Honor, may I make one other point here?

The ruling logically doesn't make sense because the provider in this case, if the person had, if Mr. Canty had no-fault insurance, would be getting the fee schedule and this hospital case would be 2 to 300 times the point of Medicare.

Since if he opts out and the provider now only gets Medicare rates. So yes, your ruling

on the second part is correct. It shouldn't be capped at Medicare. But the provider now, is getting less, way less because you're allowing the bill -- You're not allowing the bill.

MS. ESSEILY: Judge, if I may reply?

THE COURT: I'm not sure what you just said, so you'll have to go through that. You have like four different providers. You got a provider that --

MR. STONE: Right. Let's say it's no-fault, Your Honor. And the Medicare bills, he goes to Medicare, he bills Medicare because all right, the provider bills Medicare, they get a fee schedule. No-fault would pay him two and a half times Medicare, 200 percent of Medicare.

We go to the third party case. That bill now is not 200 times Medicare. That's just the Medicare bill. So the provided is getting jobbed because there's no no-fault insurance. And that is fine but that isn't what they opted out of no-fault for.

They opted out to have their no-fault reduced, not the amount of damages or where they can go reduce. They opted out to have their -

THE COURT: You're arguing two

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different points. One is the person paying for no-fault. And again, they can only opt out if they have a qualified insurance.

And secondly, these providers that accept Medicare have already agreed to accept those reduced rates because they work under a Medicare fee agreement.

So I disagree with you.

MR. STONE: Okay. Then if Medicare rejects and in this case the other providers do not, have never billed, they're not associated with Medicare, those bills are still in then.

THE COURT: Right. You have to submit them if they accept Medicare. And then if anything, if they reject or anything over and above is subject to the third party case.

It doesn't make sense to me, honestly. But that's so far what the statute says. I imagine there'll be an amendment down the line. But that's how I view it.

MR. STONE: Thank you for your time today, Your Honor.

MS. ESSEILY: If I can just add one more thing --

THE COURT: Sure.

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MS. ESSEILY: For the record.

THE COURT: Sure.

MS. ESSEILY: To his reply, I mean, I think it should be noted that 3135(3)(c) 3107 and 3110 as allowable expenses and I think it goes, saying that it would lead to 3157. And I understand the Judge's point that this is, it's not necessarily mentioned in 3135(3)(c), however, I think it needs to be noted.

Additionally, even if, I mean in the case of Lucid's bill because he did note it, I just want to make it clear for the record.

My understanding is the Lucid bill was denied because they did not, they did not provide complete information for it to be completely processed through Medicare. It wasn't denied because they don't accept it.

And then lastly --

THE COURT: That was my point about saying that they have to be submitted in good faith. I agree with you, if there's something that's missing, that needs to be provided to get Medicare to pay for it. That is required on the Plaintiff to do that.

I don't know how you're going to word

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that in an order. That's why I said good faith submission with responding to them if they say there's a defect for something that can be easily cured.

You know, that gets into a Toussaint argument. I mean, you have kind of the same issue.

MS. ESSEILY: So I guess, just to clarify too for the order, I can, as far as the mitigation issue, that is granted. And then as far as the duty to submit these bills to Medicare, it's just in good faith.

Is that how you would like it worded?

THE COURT: I guess.

MS. ESSEILY: I just want to make sure that I'm not wording --

THE COURT: I was hoping that you're going to sound more eloquent than I was.

MS. ESSEILY: I know, I need to write it.

THE COURT: You work with that. Granted in part and denied in part because I don't think he has an obligation to treat with Medicare providers. I don't see that anywhere in the statute.

MS. ESSEILY: Okay. And --

THE COURT: Appeal me. And then you'll get the Court of Appeals to decide this issue. I don't know.

MS. ESSEILY: I guess, Judge, I just want to clarify, my argument wasn't necessarily that he had to treat with Medicare.

THE COURT: Object to the fee schedule, yes.

MS. ESSEILY: Okay.

THE COURT: That's where I disagreed with you, that it's not subject to the fee, it's subject to the auto neg fee schedules. But it's not subject to the Medicare fee schedule if the provider isn't a Medicare recipient, isn't a Medicare provider, I mean.

MS. ESSEILY: Okay. But it would still be subject to the fee schedule based on 3107. Okay.

THE COURT: You're muted, Mr. Stone.

MR. STONE: What would be subject to the fee schedule?

THE COURT: Anything after the treatment date of the changes. Is there a fee schedule after June of 2019 or 2020?

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MR. STONE: And what about the excess that Medicare, that's beyond Medicare?

THE COURT: Right. Then that is the responsibility of the insurance company. That's what I've indicated.

But on Medicare, people that submit the Medicare, there should be any, they're agreeing to the Medicare rate so I don't know how there would be anything in excess. But -

MR. STONE: Well, the bills -- well, okay. They don't have to agree to the Medicare rates, that's the thing.

THE COURT: If they're a Medicare provider, they do. That's the contract that they signed up to accept Medicare.

MS. ESSEILY: At the end of the day, the providers were aware there was Medicare and they continued to treat. They could have --

THE COURT: Okay. I don't want to go back and forth. You have my ruling. Please submit an order.

MS. ESSEILY: Thank you, Judge.

THE COURT: All right.

Have a great day, guys.

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MS. ESSEILY: Thank you.

You as well.

THE COURT: Thanks.

- - -

(Whereupon proceedings concluded.)

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S T E N O G R A P H E R ' S C E R T I F I C A T E

STATE OF MICHIGAN)
) SS
COUNTY OF WAYNE)

I, **Shelee Beard**, CSR-5493, Certified Court Reporter in and for the Third Circuit Court, Wayne County, State of Michigan, do hereby certify that the foregoing pages 1 through 16 inclusive, was reduced to typewritten form by means of Computer-Assisted Transcription and comprise a true and accurate transcript of the proceedings in the above-entitled matter, on Wednesday, January 4, **2023.**

Shelee Beard

SHELEE BEARD, CSR-5493
Certified Court Reporter
Third Circuit Court
921 CAYMC
Detroit, MI 48226

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MOA App'x 10: Brehmer v. State Farm Mut. Ins. Co., 2015 Mich. App. LEXIS 53

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Brehmer v. State Farm Mut. Ins. Co.

Court of Appeals of Michigan

March 17, 2015, Decided

No. 318839

Reporter
2015 Mich. App. LEXIS 530 *

RICHARD BREHMER, Plaintiff-Appellee, v STATE FARM MUTUAL INSURANCE COMPANY and NICOLE ALISE ROTHMAN, Defendants, and AUTO OWNERS INSURANCE COMPANY, Defendant-Appellant.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: [*1] Lenawee Circuit Court. LC No. 11-004097-NF.

Counsel: For Richard Brehmer, Plaintiff-Appellee: Courtney E. Morgan Jr., Dearborn, MI.

For State Farm Mutual Insurance Company, Defendant: John C. Fish, Kalamazoo, MI.

For Nicole Alise Rothman, Defendant: Jennifer M. Kelly, Jackson, MI.

For Auto Owners Insurance Company, Defendant-Appellants: Frederick W. Girodat II, Jennifer M. Kelly, Jackson MI.

Judges: Before: BOONSTRA, P.J., and SAWYER and O'CONNELL, JJ.

Opinion

PER CURIAM.

In this third-party auto accident case, defendant Auto Owners Insurance Company (Auto Owners) appeals as of right the trial court's order granting Richard Brehmer's motion for judgment notwithstanding the verdict (JNOV). We reverse.

I. FACTS AND PROCEDURAL HISTORY

A. TRIAL TESTIMONY

Brehmer and Nicole Rothman were involved in a traffic accident in May 2010. Brehmer testified that he was driving a tractor for the City of Adrian when Rothman ran into it. The tractor flipped over on Brehmer, and his right arm and shoulder were injured. Brehmer had an underinsured motorist policy with Auto Owners. The only issues at trial were whether Brehmer's shoulder injury constituted a serious impairment of a bodily function and whether Brehmer failed to mitigate his damages.

Brehmer testified that he began physical therapy shortly after the accident. In July 2010, Brehmer's family physician referred him to Dr. Michael Diment. Brehmer testified that Dr. Diment prescribed him physical therapy, which he did, but his shoulder continued to hurt. Dr. Diment took an MRI of Brehmer's shoulder. Dr. Diment [*2] testified that Brehmer had suffered three shoulder injuries: a rotator cuff tear, a deformity to the dimple in the bone, and an injury to the shoulder socket. Brehmer testified that Dr. Diment performed surgery on his shoulder in October 2010.

According to Brehmer, he discussed the exercises he had learned at his prior physical therapy with Dr. Diment, and Dr. Diment told Brehmer to do those exercises at home. Brehmer testified that he did the exercises for 10 to 15 minutes a day, and Dr. Diment said that his at-home exercises were "fine." According to Dr. Diment, he ordered Brehmer to do exercises at home. Dr. Diment acknowledged that in November 2010, he noted in Brehmer's file that Brehmer might need formal physical therapy. However, Dr. Diment opined that Brehmer's at-home exercises were sufficient in lieu of physical therapy. Dr. Diment testified that physical therapy could not address Brehmer's bone dimple or shoulder socket injury.

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Brehmer had not improved by April 2011. Dr. Diment told Brehmer that he could have an additional surgery that would manipulate Brehmer's shoulder under anesthesia. Dr. Diment testified that the procedure was "somewhat risky," unpredictable, and that [*3] it could lead to a different pain and instability. Brehmer testified that he decided that he did not want to have the surgery because Dr. Diment told him that there was a risk he could lose his arm or that the surgery would make his problem worse. Dr. Diment supported Brehmer's decision not to have further surgery.

Dr. Diment testified that as of September 2011, Brehmer had improved his range of motion with home exercises. Dr. Diment testified that Brehmer was a compliant patient and he believed that Brehmer was doing his at-home exercises. Dr. Diment did not recommend another surgery or physical therapy. Dr. Diment opined that physical therapy at a rehabilitation center would not have given Brehmer a better result than the exercises he did at home.

Aaron Deline, Brehmer's physical therapist until August 2010, testified that he believed that physical therapy would have helped Brehmer to improve his range of motion. Deline acknowledged that a patient needs a doctor's prescription to receive physical therapy and that Dr. Diment did not refer Brehmer back to physical therapy. Deline testified that Brehmer was compliant at physical therapy sessions, but his therapy notes questioned Brehmer's [*4] compliance with at-home exercises.

Dr. Joseph Salama testified that he interviewed and examined Brehmer in September 2010 and February 2011. According to Dr. Salama, Brehmer needed formal physical therapy to increase his range of motion and decrease his pain. Dr. Salama would have recommend manipulating Brehmer's shoulder under anesthesia and that, if the manipulation went well, it would have a 70 percent chance of success. Dr. Salama did not believe that Brehmer had failed to comply with Dr. Diment's advice.

Dr. Brian Chodoroff testified that he specializes in physical medicine and rehabilitation and that he reviewed Brehmer's medical records. According to Dr. Chodoroff, Brehmer's home exercises were inadequate, and he should have done physical therapy to increase his range of motion. Dr. Chodoroff also opined that Brehmer might benefit from a manipulation under anesthesia, but testified that if Brehmer did not want to undergo a manipulation, he should at least obtain a cortisol injection and physical therapy. Dr. Chodoroff testified that he would not expect a patient to get formal physical therapy if his doctor did not prescribe it, and he opined that Brehmer's records did not indicate [*5] that he had failed to comply with Dr. Diment's orders.

Dr. Casey Bartman testified that he is an orthopedic surgeon who reviewed Brehmer's medical records. According to Dr. Bartman, Brehmer's shoulder injury was severe and Brehmer would have benefitted from formal physical therapy after surgery because it would have reduced his stiffness and pain. Dr. Bartman opined that a steroid injection and an aggressive course of physical therapy would improve Brehmer's range of motion and decrease his pain. Dr. Bartman testified that there was no evidence that Brehmer had failed to perform his home exercises, but he opined that home exercises are not very beneficial to a shoulder joint injury.

B. PROCEDURAL HISTORY

The jury awarded Brehmer $150,000 in past noneconomic damages, but it found that Brehmer did not have future noneconomic damages. The jury also found that Brehmer failed to mitigate his damages and it reduced the verdict by $50,000. On April 16, 2013, the trial court entered a judgment on the verdict for $100,000, with various costs and fees.

On May 7, 2013, Brehmer filed a motion for JNOV, new trial, or additur. According to Brehmer, Auto Owners did not meet its burden of proof to show [*6] that Brehmer failed to mitigate his damages because it did not show Brehmer failed to follow his doctor's advice. In response, Auto Owners presented several reasons why the jury could have found that Brehmer failed to mitigate his damages, including that Brehmer had failed to participate in formal physical therapy, had refused a surgery that Dr. Diment recommended, and might have financial motivations to fail to seek improvement.

After hearing arguments on the motion, the trial court ruled as follows:

> It is true that the jury completed the verdict form awarding plaintiff 150,000. They subtracted $50,000 for plaintiff's alleged failure to mitigate his damages. They awarded zero dollars for future physical damages. Defendants' expert witness testified if plaintiff had undergone formal physical therapy, even to this day, that being the day of trial, he would've gained greater range of motion or less pain.
>
> I did not find that in my own assessment, and I was

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> taken [a]back by the jury penalizing [Brehmer] significantly for what they alleged to be failure to mitigate.
>
> Defendants' experts testified there was no evidence that [Brehmer] failed to follow his doctor's order. Dr. Diment, treating physician, [*7] the person in the best position to make a decision about [Brehmer's] actions, testified unequivocally that he never prescribed physical therapy for [Brehmer] and that [Brehmer] made all decisions—and that he made all decisions regarding [Brehmer's] care and treatment, and that they together determined that home exercises were in fact in [Brehmer's] best interest, and Dr. Diment fully supported that determination.
> I think that what was anticipated was not far off the mark, and I think that from the jury verdict's determ—the jury verdict supports that there may very well have been significant confusion with regard to the jurors speculating with regard to [Brehmer's] duty to follow non-treating physicians' recommendations.
> If mitigation of damages is in fact a doctrine that seeks to minimize economic harm arising from wrong doing, I don't think that [Brehmer] did anything wrong. I think that it was clear from the testimony that [Brehmer] followed his doctor's orders and that Dr. Diment prescribed and allowed the therapy that he and [Brehmer] thought to be appropriate under [Brehmer's] condition and circumstances.
>
> I do not believe that plaintiff is entitled to a new trial. I do believe that [*8] the verdict may have in fact employed improper procedures and in fact demonstrate a mistake of law or fact based upon the evidence that was presented and the jury verdict form that was agreed upon that went with the jury to the jury room for deliberation. I thought that the jury verdict—and would not disturb the jury verdict as to a finding of $150,000. They made a determination based upon on [sic] what they heard. And with the exception of the reduction, which I believe does in fact result in a problem that needs the Court's attention, and it is supported by the evidence as I [sic] was heard during trial. [Brehmer] followed his treating physician's orders, jury awarded 150,000 and subtracted 50,000 based upon mitigation of damages. I don't believe that [Brehmer] didn't do what he needed to do, and I, therefore, order an additur of the amount deducted, awarding plaintiff $150,000.

At a subsequent hearing, the trial court clarified that it did not mean to grant an additur, it meant to grant JNOV. Auto Owners now appeals.

II. ANALYSIS

Auto Owners contends that the trial court improperly granted Brehmer's motion for JNOV because a question of fact existed regarding whether Brehmer mitigated [*9] his damages. We agree.

This Court reviews de novo a trial court's decision on a motion for JNOV. *Genna v Jackson*, 286 Mich App 413, 417; 781 NW2d 124 (2009). We view the evidence and inferences arising from the evidence in the light most favorable to the nonmoving party to determine whether the moving party was entitled to judgment as a matter of law. *Id*. The trial court should only grant a motion for JNOV "when there is insufficient evidence presented to create a triable issue for the jury." In contrast, "[w]hen reasonable jurors could honestly reach different conclusions regarding the evidence, the jury verdict must stand." *Id*. JNOV is only appropriate when the evidence "fails to establish a claim as a matter of law[.]" *Barrett v Kirtland Community College*, 245 Mich App 306, 311; 628 NW2d 63 (2001).

The doctrine of mitigation of damages provides that a party must minimize the harm that arises from another party's wrongdoing. *Morris v Clawson Tank Co*, 459 Mich 256, 263; 587 NW2d 253 (1998). When a person has been injured, "it is incumbent upon [that person] to use such means as are reasonable under the circumstances to avoid or minimize the damages." *Id*. (quotation marks and citation omitted). An injured party's duty to exercise reasonable care to minimize damages includes the obligation to obtain proper medical or surgical treatment. *Klanseck v Anderson Sales & Serv, Inc*, 426 Mich 78, 91; 393 NW2d 356 (1986). The defendant has the burden to prove that a plaintiff [*10] failed to make a reasonable effort to mitigate his or her damages. *Landin v Healthsource Saginaw, Inc*, 305 Mich App 519, 539; 854 NW2d 152 (2014). "The question whether the plaintiff's efforts to mitigate damages were reasonable under the circumstances is one for the trier of fact." *Id*.

There are two flaws with the trial court's ruling in this case. First, the trial court improperly expanded the elements of mitigation to include an element that does not exist: that the plaintiff disobeyed his or her doctor's orders. This Court is unable to find support for such an element. The doctrine of mitigation of damages does not ask whether a specific plaintiff obeyed or disobeyed his or her doctor's orders; it asks whether a person used

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reasonable means to minimize his or her damages. See *Morris*, 459 Mich at 263; *Landin*, 305 Mich App at 539. Whether a plaintiff complied with his or her doctor's orders is certainly *a* factor concerning the plaintiff's reasonableness. See *Klanseck*, 426 Mich at 91. But it is only *one* factor, and the jury must consider the totality of the circumstances. See *Morris*, 459 Mich at 273. To the extent that the trial court determined that Auto Owners failed as a matter of law to establish that Brehmer failed to mitigate his damages, we conclude that it erred.

Second, the trial court usurped the jury's role to determine what was reasonable under [*11] the circumstances. In essence, the trial court in this case acted as an impermissible "thirteenth juror" when it substituted its determination of the weight of the evidence for the jury's determination. Michigan disapproves of allowing a trial court judge to sit as a thirteenth juror. See *People v Lemmon*, 456 Mich 625, 638-640; 576 NW2d 129 (1998). The trial court's ruling is replete with statements of belief that are based on its own assessments of the weight of the evidence. This is not the proper standard under which to analyze a motion for JNOV. The question is whether reasonable jurors could honestly reach different conclusions. *Genna*, 286 Mich App at 417.

Our review of the record indicates that there were at least two reasons why reasonable jurors could have reached different conclusions regarding whether Brehmer mitigated his damages. The jury could have found that Brehmer's decision not to have additional surgery was unreasonable. It is undisputed that Dr. Diment supported Brehmer's decision not to have a second surgery because of the possible adverse consequences. However, a variety of doctors testified that surgery was likely to improve Brehmer's condition. That these doctors did not treat Brehmer went to the weight of the evidence. This conflicting evidence [*12] created at least a triable issue of fact regarding whether Brehmer's refusal of further surgery was reasonable.

The jury also could have found that Brehmer failed to reasonably perform his physical therapy. Dr. Diment testified that he believed that Brehmer was doing at-home physical therapy. But Brehmer testified that he only exercised 10 to 15 minutes a day or when his shoulder "seized up[.]" Deline indicated that there were reasons to believe that Brehmer was not properly complying with at-home therapy, and Dr. Chodoroff referred to Brehmer's home therapy setup as "pretty lame." Dr. Chodoroff testified that Brehmer's outcome indicated that he was not successfully rehabilitating himself. This evidence created at least a triable issue of fact regarding whether Brehmer took reasonable steps to address his condition through physical therapy.

For these reasons, we conclude that the trial court erred when it set aside the jury's verdict regarding whether Brehmer mitigated his damages. We do not reach the remainder of Auto Owners's issues because our conclusion renders resolution of those issues unnecessary.

We reverse the trial court's grant of Brehmer's motion for JNOV and remand for the [*13] trial court to reinstate the jury verdict. We do not retain jurisdiction. As the prevailing party, Auto Owners may tax costs. MCR 7.219(A).

/s/ Mark T. Boonstra

/s/ David H. Sawyer

/s/ Peter D. O'Connell

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MOA App'x 11: Chapter 2 Medicare Secondary Payer (MSP) Manual

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Medicare Secondary Payer (MSP) Manual
Chapter 2 - MSP Provisions

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The purpose of Pub. 100-05, Chapter 2 is for the Centers for Medicare & Medicaid Services (CMS) to provide detailed information regarding the MSP provisions, and the relationship of MSP to other laws. This information can assist the A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs)with responses to questions from providers, physicians and other suppliers, attorneys, employers, and other payers.

10 -MSP Provisions for Working Aged Individuals

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.100, and further specified in § 411.170 and § 411.172, Medicare pays secondary to GHP coverage for individuals age 65 or over if the GHP coverage is by virtue of the individual's current employment status or the current employment status of the individual's spouse. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. The law requires employers (as defined in Pub. 100-05, Chapter 1) to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65. For example, a plan may not provide benefits that are less for individuals age 65 or over or charge policyholders premiums that are higher for individuals age 65 or over since this would create an incentive for these individuals to reject the GHP coverage and make Medicare the primary payer. This provision applies whether or not the individual age 65 or over is entitled to Medicare. This equal benefit rule applies to coverage offered to full-time and part-time employees. CMS accepts that an individual attains a particular age on the day preceding his or her birthday.

Medicare beneficiaries who have current employment status are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage in accordance with 42 CFR § 411.172. If the employee or spouse refuses the plan Medicare is primary payer for that individual; and the plan may not offer that individual coverage complementary to Medicare. The requirements for employer compliance with the MSP provisions may differ in some respects from the requirements for compliance with the Age Discrimination in Employment Act (ADEA). For example, the ADEA law applies only to employees, while the Medicare provision applies also to self-employed individuals. Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries who have or whose spouse has current employment status, as outlined in 42 CFR § 411.108.

Where a GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid to supplement the amount it paid for Medicare-covered services. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may NOT be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries. (See 42 CFR § 411.108.)

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. A/B MACs and DME MACs evaluate claims under existing guidelines derived from the law and regulations to assure that Medicare covers the

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services regardless of any employer plan involvement.

A/B MACs and DME MACs assume for developing claims and the requirement that GHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. The A/B MACS or DME MAC refers an employer's allegation that the 20-employee requirement is not met to the MSP contractor for coordination of benefits.

A/B MACs and DME MACs must refer a multi-employer plan's (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of fewer than 20 employees, as a basis for making Medicare primary payer, to the MSP contractor for coordination of benefits. Refer to the Employer Exception (SEE) provisions process on the following link: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception

NOTE: The request to exempt is done on a prospective basis.

10.1 - Individuals Subject to Limitations on Payment

(Rev. 11755, Issued :12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare pays secondary for Part A and Part B benefits for an individual who:

- Is age 65 or over;
- Is entitled to Part A (hospital insurance) on the basis of the individual's own Social Security or Railroad Retirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person; and
- Is covered on the basis of individual's own current employment status or the current employment status of the individual's spouse.

Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that the employer furnishes to other similarly situated employees (i.e., non-retirees). Medicare is the secondary payer to the GHP that the employer provides to the re-employed retiree even if the premiums for coverage in the plan are paid from a retirement pension or fund. Medicare is also secondary payer for individuals associated with the employer in a business relationship such as consultants who are former employees, if the employer provides insurance coverage for other such individuals. (See 42 CFR §411.172(d))

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10.2 - Individuals Not Subject to the Limitation on Payment

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The MSP provision for working aged does not apply to:

- Individuals enrolled in Part B only;
- Individuals enrolled in Part A on the basis of a monthly premium;
- Anyone who is under age 65. (Medicare is secondary to LGHPs that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);
- Individuals covered by a health plan other than a GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;
- Employees of employers of fewer than 20 employees who are covered by a single employer plan;
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;
- Individuals enrolled in single employer GHPs of employers with fewer than 20 employees;
- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees;
- Domestic partners who are given “spousal” coverage by the GHP; or
- Former spouses who have Federal Employees Health Benefit (FEHB) coverage under the Spouse Equity Act

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10.3 - The 20-or-More Employees Requirement

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The working aged MSP provision applies only to GHPs of employers with 20 or more employees and to multi-employer and multiple employer GHPs in which at least one employer employs 20 or more employees. See 42 CFR § 411.100(a)(1)(i). 42 CFR § 411.170(a)(2)(i) which specifies this requirement is met if an employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full-time or part-time employees on its employment rolls each working day of that week. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 20 regardless of the number of employees who work or who are expected to report for work on a particular day. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20-or-more employee requirement is met. An individual is considered to be on the employment rolls even if the employee does not work on a particular day. An employer may not have different employment rolls for different days reflecting those scheduled.

Where an employer does not have 20 or more employees in the preceding year, it is required to offer its employees and spouses age 65 or over primary coverage beginning with the point in time at which the employer had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year even if the number of employees drops below 20 after the employer has met the requirement.

The 20-or-more employees requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. During the time the employer has met the 20-or- more employees requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the GHP.

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10.4 – Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A multi-employer GHP having at least one employer participating that has at least one employer with 20 or more employees may **prospectively** request to except employees (and their spouses) of identified employers with fewer than 20 employees from the working aged provision. The small employer provision of the MSP statute can be found at 42 U.S.C. 1395y(b)(1)(A)(iii) and 42 CFR 411.172(b). Under this provision, multi-employer GHPs may elect Medicare as the primary payer for services provided to working aged Medicare beneficiaries covered through qualified employers participating in the plan that have fewer than 20 employees. These employees and their spouses are not subject to the working aged provision once an exception has been granted as long as the employer continues to meet the requirements for the exception.

Be advised that it is the GHP's responsibility to provide written updates of any information that may affect the original exception request (updates should include identification of any employees not previously identified as well as information on any terminated coverage issues, etc.) to the MSP Contractor as soon as any changes take place.

All requests for exceptions from the multi-employer plan/administrator of the small employer shall be submitted to the MSP Contractor. A/B MACs and DME MACs having received a request or an update to a previous request shall forward these requests within 14 calendar days of receipt to the MSP Contractor. Please refer to the following link to identify the appropriate contact: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.

The MSP contractor shall not make an exception for beneficiaries entitled to Medicare based on permanent kidney failure (End-Stage Renal Disease) or Disability.

The MSP Contractor shall only grant requests on a prospective basis.
Detailed information regarding the Small Employer Exception and requirements for requesting an exception can be found on the CMS Web site at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception

10.5 - Rules Defining Employees Covered by GHPs and Large Group Health Plans (LGHPs)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

[See 42 CFR § 411.104 regarding current employment status]

A. Current Employment Status

An individual has current employment status if the individual is:

- Actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or
- The individual is not actively working and is receiving disability benefits from an

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employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or not actively working but meets **all** of the following conditions:

- Retains employment rights in the industry;
- His or her employment terminated by the employer if the employer provides the coverage or has not had his/her membership in the employee organization terminated if the employee organization provides the coverage;
- Is not receiving disability benefits from an employer for more than 6 months;
- Is not receiving Social Security disability benefits, and
- Has employment-based GHP coverage that is not COBRA continuation coverage. [See 29 U.S.C. 1161-1168.]

A person aged 65 or older and receiving disability payments from an employer is considered to have current employment status if such payments are subject to taxes under FICA. Employer disability payments are subject to FICA tax for the first six months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE: Adam Green stopped working because of disability in December 2021 at age 63. His employer began paying him disability payments January 2022. Since disability payments are taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 2022. Beginning with July 2022, Medicare becomes the primary payer as the disability payments are no longer considered wages under FICA.

B. Retain Employment Rights [See 42 CFR § 411.104(b)]

Persons who retain employment rights include but are not limited to:

- Those who are furloughed, temporarily laid off, or who are on sick leave;
- Teachers and seasonal workers who normally do not work throughout the year;
- Those who have health coverage that extends beyond or between active employment periods (e.g., based on an "hours bank" arrangement). (Active union members in certain trades and industries (e.g., construction) often have "hours bank" coverage); and
- Those who take an employer-approved temporary leave of absence for any reason. Temporary leaves of absence include, but are not limited to, periods when an individual qualifies for short-term or long-term medical disability.

C. Coverage by Virtue of Current Employment [See 42 CFR § 411.104(c)]

An individual has coverage as a result of current employment status with an employer

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if the individual has:

- GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and

- Current employment status with that employer, as defined above.

10.5.1 - Clarification of Current Employment Status for Specific Groups
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

[See 42 CFR § 411.104 for references to employment status of specific groups]

A. Member of Religious Order [See 42 CFR § 411.104(e)]

A member of a religious order whose members are required to take a vow of poverty is not considered to have current employment status with the religious order if the services he/she performs as a member of the order are considered employment by the order for Social Security purposes only. This is because the religious order elected Social Security coverage for its members under section 3121(r) of the Internal Revenue **Member of Religious Order** Code. Thus, Medicare is primary payer to any group health coverage provided by the religious order.

This exception applies only to members of religious orders who have taken a vow of poverty. It does not apply to clergy or to any member of a religious order who has not taken a vow of poverty or to lay employees of the order. This exception applies not only to services performed for the order itself (such as administrative, housekeeping, and religious services), but also to services performed at the direction of the order for employers outside of the order, provided that the outside employer does not provide the member of the religious order with its own GHP coverage. A member of a religious order has current employment status with the outside employer as a result of providing services on behalf of the outside employer (an ongoing business relationship exists). If the outside employer provides GHP coverage to the member of the religious order on the basis of that current employment status relationship, the usual MSP rules apply.

Medicare is the secondary payer to the GHP of the outside employer if the outside employer has the requisite number of employees.

EXAMPLE 1:

Sister Mary Agnes is a member of a religious order where members are required to take a vow of poverty. Sister Mary Agnes was assigned to teach at a church school in the Diocese of the Metropolis. The Diocese does not provide GHP coverage to

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Sister Mary Agnes. The only group health coverage available to Sister Mary Agnes is provided by the religious order. Medicare is the primary payer for services provided to Sister Mary Agnes.

EXAMPLE 2:

Sister Mary Teresa is a member of a religious order whose members are not required to take a vow of poverty. Sister Mary Teresa was assigned to teach at a church school in the Diocese of Smallville. On the basis of her teaching relationship with the Diocese of Smallville, the Diocese provides GHP coverage to Sister Mary Teresa. The GHP provided by the Diocese of Smallville is the primary payer and Medicare is the secondary payer for services provided to Sister Mary Teresa.

A/B MACs and DME MACs should note that the exemption only applies to the working aged and disability provisions that base a GHP's obligation to be a primary payer on a current employment status relationship. The exception does not apply to the ESRD, workers compensation, or liability and no-fault provisions.

B. Insurance Agents

The following guidelines apply in determining the status of insurance agents.

A self-employed insurance agent is considered to have coverage based on current employment status if the agent:

1. Has an "active agent" relationship with the company; or

2. Has a "retired agent" relationship with the company and has reached the "earning threshold" of $400 or more pursuant to §211(b) of the Act. The fact that a self-employed insurance agent is authorized to represent the company, e.g., to write policies on behalf of the company, does not itself imply current employment status.

C. Senior Federal Judges

Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. By law, the remuneration they receive as senior judges is not considered wages for Social Security retirement offset purposes. Since they are considered retired for Social Security purposes, they are not considered to have current employment status for purposes of the working aged and disability provisions.

D. Volunteers

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Volunteers are considered to have current employment status when they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of §1862(b) of the Act, AmeriCorps members in the Volunteers In Service To America program (VISTA) are considered to have current employment status since they receive remuneration from the Federal Government. Also, remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a volunteer receives, are considered remuneration.

E. Directors of Corporations

Directors of corporations (i.e., persons serving on a Board of Directors of a corporation who are not officers of the corporation) are self-employed. (Officers of a corporation are employees.) Directors who receive remuneration for serving on a board are considered to have current employment status. Remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a corporation provides to a board member, are considered remuneration if they are subject to FICA taxes under the IRC.

Directors who receive no remuneration for serving on the Board (unpaid directors) are not considered to have current employment status. However, remuneration may consist of deferred compensation (i.e., amounts earned but not payable until some future date usually when the individual reaches age 70 and is no longer subject to the Social Security retirement test). A director receiving deferred compensation is considered to have current employment status only while serving as a director. (See subsection F.)

F. Individuals Receiving Delayed Compensation Payments Subject to FICA Taxes
[See 42 CFR § 411.104(f)]

An individual who is not working is not considered to have current employment status solely on the basis of receiving delayed compensation payments for previous periods of work even though those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working and in 2021 receives payments subject to FICA taxes for work performed in 2020 is not considered to be an employee in 2021 solely on the basis of receiving those payments.

G. Leased Employees

Leased employees (as defined in §414(n)(2) of the IRC) are treated as employees of the recipient. The term "leased employee" means any person who is not an employee of the recipient of the services but who provides services to the recipient if the:

- Services are provided based on an agreement between the recipient and any other person (i.e., the leasing organization);

- Person has performed such services for the recipient on a substantially full-time basis for at least 1 year. (In general, an employee who works 30 hours or more is considered to be full time.); and

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- Services are of a type historically performed in the business field of the recipient by employees. An example of a leased employee is an employee of a temporary agency who is assigned to work full time for at least one year doing bookkeeping for an accounting firm.

In implementing these provisions, CMS relies on the regulations and decisions made by the Secretary of the Treasury. Specific questions relating to application of these provisions may be directed to CMS.

H. Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that is furnished to other employees (i.e., non-retirees). Thus, an employer is required to provide primary coverage for a re-employed retiree if the amount of work the individual performs (based on hours, productivity, etc.) would be sufficient to earn the employee coverage from the employer had the employee not retired. The GHP or LGHP coverage is primary to Medicare because of the current employment status. This rule applies even if the:

- Plan is the same plan that previously provided coverage to the individual retiree or annuitant;
- Premiums for the plan are paid from a retirement pension or fund; or
- Re-employed retiree pays the entire premium.

I. Coverage for Self-Employed Individuals [See 42 CFR § 411.104(d)]

When Medicare is secondary payer, the employer is not required to provide GHP coverage to self-employed individuals. However, if an employer subject to the MSP provisions provides coverage to a self-employed individual (including owners, a consultant, or a contractor), the employer may not take into account the individual's Medicare entitlement (i.e., the GHP must pay primary to Medicare). Also see 42 CFR § 411.104(d).

10.6 - Aggregation Rules Applicable to Determine the Employer Size

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The size of the employer is a factor in determining whether Medicare is secondary or primary payer under the working aged and disability provisions of the law. For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. Ordinarily, the identity of that entity is clear.

There are situations, however, when it is not clear which corporation or individual is the employing entity for MSP purposes. For example, when a corporation is owned or controlled by another corporation, it must be decided which corporation is the employer.

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Similarly, when related individuals each have businesses and each claim to be a separate employer with either fewer than 20 or fewer than 100 employees, it must be decided whether the individuals are separate employers or a single employer.

The MSP law contains the following rules for determining the size of the employer under the MSP for the aged and disabled provisions. [See 42 CFR § 411.106]

A. Single Employers

Single employers under Section §52 of the IRC are defined as follows:

- All employers that are treated as single employers under subsections (a) or (b) of §52 of the IRC are treated as single employers;

- Section 52(a) of the IRC provides that all employees of all corporations that are members of the same controlled group of corporations are treated as if employed by a single employer; and,

- Section 52(b) of the IRC provides that all employees of trades or businesses (whether or not incorporated), e.g., employees of partnerships or proprietorships that are under common control, shall be treated as employed by a single employer.

In general, two or more individuals or corporations are considered to be separate employers under §52(a) or (b) of the IRC if they file separate income tax returns. Two or more individuals are considered to be a single employer if they file a consolidated tax return.

When there is a question about the tax status of a particular employer that claims to have fewer employees than the 20 or 100 employee thresholds, A/B MACs and DME MACs must request the employer to submit copies of its most recent tax return to resolve the question.

B. Affiliated Service Groups

All employees of the members of an affiliated service group (as defined in Section 414(m) of the IRC) are treated as employed by a single employer.

C. Treatment of Religious Organizations

CMS does not aggregate religious organizations for MSP purposes. Incorporated parishes and churches that are part of a church-wide organization, such as a diocese or synod, are considered to be individual employers. A GHP or LGHP for employees of such parishes or churches is considered to be a multi-employer GHP. (See §10.3 and §10.4 of this chapter, for policies regarding multi-employer GHPs in which at least one participating employer employs 20 or 100 or more employees respectively.)

10.7 - Effect of GHPs Payments on Deductible, Coinsurance, and Utilization

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

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Expenses that serve to meet the beneficiary's Part A or Part B cash and blood deductibles, if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by a GHP. This is true even if the GHP paid the entire bill and there is no secondary Medicare benefit payable. If a GHP paid for Medicare covered expenses in whole or in part, the Part B deductible is credited on the basis of the Medicare fee schedule amount rather than the amount paid by the GHP. Also, GHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, GHP payments are credited to deductibles before being used to satisfy the coinsurance.

Where no Medicare secondary benefit is payable, no utilization is charged the beneficiary. Where a Medicare secondary payment is made, the A/B MAC charges the beneficiary with utilization. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

Expenses for which payments are made and Medicare conditional payments are recovered from no-fault or liability insurance are credited toward the deductible amounts for both Parts A and B. Also, no-fault and liability payments are applied to satisfy a beneficiary's obligation to pay Part A or Part B coinsurance amounts. No-fault and liability payments are credited to deductibles before being used to satisfy the coinsurance. For services provided prior to November 13, 1989, payments by the primary payer are not counted toward the Medicare deductible. The discharge date is used for determining when a provider furnished the services.

Services for which Medicare conditional payments are recovered from liability or no-fault insurance are not counted against the number of inpatient care days available to the beneficiary. If an individual is hospitalized twice in the same benefit period and Medicare recovers its payment from a no-fault or liability insurance for the first hospitalization, the first hospitalization would not be charged to the beneficiary. See CFR 42 § 411.30 and 411.33

EXAMPLE 1:

An individual who previously had not met any of the $233 Part B deductible incurred $233 in charges for which the GHP paid $200. The Medicare fee schedule amount was $233. No Medicare benefits are payable. The individual is credited with $233 toward the Part B cash deductible.

The beneficiary can be charged $33. (The $233 fee schedule amount minus the sum of the $200 primary payment plus the $0 Medicare payment).

EXAMPLE 2:

An individual who previously had met $100 of the $233 Part B deductible incurred $150 in charges that were paid in full by the GHP. The Medicare fee schedule amount was $150. No Medicare benefits are payable. The individual is credited with an additional $150 toward the Part B cash deductible and now has satisfied the Medicare deductible.

The physician cannot bill the beneficiary because the sum total of the primary payment ($150) and the Medicare payment ($0) meets the fee schedule amount of ($150).

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10.7.1 - Crediting Deductible for Non-Inpatient Psychiatric Services
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The Part B deductible for non-inpatient psychiatric services is credited on the basis of the Medicare fee schedule amount. There is no annual limit on incurred expenses for non-inpatient psychiatric services.

EXAMPLE 1:

An individual received non-inpatient psychiatric services for which a physician charged $250. The $233 Part B deductible had not been met. The GHP allowed $100 and paid $100. The Medicare fee schedule amount is $210.

A. Actual charge by the physician minus the third-party payment: $250 - $100 = $150.

B. The Medicare payment is determined in the usual manner: $210 - $233 = 0 x .80 = $0.

C. Medicare's allowable charge of $210 (which is higher than GHP's allowed amount of $200) minus GHPs payment of $100 equals $110.

Medicare pays $0 (lowest of amounts in steps A, B, or C).

The beneficiary can be charged $110 (the $210 fee schedule amount minus the sum of the $100 primary payment plus the $0 Medicare payment). The unmet Part B deductible is credited with $210. The beneficiary still must meet $13 of the annual Part B deductible before Medicare benefits become payable.

EXAMPLE 2:

An individual received non-inpatient psychiatric services for which the physician charged $250. None of the individual's Part B deductible had been met. The GHP allowed charges in full and paid $250. The Medicare fee schedule amount for the services was
$200. No Medicare secondary benefit is payable since the GHP paid charges in full. The $233 Part B deductible is credited by the first $200 of the fee schedule amount.

The beneficiary cannot be billed by the physician because the sum total of the primary payment ($250) and the Medicare payment ($0) exceeds the fee schedule amount ($200).

EXAMPLE 3:

An individual received non-inpatient psychiatric services from a physician for which the physician charged $500. None of the individual's $233 Part B deductible had been met. A GHP allowed charges in full and paid $400 (80 percent of the $500). The Medicare fee schedule amount for the services was also $500. The $233 Part B deductible is credited in full. The Medicare secondary benefit calculated is $100.

The physician cannot bill the beneficiary because the sum total of the primary payment ($400) and the Medicare secondary payment ($100) equals the Medicare fee schedule amount.

10.8 - Beneficiary's Rights and Responsibility
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. Beneficiary's Responsibility with Respect to GHPs that are Primary to Medicare

The A/B MACs and DME MACs shall not make any Medicare payment if the beneficiary has not filed a claim or cooperated fully with the provider, physician or other supplier or the GHP. Also, the A/B MACs and DME MACs will not make any Medicare payments until the beneficiary has exhausted the entire claims process. Conditional benefits are not payable if payment cannot be made under the GHP because the beneficiary failed to file a proper claim (See §100 of this chapter for definition of proper claim) unless the failure to file a proper claim is due to mental or physical incapacity of the beneficiary. [See CFR 42 § 411.165, 411.175 and 411.206]. A beneficiary need not file any appeal if not inclined to do so.

B. Beneficiary's Right to Take Legal Action Against A GHP

Section 1862(b)(3)(A) of the Act provides that any claimant (including a beneficiary, provider, physician, or supplier) has the right to take legal action against, and to collect double damages from a GHP, that fails to pay primary benefits for services covered by the GHP. Any claimant, also, has the right to take legal action against, and to collect double damages from, a no-fault or liability insurer that fails to pay primary benefits for services covered by the no-fault or liability insurer where required to do so under §1862(b) of the Act.

20 -MSP Provisions for End-Stage Renal Disease (ESRD) Beneficiaries
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.162, Medicare is secondary payer to GHPs for individuals eligible for, or entitled to Medicare Part A based on ESRD during a coordination period described below. This provision applies regardless of the number of employees employed by the employer and regardless of whether the individual or other family member has current employment status. The ESRD provision applies to former as well as to current employees. This provision applies where an individual is eligible for Medicare based on ESRD and where an individual is entitled to Medicare based on ESRD. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for Medicare based on ESRD for purposes of §20.1.1 or §20.1.3 if the individual meets the other requirements.

In general, §13561(c)(2) and (3) of OBRA 1993 provided that plans must pay primary benefits during the coordination period regardless of whether the individual is also entitled to Medicare on another basis. (See
§20.1.3 for dual entitlement provisions. Specifically, see §20.1.3.B, which discusses the dual entitlement provision under which a GHP remains secondary to Medicare during the

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30-month coordination period and litigation challenging that provision.)

This provision applies to all Medicare-covered items and services furnished to beneficiaries who are in the 30-month period, including services for non-ESRD treatment and services required by kidney donors in cases of transplantation. This limitation applies for claims processing for items or services furnished to ESRD beneficiaries who are in their 30-months of eligibility or entitlement on the basis of ESRD.

20.1 - Determining the 30 Month Coordination Period During Which Medicare May Be Secondary Payer

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If Medicare was not the primary payer for an individual on the basis of age or disability at the time the individual became eligible for or entitled to Medicare on the basis of ESRD, Medicare is secondary payer to GHPs for items and services furnished during a period of up to 30 consecutive months, which begins with the earlier of:

- The month in which a regular course of renal dialysis is initiated, or
- If the patient undergoes a course of self-dialysis training the first day of the month in which the training occurred, or
- If an individual who received a kidney transplant, the first month in which the individual became entitled.

NOTE: In the rare case of an untimely application by an individual who receives a transplant, the 30-month period could begin with the first month in which the individual would have been eligible for or entitled to Medicare benefits if a timely application had been filed. It is not necessary to consider this possibility absent a specific indication, e.g., information that the transplant occurred before the first month of eligibility or entitlement. If further development is required, the contractor should contact the SSO.

When the 30-month period begins before the month the individual becomes eligible for or entitled to Medicare, A/B MACs and DME MACs pay secondary benefits for the portion of the period during which the individual is eligible or entitled. The latter is the coordination period. Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis.

20.1.1 - Duration of Coordination Period

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The coordination period is a period that begins with the earlier of the first month of entitlement to or eligibility for Medicare Part A based on ESRD. Eligibility refers to the first month the individual would have become entitled to Medicare Part A on the basis of ESRD if he/she had filed an application for such benefits.

The Balanced Budget Act (BBA) of 1997, extended the coordination period from 18 months to 30 months.

Eligibility refers to the first month the individual would have become entitled to

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Medicare Part A on the basis of ESRD if an application were filed for such benefits. In the rare case of an untimely application by an individual, the coordination period could begin with the first month in which the individual would have been entitled to Medicare benefits if a timely application had been filed. It is not necessary to consider this possibility absent a specific indication, e.g., information that the transplant occurred before the first month of entitlement. If further development is required, A/B MACs and DME MACs contact the RO.

When the coordination period begins before the month the individual becomes entitled to Medicare, the A/B MACs and DME MACs pay secondary benefits for the portion of the period during which the individual is entitled. Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis. However, for individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 30 months of the individual's entitlement.

Individuals eligible for Medicare on the basis on ESRD cannot enroll for Part B during a Special Enrollment Period (SEP)SEP, but can defer entitlement to both Part A and B and file an initial application later, usually at the end of the coordination period.

More examples illustrating when Medicare pays secondary in cases of ESRD entitlement and eligibility are found at 42 CFR § 411.162(d).

20.1.2 - Determination for Subsequent Periods of ESRD Eligibility

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

20.1.3 - Dual Eligibility/Entitlement Situations

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If an individual also becomes entitled to Medicare based on age 65 or disability after being entitled based on ESRD, the coordination period continues for the remainder of the 30-months if Medicare was properly the secondary payer at the time of the dual entitlement. See 42 CFR § 411.163.

When an individual is eligible for, or entitled to Medicare Part A based on ESRD and also entitled on the basis of age or disability, the coordination of benefits is described below.

Except as provided in subsection B, GHPs are subject to a 30-month coordination period for any plan enrollee eligible for, or entitled to Medicare Part A based on ESRD, regardless of whether that individual also is entitled to Medicare on the basis of age or disability. The 30-month period coincides with the first 30 months of ESRD-based Part A Medicare eligibility or entitlement. (Under previous law, Medicare automatically became the primary payer at the point of dual Medicare eligibility/entitlement.) As long as dual eligibility/entitlement exists, the ESRD MSP provision applies exclusively. Medicare becomes the primary payer after the 30th month of ESRD-based eligibility/entitlement even though plan coverage may be in effect by reason of current employment status.
That is, the working aged MSP provisions and the disability MSP provisions do not

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apply to individuals who are entitled on the basis of ESRD during or after the 30-month coordination period.

Subsection A, below, deals with coordination periods governed by present law and provides examples. Subsection B specifies the circumstances under which the ESRD MSP provision does not apply in dual entitlement situations and provides an example. Subsection C deals with circumstances in which Medicare continues to be primary when an individual is entitled to Medicare based on age or disability and then ESRD with no GHP coverage, but obtains GHP coverage during the coordination period and provides an example. Subsection D deals with the effect of the cessation of dual entitlement.

A - Circumstances in Which Medicare Continues to be Secondary After Aged or Disabled Beneficiary Becomes Eligible for, or Entitled to Medicare on the Basis of ESRD

Medicare is secondary payer during the first 30 months of ESRD-based eligibility and entitlement and becomes primary payer after the 30th month of ESRD-based eligibility or entitlement if Medicare was not properly primary prior to ESRD-based eligibility. (Refer to subsection B below if Medicare is properly primary.)

EXAMPLE 1

Mr. C, who is 67 years old and entitled to Medicare on the basis of age, has GHP coverage by virtue of current employment status. Mr. C is diagnosed as having ESRD and begins a course of maintenance dialysis at an ESRD facility on June 27, 2020. Effective September 1, 2020, Mr. C is eligible for Medicare on the basis of ESRD. Medicare, which was secondary because Mr. C's GHP coverage was by virtue of current employment, continues to be secondary payer through February 2023, the 30th month of ESRD-based eligibility, and becomes primary payer beginning March 2023.

EXAMPLE 2

Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 2020 at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 30-month coordination period (July 2020), Mr. D turned age 65. The coordination period continues without regard to age-based entitlement with the retirement plan continuing to pay primary benefits through June 2023, the 30th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer beginning July 2023.

EXAMPLE 3

Mr. Edwards retired at age 62 and maintained GHP coverage as a retiree. In July 2020, he simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 2020) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 2020 through December 2022, the first 30 months of ESRD-based eligibility. Medicare becomes the primary payer beginning January 2023.

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B - Circumstances in Which Medicare Continues to be Primary After Aged or Disabled Beneficiary Becomes Eligible on Basis of ESRD

Medicare remains the primary payer when an individual becomes eligible for Medicare based on ESRD if both of the following conditions are met:

- The individual is already entitled to Medicare on the basis of age or disability when he/she becomes eligible on the basis of ESRD, and

- The MSP prohibition against "taking into account" age-based or disability-based entitlement does not apply because plan coverage was not "by virtue of current employment status" or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

The plan may continue to pay benefits secondary to Medicare under this subsection. However, the plan may not differentiate in the services covered and the payments made between persons who have ESRD and those who do not.

EXAMPLE 1

Mrs. G, who is 67 years of age, is retired. She has GHP retirement coverage through her former employer. Her plan permissibly took into account her age-based Medicare entitlement when she retired and is paying benefits secondary to Medicare. Mrs. G subsequently develops ESRD and begins a course of maintenance dialysis in October 2020. She automatically becomes eligible for Medicare based on ESRD effective January 1, 2021. The plan continues to be secondary on the basis of Mrs. G's age-based entitlement as long as the plan does not differentiate in the services it provides to Mrs. G and does not do anything else that would constitute "taking into account" her ESRD-based eligibility.

C – Circumstances in Which Medicare Continues to be Primary When Individual is Entitled to Medicare Based on Age or Disability and then ESRD with no GHP Coverage but Obtains GHP Coverage During the Coordination Period

If Medicare is the proper primary payer for services when eligibility for Medicare based on ESRD is established, Medicare remains the primary payer (during the coordination period and afterwards). Medicare is considered to be the primary payer when Medicare is the only payer or Medicare is legally obligated to be the primary payer to any GHP coverage.

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EXAMPLE 1

Mr. Z is 67 years old and has Medicare based on age. He has no GHP coverage. Mr. Z develops ESRD and begins a course in maintenance dialysis and becomes eligible for Medicare based on ESRD which triggers the 30-month coordination period. However, Mr. Z has no GHP coverage and Medicare continues as the primary payer. In the 6th month of the coordination period Mr. Z obtains coverage through his wife's GHP. Since Medicare was the proper primary payer when eligibility for ESRD was established, Medicare remains the primary payer.

D - Dual Eligibility/Entitlement Ceases

If ESRD-based eligibility or entitlement ceases in accordance with the Medicare Pub. 100-01, Medicare General Information, Eligibility and Entitlement, Chapter 2, §10.4, Medicare is the primary payer unless plan coverage is in effect by virtue of current employment status, and the provisions of §§10 and 20 or 30 apply.

More examples illustrating the coordination of benefits in cases of dual entitlement are found at 42 CFR § 411.163(c).

20.1.4– Summary Chart for ESRD-MSP Rules and Dually Entitled Medicare Beneficiaries

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Rule: If Medicare is the proper primary payer for services when eligibility for Medicare based on ESRD is established, Medicare remains the primary payer (during the coordination period and afterwards). Medicare is considered to be the primary payer when Medicare is the only payer or Medicare is legally obligated to be the primary payer to any GHP coverage. Otherwise, Medicare is secondary to any GHP coverage that may exist during the ESRD coordination period.

BASIS OF MEDICAL ELIGIBILITY AND GHP COVERAGE	APPLICATION OF RULE
ESRD Only	Medicare secondary to any GHP coverage.
Age or Disability entitlement and GHP coverage precede ESRD eligibility with Medicare primary	Medicare primary to any GHP coverage.
Age or Disability entitlement and GHP coverage precede ESRD eligibility with Medicare secondary	Medicare secondary to any GHP coverage.
Age or Disability entitlement and ESRD eligibility occur on same day	Medicare secondary to any GHP coverage at time of ESRD eligibility or obtained later.
ESRD eligibility precedes entitlement based on Age or Disability	Medicare secondary to any GHP coverage.
Age or Disability entitlement and NO GHP coverage precedes ESRD eligibility	Medicare primary to any GHP coverage.

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20.2 - Effect of ESRD MSP on Consolidated Omnibus Budget Reconciliation Act (COBRA)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. General

The COBRA requires that certain GHPs offer continuation of plan coverage for 18 to 36 months after the occurrence of certain qualifying events, including loss of employment or reduction of employment hours. Those are events that otherwise would result in loss of GHP coverage unless the individual is given the opportunity to elect and does elect to continue plan coverage at his/her own expense.

On June 8, 1998, the Supreme Court in "Geissal v. Moore Medical Corp." invalidated the COBRA continuation of health care coverage regulations with respect to when a GHP may terminate COBRA coverage. The court ruled that individuals who obtain other coverage (including Medicare) on or before the COBRA election date are permitted to continue this coverage along with COBRA. Thus, where ESRD-based Medicare Part A entitlement predates the COBRA qualifying event, the plan is obligated to offer COBRA coverage for a qualifying event such as termination of employment. To the extent the period of COBRA coverage overlaps the ESRD MSP coordination period, COBRA is primary and the employer plan has no discretion to terminate COBRA because of the ESRD-based Medicare entitlement. Those individuals who obtain other coverage (including Medicare) after the COBRA election date can be terminated from COBRA coverage. This means that where COBRA coverage came first, the employer may terminate existing COBRA coverage under its health plan when Medicare entitlement occurs. Where COBRA expressly permits termination of continuation coverage upon entitlement to Medicare there is one exception. The exception is that the plan may not terminate continuation coverage of an individual (and the individual's qualified dependents) if the individual retires on or before the date the employer substantially eliminates regular plan coverage by filing for Chapter 11, Bankruptcy. (See 26 U.S.C. 4980B(g)(1)(D), 29 U.S.C. 1162(2)(D), and 1167(3)(C).)

B. Medicare is Secondary to COBRA Coverage

To the extent COBRA coverage overlaps the 30-month ESRD MSP coordination period, Medicare is secondary payer for benefits that a GHP:

- Is required to keep in effect under the COBRA continuation requirements where Medicare entitlement occurs first; or
- Is required to keep in effect under the COBRA continuation requirements even after the individual becomes entitled to Medicare based on ESRD (i.e., the bankruptcy situation as described in subsection A above); or

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- Voluntarily keeps in effect after the individual becomes entitled to Medicare on the basis of ESRD even though not obligated to do so under the COBRA provisions. [See 42 CFR § 411.162(a)(3)]

30 - MSP Provision for Disabled Beneficiaries

Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.204, Medicare is secondary payer to LGHPs for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member. (See Pub. 100-05, Chapter 1 for definition.)

Under the law, a LGHP may not "take into account" that such an individual is eligible for, or receives, Medicare benefits based on disability. Apply the instructions in this chapter when processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to a GHP of 20 or more employees, substitute the term "large group health plan" as defined in Pub. 100-05, Chapter 1 to apply them to disabled individuals.

30.1 - Individuals Not Subject to MSP Provision

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare is **not** secondary under the MSP provision for disabled individuals:

- Who work or whose family member works for employers having fewer than 100 employees unless the GHP is a multi-employer plan in which at least one employer of 100 or more employees participates;

- Covered by an LGHP as a result of past employment (e.g., as a retired former employee or as the spouse of a retired former employee) and whose coverage is not also based on current employment status of their own or a family members current employment status;

- Covered by a health plan other than an LGHP (e.g., one that is purchased by the individual privately and not through an employer);

- Who have FEHB coverage under the Spouse Equity Act;

- Enrolled in Part B only; or

- Enrolled in Part A on the basis of a monthly premium.

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30.2 - The 100 or More Employees Requirement

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The Medicare as secondary for the disabled provision applies only to LGHPs that cover employees of at least one employer that employed 100 or more full-time and/or part-time employees on 50 percent or more of its business days during the previous calendar year.

Medicare is secondary for all employees enrolled in the plan if a plan is a multi- employer plan, such as a union plan which covers employees of some small employers and also employees of at least one employer that meets the 100-or- more employee requirement, including those that work for small employers. The exception discussed in this chapter, with respect to the working aged provision, does not apply to the Medicare as secondary for the disabled provision. An employer will be considered to employ 100 or more employees on a particular day if the employer has at least 100 full-time or part-time employees on his/her employment rolls on that day. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 100 regardless of the number of employees who work or who are expected to report for work on that day.

Self-employed individuals who participate in an LGHP are not counted as employees for purposes of determining if the 100-or-more employee requirement is met. If an employer does not meet the 100-or-more employees requirement in a particular year, the employer may offer employees coverage that is secondary to Medicare during the following year. If the employer meets the 100-or-more employee requirement at any time during the current year, the employer is required to provide employees with coverage that is primary to Medicare during the following year.

30.3 - Disabled Individuals Who Return to Work

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If a disabled individual who has LGHP coverage based on prior service to the employer returns to work, the coverage is considered to be by virtue of current employment status if the employer provides coverage to similarly situated individuals who are not disabled. Similarly situated individuals are individuals who work in the same category of employment and who perform the same amount of work. Such services may be based, for example, on the number of hours worked or the amount of earnings. [See 42 CFR § 411.104 for current employment status regulations.]

30.4 - Dually Entitled Individuals

(Rev.11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If a disabled individual is also eligible for, or entitled to Medicare under the ESRD provisions, follow the rules in §20.1.3 under which Medicare is the secondary payer for the applicable 30-month coordination period.

40 - Liability Insurance

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

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Under (42 U.S.C. 1395y(b)(2)), and outlined in 42 CFR § 411.50, Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan (including a self-insured plan). Under certain circumstances, Medicare may make conditional payments if the liability insurance will not pay or will not pay promptly. Conditional payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan).

40.1 - Medicare's Recovery Rights

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.24 and with reference to 42 CFR Subpart D, Medicare has a statutory direct right of recovery from the liability insurance as well as any entity that has received payment directly or indirectly from the proceeds of a liability insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to other entities including Medicaid because Medicare's direct right of recovery is explicitly prescribed in Federal law and other entities' recovery rights are based on either State law or subrogation rights.

In addition to its direct rights of recovery, Medicare has subrogation rights. "Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare is a claimant against the responsible party and the liability insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the alleged tortfeasor (and the alleged tortfeasor's liability insurance). Medicare can be a party to any claim by a beneficiary or other entity against an alleged tortfeasor and/or his/her liability insurance and can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare.

40.2 - Billing in MSP Liability Insurance Situations

(Rev. 12436: Issued: 12-28-23: Effective: 01-29-24; Implementation: 01-29-24)

A - Difference Between Liability Insurance and Other Primary Plans

Liability insurance differs from the other insurance policies or plans that, under §1862(b) of the Act, are primary to Medicare. In the case of other types of insurance that are primary to Medicare, i.e., no-fault insurance, GHPs, and WC, the insurance has a contractual obligation to pay for medical services provided to the covered/injured person. Liability insurance, however, has a contractual obligation to compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party.

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made..." under liability insurance (including self- insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where Ongoing Responsibility of Medicals (ORM) has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

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See IOM 100-05, Chapter 5, Section 20.4 for detailed instructions regarding ORM.

B – Billing Options and Requirements – Alternative Billing

Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary's liability insurance settlement is considered billing the liability insurance.) As specified in 42 CFR § 411.50, promptly means payment within 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge) rather than bill Medicare. Following expiration of the promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid and the liability insurer indicates, on the claim, the reason why the claim is not being paid. Note: If the reason for primary payer denial is not identified on the claim, the A/B MAC or DME MAC denies/rejects the claim). If liability insurance will not pay during the promptly period, a provider, physician, or other supplier may either:

- Bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance); or

- Maintain all claims/liens against the liability insurance/beneficiary's liability insurance settlement.

C – Special Rule for Oregon [See 42 CFR § 411.54(d)(2)]

As a result of a court order, providers, physicians, and other suppliers in Oregon:

- May either (i.e., double billing is not permitted) bill Medicare or bill liability insurance (the filing of a lien against a beneficiary's liability insurance settlement is considered billing the liability insurance) if the liability insurer pays within 120 days after the earlier of the following dates:

    - The date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement; or

    - The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

- Must withdraw claims/liens against the liability insurance/beneficiary's liability insurance settlement following expiration of the 120-day period and bill Medicare.

However, CMS will not terminate the provider agreement of a provider that does not comply with the court order if that provider is following the procedures outlined in B above.

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D – Charges to Beneficiaries

Provider Charges to Beneficiaries for Services Covered By Medicare

The following applies to providers that participate in Medicare, emergency hospitals that do not participate in Medicare, and foreign hospitals with an election to bill Medicare:

- If the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the provider pursues liability insurance, the provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

Physician and Other Supplier Charges to Beneficiaries for Services Covered By Medicare

The following applies to physicians and other suppliers who participate in Medicare:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

The following applies to physicians and other suppliers who do not participate in Medicare and who submit or would be required to submit an assigned claim:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

- Physicians and other suppliers (with the exception of DMEPOS suppliers) who do not participate in Medicare and who submit an unassigned claim may charge beneficiaries no more than the limiting charge and may collect payment without regard to whether the liability insurance is available to the beneficiary.

Physicians and other suppliers who do not participate in Medicare, do not submit an

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unassigned claim, and are not required to submit an assigned claim if they submitted a claim to Medicare, may pursue liability insurance but the amount may not exceed the limiting charge.

Charges to Beneficiaries for Services Not Covered by Medicare

- For services for which there is no Medicare coverage available regardless of who furnishes them, providers, physicians, and other suppliers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

- For services of foreign hospitals that have no election to bill Medicare, providers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

- For services of foreign physicians and other suppliers, the physician or other supplier may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

E – Provider, Physician, or Other Supplier Bills Medicare and Maintains Claim/Lien Against the Liability Insurance/Beneficiary's Liability Insurance Settlement

As cited above in B, providers, physicians, and other suppliers must withdraw all claims/liens against liability insurance/beneficiary's liability insurance settlement (except for claims related to services not covered by Medicare and for Medicare deductibles and coinsurance) when they bill Medicare. A/B MACs and DME MACs may learn of a situation where the provider, physician, or other supplier billed Medicare but did not withdraw the claim/lien. In such situations, A/B MACs and DME MACs must:

- Advise the provider, physician, or other supplier and beneficiary that the act of billing Medicare limits the payment that the provider, physician, or other supplier may receive for the services billed to the Medicare approved amount. This applies even if Medicare did not pay the claim or the provider, physician, or other supplier refunded the Medicare payment to Medicare.

- If the provider, physician, or other supplier collected on a claim/lien after billing Medicare, advise the provider, physician, or other supplier and beneficiary that:
    - The provider, physician, or other supplier must refund the Medicare payment in instances where the amount collected on the claim/lien is for the full charges of the claim/lien and the Medicare payment is greater than or equal to the full charges of the claim/lien and greater than or equal to the amount collected on the claim/lien (see example one below for an illustration of this policy); or

    - The provider, physician, or other supplier must refund the lesser of the amount collected on the claim/lien or the Medicare payment in instances where the amount collected on the claim/lien is less than

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the full charges of the claim/lien due to policy limits (see example two below for an illustration of this policy); and

- The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment if the provider, physician, or other supplier received payment for services not covered by Medicare and for Medicare deductibles and coinsurance (see example three below for an illustration of this policy); or

- The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment less any amounts due from the beneficiary for services not covered by Medicare and for Medicare deductibles and coinsurance (see example four below for an illustration of this policy).

- *Nothing within this manual, or the respective regulations cited herein, prevents a provider, physician, or other supplier, from maintaining a claim or lien against the liability insurance or beneficiary's liability insurance settlement once the Medicare timely filing period has lapsed.*

EXAMPLES

EXAMPLE 1: Charges from the facility are $5,000. Medicare is billed. The facility receives $8,000 from Medicare. The facility receives $5,000 from the liability insurance. The facility must repay Medicare $8,000.

EXAMPLE 2: Charges from the facility are $150,000. Medicare is billed. The facility receives $110,000 from Medicare. The facility receives $100,000 (due to policy limits) from the liability insurance. The facility must repay Medicare $100,000.

EXAMPLE 3: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deductible has been satisfied. The Medicare coinsurance of $160.00 has been paid. There are no charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives $1,000 from the liability insurance. The facility must repay Medicare $640.00 and send $360.00 to the Medicare beneficiary.

EXAMPLE 4: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deducible has been satisfied. The Medicare coinsurance of $160.00 has not been paid. There are $50.00 in charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives $1,000 from the liability insurance. The facility must repay Medicare $640.00. The facility may retain $210.00 for the unpaid Medicare coinsurance and charges for the non-covered Medicare services. The facility must send to the Medicare beneficiary the remainder of the liability insurance payment ($150.00).

F – Permissible Liens

The MSP provisions do not create lien rights when those rights do not exist under State

law. Where permitted by State law, a provider, physician, or other supplier may file a lien for full charges against a beneficiary's liability settlement. (A lien against a beneficiary will be considered a lien against a liability settlement if there is a binding agreement that the lien will only be enforced if there is a settlement and will be withdrawn otherwise.)

- The provider, physician, or other supplier may enforce a permissible lien up to the lesser of the amount of the settlement and charges for the services incorporated in the lien. The provider, physician, or other supplier may not charge interest, lien filing, and administrative fees to the beneficiary or against the lien.

50 - Workers' Compensation (WC)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A - General

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(2)), and outlined in 42 CFR § 411.40, payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any State. If it is determined that Medicare has paid for items or services that can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC

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plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program).

These Federal programs provide WC protection for Federal Civil Service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, for example:

- Coal miners totally disabled due to pneumoconiosis;
- Maritime workers (with the exception of seamen);
- Employees of companies performing overseas contracts with the United States government;
- Employees of American companies who are injured in an armed conflict;
- Employees paid from non-appropriated Federal funds (such as employees of post- exchanges);
- Offshore oil field workers; and
- Qualified claimants under the Department of Labor’s Energy Employees Occupational Illness Compensation Program.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion. However, they are considered liability insurance and the MSP liability rules apply.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory. If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

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B. - Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

A WCMSA is an agreement between CMS and the CMS beneficiary surrounding the allocation of funds from a workers' compensation (WC) settlement, judgment or award for future medical and/or future prescription drug expenses related to the WC injury and/or illness/disease. A WCMSA identifies the conditions that must be met before Medicare will resume primary payment of all settled WC injuries or illnesses. Where a WC settlement specifies that a portion of the settlement is for future medical care, Medicare may not pay for future medical and/or prescription drug services until the administrator of the WCMSA allocated funds provides evidence that payments were made appropriately for services that Medicare would otherwise reimburse and that the funds deposited in the WCMSA account were appropriately exhausted (disbursed only for services related to the WC injury or illness/disease). In addition, Medicare will not pay conditionally for diagnosis codes related to the set-aside occurrence. Once the set-aside amount is exhausted and accurately accounted for as set forth in the following sections, Medicare will pay primary for future Medicare covered medical and/or prescription drug expenses related to the WC injury or illness/disease. For additional information on WCMSAs, please visit the following website on CMS.gov: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview. The WCMSA Reference Guide, located in the Downloads section, details the CMS WCMSA approval process used by CMS while serving as a reference for those choosing to submit a WCMSA for CMS approval.

NOTE: There are situations where WCMSA benefits may terminate, or deplete, during a beneficiary's provider facility stay or upon a physician's visit and a residual payment is due. Under these circumstances Medicare may make a residual Medicare secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA benefit or responsibility for payment terminates mid-service. The shared systems, the A/B MACs, and DME MACs may pay this residual secondary payment by sending the primary payer amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare.

50.1 50.1 - **Effect of Payments Under WC Plan**

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

No Medicare payment may be made if WC has paid an amount:

- Which equals or exceeds the gross amount payable by Medicare;
- Which equals or exceeds the provider's charges for Medicare covered services; or
- The provider, physician or other supplier is either obligated to accept, or voluntarily accepts, a primary plan's payment as full payment.

NOTE: In general, WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for services. In such cases, providers are obligated to accept the WC payment as payment in full, and no secondary Medicare benefits are payable. If WC pays for Medicare covered services and under the WC law or plan the provider is not obligated to accept the payment as payment in full, Medicare

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secondary benefits may be payable as described in Pub. 100-05, Chapter 5. If the beneficiary has an open WCMSA on CWF, Medicare will not make any payment related to the WC accident or injury.

A - Secondary Medicare Payments

When a primary plan's payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare, and the provider does not accept and is not obligated to accept the primary plan's payment as full payment, then Medicare secondary payment can be made as appropriate. In general, the Medicare secondary payment is the least of:

- The Medicare gross payable amount minus the amount paid by the primary plan for Medicare covered services; or,
- The gross amount payable by Medicare minus the applicable deductible and/or coinsurance amount; or
- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full) minus any applicable deductible or coinsurance amounts; or
- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full), minus the amount paid by the primary plan for Medicare covered services.

NOTE: Medicare uses the amount the provider is obligated to accept as payment in full when:

1. The provider is obligated to accept an amount that is less than its charges (e.g., under the terms of a preferred provider agreement), and
2. The primary payer pays less than charges and less than the amount the provider is obligated to accept as payment in full for reasons other than failure to file a proper claim (e.g., because of the imposition of a primary payer deductible and/or copayment).

In the absence of a lower amount that the provider is obligated to accept as payment in full, the amount of the provider's actual charges is used in determining Medicare's secondary payment.

If WC pays a physician's or other supplier's full charges for medical services or pays a lesser amount based on its reasonable charge screen or fee schedule which must be accepted as payment in full, secondary Medicare benefits may not be paid to supplement the amount paid by WC. In addition, the physician or other supplier cannot charge the beneficiary or any other party for the services. This is because WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for the services.

B - Workers' Compensation Does Not Pay for All Services

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As stated in 42 CFR § 411.40(b)(2), where WC does not cover and therefore pay for all services furnished to a beneficiary, Medicare benefits may be paid for those services. For example, the services of a physician not authorized to furnish medical care under WC, may be reimbursed under Medicare. However, where a WCMSA exists, CMS may not pay for any treatments, services or medications related to the settled injury or illness until the fund administrator demonstrates complete and total exhaustion of the WCMSA funds, regardless of whether the treatment, service or medication might not have been covered under the WC plan.

C - Charges Included Non-Work Related Items or Services

If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work-related, Medicare benefits may be paid to the extent that the services are not covered by any other source which is primary to Medicare. A physician/supplier is permitted under WC law to charge an individual or the individual's insurer for services that are not work related. (See 42 CFR § 411.43(d)).

D - WC Cases Involving Liability Claims

Most State laws provide that, if an employee is injured at work due to the negligent act of a third party, the employee cannot receive payments from both WC and the third party for the same injury. If the individual is covered by a GHP and is age 65 or over, or is eligible or entitled to Medicare based on ESRD and covered by a GHP, or is under age 65 and has LGHP coverage and entitled to Medicare based on disability, the GHP may also be primary to Medicare. Generally, WC benefits are paid while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, WC may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

If WC does not pay for services or recovers benefits it previously paid for services solely because a third party is determined to be liable, Medicare is not secondary under this provision, to the extent of the nonpayment or recovery by WC. However, Medicare may be secondary for services covered under the liability insurance provision. Consider these cases under the policies within this chapter and Pub. 100-05, Chapter 7.

E - Possible Coverage of Work Related Services Under No-Fault Insurance or Group Health Plan

Where services are covered in part by WC and also under no-fault insurance, WC pays first, the no-fault insurance pays second and Medicare would be the residual payer. If the individual is covered by a GHP and is age 65 or over; or is under age 65 and entitled to Medicare solely because of ESRD, or is entitled as an active individual, including the member of the family of such individual, who is entitled to benefits on the basis of disability, the employer plan coverage may also be primary to Medicare.

Accordingly, whenever WC pays in part for services, and the physician or other supplier does not accept and is not obligated to accept such payment as payment in full, and there

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is information which indicates that the services may also be reimbursable under no-fault insurance or under a GHP, the A/B MAC or DME MAC follows the instructions in Pub. 100-05, Chapter 5.

If there is no coverage under no-fault insurance, but another insurer is shown on the bill, and there is indication of primary GHP coverage under §10, §20, or §30, the other insurer is to be billed for the services not paid for by WC. The other insurer is billed because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is a GHP.

If the services provided to the Medicare beneficiary are not related to an automobile accident (see §60) and there is no indication of primary group health plan coverage under §10 or §20, Medicare may pay benefits for the services not covered under WC.

F - Workers' Compensation Pays Only for Services of Certain Physicians

In some States, physicians' services are covered under WC only if furnished by a physician selected by the employer or the WC carrier or if furnished by a member of a panel of physicians authorized to furnish care in WC cases. In such cases, if the individual engages the services of another physician (for whose services the individual is not entitled to receive WC benefits), Medicare payment for such services is not precluded.

G - Contested Workers' Compensation Claims

An employee may appeal the refusal of an employer to pay WC benefits, or an employer may appeal the award of benefits to an employee by the WC agency. Such appeals are generally heard by a hearing officer or judge of the agency, with further appeal from such decision to the WC agency or appeals board and from there to the courts. Sometimes contested claims are settled by compromise agreement between the parties with the approval of the WC agency.

In general, a decision by a State WC agency on a contested claim, or a compromise settlement that has been approved by the agency should be accepted as a basis for applying the WC exclusion, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses. Thus, where an individual has been denied WC benefits for a particular illness or injury, the A/B MAC or DME MAC allows claims for treatment of that condition unless the decision or settlement is clearly inconsistent with the medical facts and applicable State law and has the effect of shifting to the Medicare program liability for medical expenses which are the responsibility of the State WC program. Where it is clear that an attempt was made to shift responsibility to the Medicare program, the A/B MAC or DME MAC denies the Medicare claim. The conclusions should be explained in detail in the denial notice and state that the beneficiary may wish to request a reopening under the WC law.

60 - No-Fault Insurance

Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), Medicare does not make payment

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for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under no-fault insurance. Medicare is secondary to no-fault insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. Under certain circumstances, Medicare may make conditional payments if the no-fault insurance will not pay or will not pay promptly (i.e., 120 days after receipt of the claim). Conditional payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under no-fault insurance.

If services are covered under no-fault insurance, that insurance must be billed first. If the insurance does not pay all of the charges, a claim for secondary Medicare benefits can be submitted. Medicare can pay for services related to an accident if benefits are not available under the individual's no-fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on non-medical items such as lost wages.

The question in each case involving accident-related medical expenses is whether no-fault benefits can be paid for these particular services. If so, the no-fault insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save insurance benefits to pay for future services or for non-covered medical services or non-medical services. Since no-fault insurance benefits would be available in that situation, they must be used before Medicare can be billed.

If there is an indication that the individual has filed, or intends to file a liability claim against a party that allegedly caused an injury, the A/B MAC or DME MAC follows the procedures related to MSP liability insurance situations once the no-fault insurance is exhausted.

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made..." under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where Ongoing Responsibility of Medicals (ORM) has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted. See IOM 100-05, Chapter 5, Section 20.4 for detailed instructions regarding ORM.

60.1 – Medicare's Recovery Rights

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare has a statutory direct right of recovery from the no-fault insurance as well as any entity that has received payment directly or indirectly from the proceeds of a no-fault insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to other entities including Medicaid because Medicare's direct right of recovery is explicitly prescribed in Federal law and other entities' recovery rights are based on either State law or subrogation

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rights.

In addition to its direct rights of recovery, Medicare also has subrogation rights. "Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare is a claimant against the no-fault insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the no-fault insurer. Medicare can be a party to any claim by a beneficiary or other entity against no-fault insurance and can participate in negotiations concerning the total no-fault insurance payment and the amount to be repaid to Medicare.

70 – Interest on MSP Recovery Claims

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Section 1862(b)(2)(B)(i) of the Social Security Act (the Act) and 42 C.F.R. 411.24(m) provide express authority to assess interest on MSP debts. Interest is calculated on the MSP debts using the method applicable to Non-MSP Medicare overpayments and underpayments as stated in 42 C.F.R. 405.378. For Medicare overpayments and underpayments and MSP debts, interest is calculated in full 30-day periods. Interest instructions for Medicare overpayments and underpayments are found in Chapter 4, Pub. 100-06, Medicare Financial Management Manual.

80 – Prohibitions Applicable to Employers Offering GHP Coverage

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

80.1- Financial Incentives

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

An employer or other entity is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in or to terminate enrollment in a GHP or LGHP that is or would be primary to Medicare, pursuant to 42 CFR § 411.103. This prohibition precludes the offering of benefits to Medicare beneficiaries that are alternatives to the employer's primary plan (e.g., prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary plan coverage through his/her own or a spouse's employer. This rule applies even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan. It is a violation of the Medicare law every time a prohibited offer is made regardless of whether it is oral or in writing. Any entity that violates the prohibition is subject to a civil money penalty of up to $5,000 for each violation

80.2 - Discrimination in Offering Equal Benefits for Older and Younger Employees and Spouses

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Section 1862(b)(1)(A)(i)(II) of the Act provides that GHPs of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits under the same conditions that they provide to employees and spouses under 65 if those 65 or older are covered under the plan on the basis of the individual's current employment status or the current employment status of a spouse of any age. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare. (See 42

CFR § 411.100 and 102.)

80.3 - Differentiation for ESRD

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during a coordination period described earlier in this chapter. The following are examples of potential taking into account the Medicare eligibility or entitlement of ESRD patients:

- The plan does not cover routine maintenance dialysis services or kidney transplants;
- The plan excludes benefits, makes itself secondary to government benefits, or charges a higher premium for individuals with ESRD;
- The plan imposes limitations on benefits for persons with ESRD which are not applicable to others, e.g., a higher deductible or coinsurance, a longer waiting period or a lower annual or lifetime benefit limit.

Section 1862(b)(1)(C)(ii) of the Act provides that GHPs may not differentiate in the benefits they provide between individuals who do not have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute differentiation in plan benefits (and that may also constitute "taking into account" Medicare eligibility or entitlement) include, but are not limited to, the following:

- Terminating coverage of individuals with ESRD for reasons that would not be a basis for terminating individuals who do not have ESRD;
- Imposing benefit limitations (such as less comprehensive health plan coverage, reductions in benefits, exclusion of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations) on persons who have ESRD but not on others enrolled in the plan;
- Charging individuals with ESRD higher premiums;
- Paying providers/suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such as paying 80 percent of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable, and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD; and
- Failing to cover routine maintenance dialysis or kidney transplants when a plan covers other dialysis services or other organ transplants.

A plan is not prohibited from limited covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD

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and those who do not.

80.3.1- Paying Benefits Secondary to Medicare

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The nondifferentiation provision does not prohibit a plan from paying benefits secondary to Medicare after the coordination period. However, a plan may not otherwise differentiate, as described in §70.2 and §70.3, in the benefits it provides.

EXAMPLE 1:

Mr. Smith works for employer A and he and his wife are covered through employer A's GHP (Plan A)**.** Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services, such as prescription drugs, which Plan B does not cover. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs. Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 30 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplemental policy. That policy pays Medicare's deductible and coinsurance amounts but does not pay for items and services not covered by Medicare which Plan A would have covered. That conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones who has ESRD than it provides for Mrs. Smith who does not. In other words, if Plan A pays secondary to primary payers other than Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

80.4 - Taking Into Account Medicare Entitlement

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Sections 1862(b)(1)(A), (B), and (C) of the Act provide that GHPs and LGHPs may not take into account that an individual is entitled to Medicare in any of the following situations:

- Beneficiaries age 65 or older who are covered by a GHP (of employers who employ at least 20 employees) by virtue of the individual's current employment status or the current employment status of a spouse of any age (see Chapter 2, §10);

- Beneficiaries who are eligible for or entitled to Medicare on the basis of ESRD and who are covered by a GHP (without regard to the number of individuals employed and regardless of current employment status) during the first 30 months of ESRD-based Medicare eligibility or entitlement (See Pub. 100-05, Chapter 2, §20); or

- Beneficiaries under age 65 who are entitled to Medicare on the basis of disability

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and who are covered under a LGHP (i.e., a plan of an employer who employs at least 100 employees) and are covered under the plan by virtue of the individual's or a family member's current employment status. (See Pub. 100-05, Chapter 2, §30)

A. Examples of Actions that Constitute "Taking Into Account" Medicare Entitlement

Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

- Failing to pay primary benefits;

- Offering to individuals entitled to Medicare coverage that is secondary to Medicare;

- Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (see 26 U.S.C. Section 4980B(f)(2)(B)(iv); 29 U.S.C. Section 1162(2)(D); and 42 U.S.C. Section 300bb-2 (2)(D));

- In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated disabled individuals who do not meet the Social Security definition of disability;

- Imposing limitations (such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, or providing for lower annual or lifetime benefit limits or more restrictive preexisting illness limitations) on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan;

- Charging the Medicare-entitled individual higher premiums;

- Requiring a Medicare-entitled individual to wait longer for coverage to begin;

- Paying providers and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare;

- Providing misleading or incomplete information that could have the effect of inducing a Medicare-entitled individual to reject the employer plan, thereby making Medicare the primary payer. (An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that if he/she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.);

- Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer; and

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- Refusing to enroll an individual for whom Medicare would be secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

80.5 - Permissible Distinctions in Coverage Allowed a GHP or LGHP
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

If a GHP or LGHP makes benefit distinctions between various categories of individuals (distinctions unrelated to the fact that an individual is entitled to Medicare but based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP plan may make the same distinctions between the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than one year and who are not entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than one year and who are entitled to Medicare on the basis of disability or age.

- A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the employer employs fewer than 20 or 100 employees, respectively.

- A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he/she has current employment status, the GHP or LGHP coverage is by reason of the COBRA law rather than by virtue of current employment status.

- A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD when permitted under the COBRA provisions. The only exception in the COBRA law (see 29 U.S.C.1162(2)(D)(ii)) prohibits GHPs from terminating COBRA coverage for retirees and dependents who are entitled to Medicare when the employee retired before the employer effectively terminated the regular plan coverage by filing for bankruptcy.

90 - Actions Resulting from GHP or LGHP Nonconformance
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. Determination [See 42 CFR § 411.110]

A determination of nonconformance is a CMS determination that a GHP or LGHP is a nonconforming plan as provided in this section. The CMS may make a finding of nonconformance for any GHP or LGHP that at any time during a calendar year fails to

comply with any of the following statutory provisions:

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- The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the basis of ESRD, age, or disability or eligible on the basis of ESRD (see §70.4 above);

- The equal benefits clause for the working aged (see §70.5 above);

- The non-differentiation clause for individuals with ESRD (see §70.3 above); or

- The obligation to refund conditional Medicare primary payments.

The CMS may make a finding of nonconformance for a GHP or LGHP that fails to provide correct, complete, and timely information, either voluntarily or in response to a CMS request, on the plan's primary payment obligation with respect to a given beneficiary if that failure contributes to:

- Medicare mistakenly making a primary payment; or

- A delay or foreclosure of CMS's ability to recover a mistaken primary payment.

If CMS determines that a GHP fails to comply with the provision that prohibits taking into account entitlement to Medicare (see §70.4 above) in a particular year, the GHP is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments, the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 2019, that plan was nonconforming for 2019. If in 2022 CMS identifies mistaken primary payments attributable to the 2019 violation and the plan refuses to repay, it is also nonconforming for 2022.

B. Starting Dates for Determination of Nonconformance [See 42 CFR § 411.114]

The CMS's authority to determine nonconformance of GHPs and LGHPs begins on the following dates:

- January 1, 1987, for MSP provisions that affect the disabled;

- December 20, 1989, for MSP provisions that affect ESRD beneficiaries and the working aged; and

- August 10, 1993, for failure to refund mistaken Medicare primary payments.

C. Notice to GHP or LGHP of Determination of Nonconformance [See 42 CFR § 411.115(a)]

If central office determines that a GHP or a LGHP is nonconforming with respect to a particular calendar year, CMS will mail a written notice to the plan with the following:

- The determination;

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- The basis for the determination;
- The right of the parties to request a hearing. (The Parties are the GHP or LGHP for which CMS determined the nonconformance and any employers or employee organizations that contributed to the plan during the calendar year for which CMS determined nonconformance.);
- An explanation of the procedure for requesting a hearing;
- The tax that may be assessed by the IRS in accordance with §5000 of the IRC; and

The fact that, if none of the parties requests a hearing within 65 days from the date on the notice, the determination is binding on all parties unless it is reopened.

The notice also states that the plan must submit to CMS, within 30 days from the date on its notice, the names and addresses of all employers and employee organizations that contributed to the plan during the calendar year for which CMS has determined nonconformance.

D. Notice to Contributing Employers and Employee Organizations [See CFR 42 §v 411.115(b)]

The CMS mails written notice of the determination, including all the information specified in subsection C, above, to all contributing employers and employee organizations already known to CMS or identified by the plan in accordance with subsection C. Employer and employee organizations have 65 days from the date of their notice to request a hearing.

E. Penalties

Any entity that violates the prohibition described in subsection A is subject to a civil money penalty of up to $5,000 for each violation.

If CMS Central Office determines that a plan has been a nonconforming GHP in a particular year, it refers its determination, including the identity of the contributors that it has identified, to the IRS, but only after the parties have exhausted all appeal rights with respect to the determination. Section 5000 of the Internal Revenue Code of 1986 imposes an excise tax penalty on employers and employee organizations that contribute to nonconforming GHPs. They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each GHP (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers. The IRS administers Section 5000 of the IRC, which imposes the tax on employers (other than governmental entities) or employee organizations that contribute to a nonconforming GHP mentioned in §80.

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100 - GHP or LGHP Actions to Document Conformance

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A GHP or LGHP may be required to demonstrate that it has complied with the MSP prohibitions and requirements, set forth in §70 of this chapter, and to submit supporting documentation. If the GHP or LGHP fails to provide acceptable documentation, the GHP or LGHP could be found to be nonconforming. The A/B MAC or DME MAC must notify the RO and furnish complete information.

A. Examples

The following are examples of acceptable documentation:

- A copy of the employer's plan or policy that specifies the services covered, conditions of coverage, and benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability for whom Medicare is secondary payer, as compared to the provisions applicable to other enrollees and potential enrollees; and

- An explanation of the plan's allegation that it does not owe CMS any amount CMS claims the plan owes as refund for conditional or mistaken Medicare primary payments. The plan must include all information requested by the A/B MAC or DME MAC.

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Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12436MSP	12/28/2023	Update to Internet Only Manual 100-05, Chapter 2, Section 40.2 to Clarify the Liability Insurance Settlement Provisions	01/20/2024	13475
R11755MSP	12/21/2022	Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapters 1 and 2	01/23/2023	13000
R118MSP	04/28/2016	Individuals Not Subject to the Limitation on Medicare Secondary Payment (MSP)	05/31/2016	9576
R113MSP	08/06/2015	Instructions for the Shared Systems and Medicare Administrative Contractors (MACs) to follow when a Medicare Residual Payment must be Paid on Workers' Compensation Medicare Set-aside Arrangement (WCMSA) or for Ongoing Responsibility of Medicals (ORM) Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Claims	01/04/2016	9009
R65MSP	03/20/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments	04/06/2009/ 07/06/2009	5371
R64MSP	01/09/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments - Rescinded and replaced by Transmittal 65	04/06/2009/ 07/06/2009	5371
R49MSP	04/07/2006	Manualizing Long-Standing Medicare Secondary Payer (MSP) Policy	05/08/2006	4024
R45MSP	12/16/2005	Interest on MSP Debts	01/17/2006	4125

R33MSP	08/12/2005	Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)	05/20/2005	3768
R28MSP	04/28/2005	Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)	05/20/2005	3768
R25MSP	02/25/2005	Changes Included in the Medicare Modernization Act (MMA)	04/25/2005	3219
R18MSP	08/27/2004	Application of Medicare Secondary Payer Provisions for the Working Aged, Disabled Former Spouses and Certain Family Members with Coverage Under the Federal Employees Health Benefits (FEHB) Program	11/29/2004	3120
R02MSP	10/17/2003	Individuals Not Subject to the Limitation on Payment	04/01/2004	2252
R01MSP	10/01/2003	Initial Issuance of Manual	N/A	N/A

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MOA App'x 12: MCL 600.6303

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MCLS § 600.6303

This document is current through Act 35 of the 2025 Regular Legislative Session and E.R.O. 2025-1

§ 600.6303. Payment of plaintiff's expense or loss by collateral source; notice to contractual lien holder; failure to exercise right of subrogation; contracts to which subsection (3) applicable; "collateral source" defined; benefits from collateral source as payable or receivable.

Sec. 6303.

(1) In a personal injury action in which the plaintiff seeks to recover for the expense of medical care, rehabilitation services, loss of earnings, loss of earning capacity, or other economic loss, evidence to establish that the expense or loss was paid or is payable, in whole or in part, by a collateral source shall be admissible to the court in which the action was brought after a verdict for the plaintiff and before a judgment is entered on the verdict. Subject to subsection (5), if the court determines that all or part of the plaintiff's expense or loss has been paid or is payable by a collateral source, the court shall reduce that portion of the judgment which represents damages paid or payable by a collateral source by an amount equal to the sum determined pursuant to subsection (2). This reduction shall not exceed the amount of the judgment for economic loss or that portion of the verdict which represents damages paid or payable by a collateral source.

(2) The court shall determine the amount of the plaintiff's expense or loss which has been paid or is payable by a collateral source. Except for premiums on insurance which is required by law, that amount shall then be reduced by a sum equal to the premiums, or that portion of the premiums paid for the particular benefit by the plaintiff or the plaintiff's family or incurred by the plaintiff's employer on behalf of the plaintiff in securing the benefits received or receivable from the collateral source.

(3) Within 10 days after a verdict for the plaintiff, plaintiff's attorney shall send notice of the verdict by registered mail to all persons entitled by contract to a lien against the proceeds of plaintiff's recovery. If a contractual lien holder does not exercise the lien holder's right of subrogation within 20 days after receipt of the notice of the verdict, the lien holder shall lose the right of subrogation. This subsection shall only apply to contracts executed or renewed on or after the effective date of this section.

(4) As used in this section, "collateral source" means benefits received or receivable from an insurance policy; benefits payable pursuant to a contract with a health care corporation, dental care corporation, or health maintenance organization; employee benefits; social security benefits; worker's compensation benefits; or medicare benefits. Collateral source does not include life insurance benefits or benefits paid by a person, partnership, association, corporation, or other legal entity entitled by law to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages. Collateral source does not include benefits paid or payable by a person, partnership, association, corporation, or other legal entity entitled by

contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3).

(5) For purposes of this section, benefits from a collateral source shall not be considered payable or receivable unless the court makes a determination that there is a previously existing contractual or statutory obligation on the part of the collateral source to pay the benefits.

History

Pub Acts 1961, No. 236, Ch. 63, § 6303, as added by Pub Acts 1986, No. 178, imd eff July 7, 1986, by § 2 eff October 1, 1986.

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MOA App'x 13: Brehmer v. State Farm Mut. Ins. Co._2015 Mich. App. LEXIS 530
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Brehmer v. State Farm Mut. Ins. Co.

Court of Appeals of Michigan

March 17, 2015, Decided

No. 318839

Reporter
2015 Mich. App. LEXIS 530 *

RICHARD BREHMER, Plaintiff-Appellee, v STATE FARM MUTUAL INSURANCE COMPANY and NICOLE ALISE ROTHMAN, Defendants, and AUTO OWNERS INSURANCE COMPANY, Defendant-Appellant.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: [*1] Lenawee Circuit Court. LC No. 11-004097-NF.

Counsel: For Richard Brehmer, Plaintiff-Appellee: Courtney E. Morgan Jr., Dearborn, MI.

For State Farm Mutual Insurance Company, Defendant: John C. Fish, Kalamazoo, MI.

For Nicole Alise Rothman, Defendant: Jennifer M. Kelly, Jackson, MI.

For Auto Owners Insurance Company, Defendant-Appellants: Frederick W. Girodat II, Jennifer M. Kelly, Jackson MI.

Judges: Before: BOONSTRA, P.J., and SAWYER and O'CONNELL, JJ.

Opinion

PER CURIAM.

In this third-party auto accident case, defendant Auto Owners Insurance Company (Auto Owners) appeals as of right the trial court's order granting Richard Brehmer's motion for judgment notwithstanding the verdict (JNOV). We reverse.

I. FACTS AND PROCEDURAL HISTORY

A. TRIAL TESTIMONY

Brehmer and Nicole Rothman were involved in a traffic accident in May 2010. Brehmer testified that he was driving a tractor for the City of Adrian when Rothman ran into it. The tractor flipped over on Brehmer, and his right arm and shoulder were injured. Brehmer had an underinsured motorist policy with Auto Owners. The only issues at trial were whether Brehmer's shoulder injury constituted a serious impairment of a bodily function and whether Brehmer failed to mitigate his damages.

Brehmer testified that he began physical therapy shortly after the accident. In July 2010, Brehmer's family physician referred him to Dr. Michael Diment. Brehmer testified that Dr. Diment prescribed him physical therapy, which he did, but his shoulder continued to hurt. Dr. Diment took an MRI of Brehmer's shoulder. Dr. Diment [*2] testified that Brehmer had suffered three shoulder injuries: a rotator cuff tear, a deformity to the dimple in the bone, and an injury to the shoulder socket. Brehmer testified that Dr. Diment performed surgery on his shoulder in October 2010.

According to Brehmer, he discussed the exercises he had learned at his prior physical therapy with Dr. Diment, and Dr. Diment told Brehmer to do those exercises at home. Brehmer testified that he did the exercises for 10 to 15 minutes a day, and Dr. Diment said that his at-home exercises were "fine." According to Dr. Diment, he ordered Brehmer to do exercises at home. Dr. Diment acknowledged that in November 2010, he noted in Brehmer's file that Brehmer might need formal physical therapy. However, Dr. Diment opined that Brehmer's at-home exercises were sufficient in lieu of physical therapy. Dr. Diment testified that physical therapy could not address Brehmer's bone dimple or shoulder socket injury.

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Brehmer had not improved by April 2011. Dr. Diment told Brehmer that he could have an additional surgery that would manipulate Brehmer's shoulder under anesthesia. Dr. Diment testified that the procedure was "somewhat risky," unpredictable, and that [*3] it could lead to a different pain and instability. Brehmer testified that he decided that he did not want to have the surgery because Dr. Diment told him that there was a risk he could lose his arm or that the surgery would make his problem worse. Dr. Diment supported Brehmer's decision not to have further surgery.

Dr. Diment testified that as of September 2011, Brehmer had improved his range of motion with home exercises. Dr. Diment testified that Brehmer was a compliant patient and he believed that Brehmer was doing his at-home exercises. Dr. Diment did not recommend another surgery or physical therapy. Dr. Diment opined that physical therapy at a rehabilitation center would not have given Brehmer a better result than the exercises he did at home.

Aaron Deline, Brehmer's physical therapist until August 2010, testified that he believed that physical therapy would have helped Brehmer to improve his range of motion. Deline acknowledged that a patient needs a doctor's prescription to receive physical therapy and that Dr. Diment did not refer Brehmer back to physical therapy. Deline testified that Brehmer was compliant at physical therapy sessions, but his therapy notes questioned Brehmer's [*4] compliance with at-home exercises.

Dr. Joseph Salama testified that he interviewed and examined Brehmer in September 2010 and February 2011. According to Dr. Salama, Brehmer needed formal physical therapy to increase his range of motion and decrease his pain. Dr. Salama would have recommend manipulating Brehmer's shoulder under anesthesia and that, if the manipulation went well, it would have a 70 percent chance of success. Dr. Salama did not believe that Brehmer had failed to comply with Dr. Diment's advice.

Dr. Brian Chodoroff testified that he specializes in physical medicine and rehabilitation and that he reviewed Brehmer's medical records. According to Dr. Chodoroff, Brehmer's home exercises were inadequate, and he should have done physical therapy to increase his range of motion. Dr. Chodoroff also opined that Brehmer might benefit from a manipulation under anesthesia, but testified that if Brehmer did not want to undergo a manipulation, he should at least obtain a cortisol injection and physical therapy. Dr. Chodoroff testified that he would not expect a patient to get formal physical therapy if his doctor did not prescribe it, and he opined that Brehmer's records did not indicate [*5] that he had failed to comply with Dr. Diment's orders.

Dr. Casey Bartman testified that he is an orthopedic surgeon who reviewed Brehmer's medical records. According to Dr. Bartman, Brehmer's shoulder injury was severe and Brehmer would have benefitted from formal physical therapy after surgery because it would have reduced his stiffness and pain. Dr. Bartman opined that a steroid injection and an aggressive course of physical therapy would improve Brehmer's range of motion and decrease his pain. Dr. Bartman testified that there was no evidence that Brehmer had failed to perform his home exercises, but he opined that home exercises are not very beneficial to a shoulder joint injury.

B. PROCEDURAL HISTORY

The jury awarded Brehmer $150,000 in past noneconomic damages, but it found that Brehmer did not have future noneconomic damages. The jury also found that Brehmer failed to mitigate his damages and it reduced the verdict by $50,000. On April 16, 2013, the trial court entered a judgment on the verdict for $100,000, with various costs and fees.

On May 7, 2013, Brehmer filed a motion for JNOV, new trial, or additur. According to Brehmer, Auto Owners did not meet its burden of proof to show [*6] that Brehmer failed to mitigate his damages because it did not show Brehmer failed to follow his doctor's advice. In response, Auto Owners presented several reasons why the jury could have found that Brehmer failed to mitigate his damages, including that Brehmer had failed to participate in formal physical therapy, had refused a surgery that Dr. Diment recommended, and might have financial motivations to fail to seek improvement.

After hearing arguments on the motion, the trial court ruled as follows:

> It is true that the jury completed the verdict form awarding plaintiff 150,000. They subtracted $50,000 for plaintiff's alleged failure to mitigate his damages. They awarded zero dollars for future physical damages. Defendants' expert witness testified if plaintiff had undergone formal physical therapy, even to this day, that being the day of trial, he would've gained greater range of motion or less pain.
>
> I did not find that in my own assessment, and I was

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> taken [a]back by the jury penalizing [Brehmer] significantly for what they alleged to be failure to mitigate.
>
> Defendants' experts testified there was no evidence that [Brehmer] failed to follow his doctor's order. Dr. Diment, treating physician, [*7] the person in the best position to make a decision about [Brehmer's] actions, testified unequivocally that he never prescribed physical therapy for [Brehmer] and that [Brehmer] made all decisions—and that he made all decisions regarding [Brehmer's] care and treatment, and that they together determined that home exercises were in fact in [Brehmer's] best interest, and Dr. Diment fully supported that determination.
> I think that what was anticipated was not far off the mark, and I think that from the jury verdict's determ—the jury verdict supports that there may very well have been significant confusion with regard to the jurors speculating with regard to [Brehmer's] duty to follow non-treating physicians' recommendations.
> If mitigation of damages is in fact a doctrine that seeks to minimize economic harm arising from wrong doing, I don't think that [Brehmer] did anything wrong. I think that it was clear from the testimony that [Brehmer] followed his doctor's orders and that Dr. Diment prescribed and allowed the therapy that he and [Brehmer] thought to be appropriate under [Brehmer's] condition and circumstances.
>
> I do not believe that plaintiff is entitled to a new trial. I do believe that [*8] the verdict may have in fact employed improper procedures and in fact demonstrate a mistake of law or fact based upon the evidence that was presented and the jury verdict form that was agreed upon that went with the jury to the jury room for deliberation. I thought that the jury verdict—and would not disturb the jury verdict as to a finding of $150,000. They made a determination based upon on [sic] what they heard. And with the exception of the reduction, which I believe does in fact result in a problem that needs the Court's attention, and it is supported by the evidence as I [sic] was heard during trial. [Brehmer] followed his treating physician's orders, jury awarded 150,000 and subtracted 50,000 based upon mitigation of damages. I don't believe that [Brehmer] didn't do what he needed to do, and I, therefore, order an additur of the amount deducted, awarding plaintiff $150,000.

At a subsequent hearing, the trial court clarified that it did not mean to grant an additur, it meant to grant JNOV. Auto Owners now appeals.

II. ANALYSIS

Auto Owners contends that the trial court improperly granted Brehmer's motion for JNOV because a question of fact existed regarding whether Brehmer mitigated [*9] his damages. We agree.

This Court reviews de novo a trial court's decision on a motion for JNOV. *Genna v Jackson*, 286 Mich App 413, 417; 781 NW2d 124 (2009). We view the evidence and inferences arising from the evidence in the light most favorable to the nonmoving party to determine whether the moving party was entitled to judgment as a matter of law. *Id*. The trial court should only grant a motion for JNOV "when there is insufficient evidence presented to create a triable issue for the jury." In contrast, "[w]hen reasonable jurors could honestly reach different conclusions regarding the evidence, the jury verdict must stand." *Id*. JNOV is only appropriate when the evidence "fails to establish a claim as a matter of law[.]" *Barrett v Kirtland Community College*, 245 Mich App 306, 311; 628 NW2d 63 (2001).

The doctrine of mitigation of damages provides that a party must minimize the harm that arises from another party's wrongdoing. *Morris v Clawson Tank Co*, 459 Mich 256, 263; 587 NW2d 253 (1998). When a person has been injured, "it is incumbent upon [that person] to use such means as are reasonable under the circumstances to avoid or minimize the damages." *Id*. (quotation marks and citation omitted). An injured party's duty to exercise reasonable care to minimize damages includes the obligation to obtain proper medical or surgical treatment. *Klanseck v Anderson Sales & Serv, Inc*, 426 Mich 78, 91; 393 NW2d 356 (1986). The defendant has the burden to prove that a plaintiff [*10] failed to make a reasonable effort to mitigate his or her damages. *Landin v Healthsource Saginaw, Inc*, 305 Mich App 519, 539; 854 NW2d 152 (2014). "The question whether the plaintiff's efforts to mitigate damages were reasonable under the circumstances is one for the trier of fact." *Id*.

There are two flaws with the trial court's ruling in this case. First, the trial court improperly expanded the elements of mitigation to include an element that does not exist: that the plaintiff disobeyed his or her doctor's orders. This Court is unable to find support for such an element. The doctrine of mitigation of damages does not ask whether a specific plaintiff obeyed or disobeyed his or her doctor's orders; it asks whether a person used

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reasonable means to minimize his or her damages. See *Morris*, 459 Mich at 263; *Landin*, 305 Mich App at 539. Whether a plaintiff complied with his or her doctor's orders is certainly *a* factor concerning the plaintiff's reasonableness. See *Klanseck*, 426 Mich at 91. But it is only *one* factor, and the jury must consider the totality of the circumstances. See *Morris*, 459 Mich at 273. To the extent that the trial court determined that Auto Owners failed as a matter of law to establish that Brehmer failed to mitigate his damages, we conclude that it erred.

Second, the trial court usurped the jury's role to determine what was reasonable under [*11] the circumstances. In essence, the trial court in this case acted as an impermissible "thirteenth juror" when it substituted its determination of the weight of the evidence for the jury's determination. Michigan disapproves of allowing a trial court judge to sit as a thirteenth juror. See *People v Lemmon*, 456 Mich 625, 638-640; 576 NW2d 129 (1998). The trial court's ruling is replete with statements of belief that are based on its own assessments of the weight of the evidence. This is not the proper standard under which to analyze a motion for JNOV. The question is whether reasonable jurors could honestly reach different conclusions. *Genna*, 286 Mich App at 417.

Our review of the record indicates that there were at least two reasons why reasonable jurors could have reached different conclusions regarding whether Brehmer mitigated his damages. The jury could have found that Brehmer's decision not to have additional surgery was unreasonable. It is undisputed that Dr. Diment supported Brehmer's decision not to have a second surgery because of the possible adverse consequences. However, a variety of doctors testified that surgery was likely to improve Brehmer's condition. That these doctors did not treat Brehmer went to the weight of the evidence. This conflicting evidence [*12] created at least a triable issue of fact regarding whether Brehmer's refusal of further surgery was reasonable.

The jury also could have found that Brehmer failed to reasonably perform his physical therapy. Dr. Diment testified that he believed that Brehmer was doing at-home physical therapy. But Brehmer testified that he only exercised 10 to 15 minutes a day or when his shoulder "seized up[.]" Deline indicated that there were reasons to believe that Brehmer was not properly complying with at-home therapy, and Dr. Chodoroff referred to Brehmer's home therapy setup as "pretty lame." Dr. Chodoroff testified that Brehmer's outcome indicated that he was not successfully rehabilitating himself. This evidence created at least a triable issue of fact regarding whether Brehmer took reasonable steps to address his condition through physical therapy.

For these reasons, we conclude that the trial court erred when it set aside the jury's verdict regarding whether Brehmer mitigated his damages. We do not reach the remainder of Auto Owners's issues because our conclusion renders resolution of those issues unnecessary.

We reverse the trial court's grant of Brehmer's motion for JNOV and remand for the [*13] trial court to reinstate the jury verdict. We do not retain jurisdiction. As the prevailing party, Auto Owners may tax costs. MCR 7.219(A).

/s/ Mark T. Boonstra

/s/ David H. Sawyer

/s/ Peter D. O'Connell

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MOA App'x 14: Blatt v College of Staten Island

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2005 WL 8160053
Only the Westlaw citation is currently available.
NOT FOR PUBLICATION
United States District Court, E.D. New York.

Irwin BLATT, Plaintiff,
v.
The COLLEGE OF STATEN ISLAND and
the City University of New York, Defendants.

04-CV-2263 (ERK)
|
Signed November 28, 2005
|
Filed 11/30/2005

Attorneys and Law Firms

Geoffrey A. Mort, Kraus & Zuchlewski LLP, New York, NY, for Plaintiff.

Steven Leon Banks, NYS Office of the Attorney General, New York, NY, for Defendants.

MEMORANDUM & ORDER

Edward R. Korman, United States Chief District Judge

***1** Irwin Blatt, a retired full-time City University of New York (CUNY) professor, alleges that CUNY and the College of Staten Island (CSI) retaliated against him in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 20003-3(a), for agreeing to assist in the employment discrimination lawsuit of another CUNY employee. The plaintiff claims that CUNY and CSI retaliated by: 1) failing to provide him with part-time teaching and counseling assignments for the Fall 2003 semester, 2) failing to provide him with counseling assignments for the Spring 2004 semester, and 3) failing to appoint him as an adjunct professor for the Fall 2004 semester. The Amended Complaint also alleges that CUNY's failure to appoint the plaintiff as an adjunct professor after Spring 2004 was retaliation for filing a charge of discrimination with the EEOC on October 8, 2003.

The defendants now move for summary judgment dismissing claims arising from plaintiff's lack of counseling assignments in Fall 2003 and Spring 2004 and CUNY's decision not to appoint the plaintiff as an adjunct professor for Fall 2004. They do not seek summary judgment on claims arising from CUNY's decision not to offer the plaintiff teaching assignments for the Fall 2003 semester. At issue is whether the plaintiff has made a prima facie case of retaliation and whether the defendants' articulated non-discriminatory, non-retaliatory reason for the decision is pretextual.

Background

The parties to this case offer two competing narratives of the same set of events. For clarity's sake, I present the defendant's narrative first, since the plaintiff disagrees only with the motivations for the events described therein. The plaintiff's additions to and disagreements with this recounting are presented at the end of the background section.

Plaintiff Irwin Blatt was a full-time, tenured professor at the College of Staten Island, a senior college within the CUNY system, from 1968 to 2003. During most of that time, he was employed in the Department of Student Services, where in addition to his teaching duties, he provided career, academic and other counseling to students. At the end of the Fall 2002 semester, plaintiff, along with the three other full-time faculty members in the Counseling Center, elected to take advantage of a new, financially attractive retirement incentive program and relinquish his tenured seat. Each professor intended, however, to continue teaching as adjunct faculty members. In particular, plaintiff claims, and defendants do not dispute, that CSI's Vice President, Carol Jackson, encouraged retirement and promised the plaintiff that he could remain at CSI indefinitely as an adjunct. Nonetheless, adjunct faculty members are appointed on a semester-by-semester basis according to the needs of the college.

Along with the other retirees, the plaintiff was retained as a part-time adjunct professor for the Spring 2003 term. On March 26, 2003, CSI Provost David Podell, as the collective bargaining agreement required him to do, sent each retiree a form letter informing them that they had been approved as adjunct faculty for the fall semester. The letter cautioned, however, that the appointment was "subject to sufficiency of registration, changes in curriculum, and financial ability." According to the defendants, uncertainty about the appointments was real. The Counseling Center had not finalized its course and counseling schedules for Fall 2003 and could not be certain that it would have assignments for all the newly appointed adjuncts.

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***2** Soon thereafter, CSI President Marlene Springer decided that the Counseling Center should retain the full-time faculty positions vacated by the retirees, Accordingly, during the spring and summer of 2003, CSI actively sought full-time replacements for the positions vacated by the retirees. This resulted in CSI's appointment of four new full-time faculty members to the Counseling Center for the start of the Fall 2003 semester. In addition, the Counseling Center arranged for a counselor from Queens College to work at CSI that term. All of these appointments were approved and in place by August 28, 2003. Finally, CSI's Vice President Jackson and its Assistant Director of Student Services, Mary Murphy, decided to give most of the remaining assignments to long-serving adjunct faculty ("the adjuncts") in the counseling center rather than to the recent retirees ("the retirees"). Defendants claim this decision was justified by the fact that the adjuncts had experience comparable to that of the retirees and were less expensive to employ.

The defendants suggest that it was because of these actions that CSI did not have enough counseling hours and teaching assignments to employ each of the retirees as adjunct faculty members for the Fall 2003 semester. Regardless of the reason, only one assignment remained for the retired professors. That assignment consisted of teaching two courses of "Issues in College Life." Jackson and Murphy decided to give each retiree the opportunity to teach for a single semester only. The Counseling Center offered the plaintiff the second opportunity to teach, which would arrive in the Spring 2004 semester. CSI contends that the order in which the opportunities were offered was random.

After the plaintiff taught in the Spring 2004 semester, the Appointments Committee voted not to recommend plaintiff's appointment as an adjunct professor for the Fall 2004 semester. This recommendation, defendant's claim, was consistent with the rotation plan CSI originally set out.

The plaintiff and the defendants dispute the significance of the remaining facts, which provide the basis of plaintiff's retaliation claims. Both sides agree that the plaintiff agreed to testify in a separate Title VII lawsuit commenced by Karen Svenningsen, a CSI reference librarian. Svenningsen had commenced two Title VII lawsuits against CUNY, the second of which was pending in August 2003. In his deposition, the plaintiff testified that Svenningsen, in August 2003, asked him for "help" in her second suit, a retaliation claim against CSI. The plaintiff agreed to do so and, in a subsequent call, confirmed with her attorney his willingness to testify. Plaintiff's cooperation is indisputably reflected in an affidavit provided to Svenningsen that is dated September 15, 2003.

Less clear, however, is whether CSI's administration knew of the plaintiff's cooperation with Svenningsen. The plaintiff claims that his cooperation was "widely known" and that at one point Vice President Jackson walked into the plaintiff's office as he was talking to Svenningsen about her lawsuit. Finally, and most significantly, the plaintiff claims that he received a call from Vice President Jackson on August 29, 2004 during which Jackson made it clear that the plaintiff was being refused teaching assignments because he was helping Svenningsen. The defendants dispute this version of events.

Discussion

Title VII prohibits an employer from retaliating against an employee for engaging in activity protected by statute. 42 U.S.C. § 20003-3(a). Claims under Title VII for retaliation are analyzed under the framework established in McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802 (1973); see also Slattery v. Swiss Reinsurance Am. Corp., 248 F.3d 87, 94 (2d Cir. 2001) (applying McDonnell Douglas to a retaliatory discharge claim and affirming summary judgment in the employer's favor). First, the plaintiff must make out a prima facie case of retaliation in violation of Title VII. A prima facie case is established by showing: 1) that the plaintiff participated in a protected activity known to the defendant; 2) that the plaintiff was adversely affected by an employment action; and 3) that there is a causal connection between the protected activity and the adverse employment action. Quinn v. Green Tea Credit Corp., 159 F.3d 759, 768-69 (2d Cir. 1998); Galdieri-Ambrosini v. Nat. Realty & Dev. Corp., 136 F.3d 276, 292 (2d Cir. 1998). Second, if the plaintiff establishes a prima facie case of retaliation, the defendant must articulate a legitimate non-discriminatory, non-retaliatory reason for its actions. Quinn at 768. If the defendant is able to articulate such a reason, then the burden shifts back to the plaintiff, who must show that the defendant's proffered reason is merely a pretext for retaliation. Id. at 769.

Prima Facie Case

***3** It is undisputed that the plaintiff was engaged in a protected activity known to the defendant. Title VII makes it unlawful to discriminate against an employee "because he made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under

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this subchapter." 42 U.S.C. § 20003-3(a). Here, neither party disputes plaintiff's involvement in the Svenningsen litigation and, although defendants deny knowledge, they do not dispute this point for summary judgment purposes.

Second, it is also not disputed that the plaintiff was adversely affected by an employment action. Both sides agree that the plaintiff received substantially fewer adjunct teaching assignments than the full course-load of teaching assignments he expected upon retiring.

The third prong of the prima facie test is contested. The defendants argue that the plaintiff cannot demonstrate a causal connection between his involvement in Karen Svenningsen's suit and his lack of teaching and counseling appointments in the Spring and Fall of 2004. Based on this argument, they urge dismissal of plaintiff's claims for relief stemming from lost employment in the Spring and Fall of 2004 separately from those claims relating to the Fall 2003 semester. The defendants acknowledge that plaintiff has established a causal connection for the Fall 2003 claims. They argue that the connection between the plaintiff's offer to assist Svenningsen and his denial of employment was too remote in time to meet the burden of establishing a prima facie case for anything after Fall 2003.

Without more, the temporal proximity between a protected activity and an adverse employment decision must be "very close" to prove retaliation. Clark County Sch. Dist. v. Breeden, 532 U.S. 268, 273 (2001). This requirement reflects an understandable wariness of circumstantial evidence of retaliation. This strictness, however, disappears when there is actual evidence of retaliatory animus. See Sumner v. United States Postal Service, 899 F.2d 203, 209 (2d. Cir. 1990). Evidence of retaliatory animus serves as direct proof of causation and is sufficient, even absent a "very close" relationship in time. Id. Here, the plaintiff has offered clear evidence of such animus. Plaintiff has alleged that Vice President Jackson intimated that he would have to cease cooperating with Svenningsen to receive future adjunct assignments. This threat, as the plaintiff describes it, was not limited to Fall 2003 assignments only; it was open ended. In addition, plaintiff persuasively points out that CSI only made hiring decisions twice a year. This undisputed fact makes it more likely that retaliation would be dragged out over a long period, rather than condensed into one swift, decisive blow. Thus, plaintiff has articulated arguments sufficient to create a triable issue of fact.

Non-discriminatory, Non-retaliatory Purpose

Since the plaintiff has succeed in establishing a prima facie case of retaliation, the burden shifts to the defendants to articulate a non-discriminatory, non-retaliatory purpose for their actions. Although the defendants need not, at this stage, establish that their explanation is true, their explanation must be "clear and reasonably specific." Texas Department of Community Affairs v. Burdine, 450 U.S. 248, 258 (1981). This requirement "arises both from the necessity of rebutting the inference of discrimination arising from the prima facie case and from the requirement that the plaintiff be afforded 'a full and fair opportunity' to demonstrate pretext." Id. By establishing a prima facie case, a plaintiff in effect creates a presumption that the employer unlawfully retaliated. See id. at 254. Thus, unless the defendant comes forward with a non-discriminatory, non-retaliatory reason for the action complained of, the plaintiffs case may go to the jury. This remains true even if the prima facie case would be insufficient to meet the plaintiff's ultimate burden of showing discrimination; indeed, in such a circumstance the jury must rule for the plaintiff unless the employer submits evidence that places in doubt the facts underlying plaintiff's prima facie case (such as the plaintiff's qualification for the job), or furnishes a satisfactory explanation for its inability to tell the reason why plaintiff was disfavored. See St. Mary's Honor Center v. Hicks, 509 U.S. 502, 509 (1993). Fisher v. Vassar College, 114 F.3d 1332, 1335 (2d Cir. 1997) (en banc), *cert. denied*, 522 U.S. 1075 (1998).

***4** Here, the defendants argue that CSI had a diminished need for adjunct faculty in the Fall 2003 semester. They claim that as a result of the appointment of new full-time faculty in the Counseling Center, CSI only had fifty-one weekly hours of counseling or teaching to offer adjunct faculty. This stands in contrast to the Spring 2003 semester, where CSI relied on adjunct faculty to provide eighty-three weekly hours of counseling and teaching. CSI suggests that it was justified in offering the bulk of the hours to the adjuncts, rather than to the retirees, for two reasons. They claim that the adjuncts offered "specialized expertise needed by the Department" and that they were cheaper to employ than the retirees. Although the plaintiff disputes both of these rationales, it is not necessary to evaluate the merit of the defendants' arguments at this stage in the litigation. The defendants' proffered reasons are both clear and reasonably specific and, accordingly, they have met their burden in rebutting the plaintiff's prima facie case.

Prextext

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Even though the defendants have articulated a non-discriminatory, non-retaliatory justification for their actions, the plaintiff still has the opportunity to show that the proffered reasons were merely pretextual. The plaintiff alleges that on August 29, 2003, Vice President Jackson telephoned plaintiff and informed him that he was not being offered teaching and counseling assignments as a result of participation in the Svenningsen litigation. The defendants deny this allegation. The denial, while perhaps plausible, is insufficient for summary judgment purposes. "Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge [when] he is ruling on a motion for summary judgment." Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986). Such determinations would be central to any decision on the plaintiff's claim of pretext here. Thus, I find that the plaintiff has met his burden for summary judgment purposes and articulated a reason why the defendants' explanations for their actions is merely pretextual.

I note in passing that, even if the plaintiff had failed to make out a prima facie case or make a sufficient showing of pretext, it still would not be wise for me to grant partial summary judgment in this case. If a case is comprised of multiple related causes of action and one cause of action has to be tried, then it makes little sense to grant a motion to dismiss as to the other causes of action, since it may prove necessary to hold yet another trial in the event that an appellate court determines that the motion to dismiss was improperly granted. As Judge Clark observed in an analogous context: "[T]here seems no question that in the long run fragmentary disposal of what is essentially one matter is unfortunate not merely for the waste of time and expense caused the parties and the courts, but because of the mischance of differing dispositions of what is essentially a single controlling issue." Audi Vision Inc. v. RCA Mfg. Co., 136 F.2d 621, 625 (2d Cir. 1943).

Mitigation of Damages

Finally, defendants argue that even if the plaintiff were to prevail and show that there were triable issues of material fact in this case, the plaintiff would be precluded from gaining relief because he has failed to mitigate damages.

Questions of damages are rarely decided at the summary judgment phase because they are too dependent on specific facts not elicited in the pleadings. Here, the defendants argue that it is not too early to consider damages because the plaintiff seeks equitable damages – namely back pay and front pay. Both front pay and back pay are equitable remedies under civil rights statutes. Broadnax v. City of New Haven, 415 F.3d 265 (2d Cir. 2005). The problem, though, is not one of authority so much as it is one of prudence. Although I could decide this issue on the pleadings, it is difficult to have confidence in the result under these circumstances. Defendants base their argument on two one-word answers in the plaintiff's deposition in response to questions about whether he has sought employment since being notified that he would not be appointed as an adjunct. Meanwhile, the plaintiff's counter to these arguments – that his opportunities to mitigate are limited and that universities would be reluctant to hire him because of his active participation in campus unions – is difficult to evaluate without more facts. Thus, I follow Judge Spatt's advice from Ackerman v. National Financial Systems: "While this alleged failure to mitigate may be pressed by the defendants at trial, at this juncture there cannot be a determination as a matter of law, to preclude the plaintiff from seeking back pay." 81 F. Supp.2d 434, 439 (E.D.N.Y. 2000); see also Chainey v. Street 2005 WL 696883, *2 ("There is no doubt that some mitigation of damages may be called for, but at [the summary judgment] stage such a ruling is premature,").

Conclusion

***5** The defendant's motion for partial summary judgment is denied.

SO ORDERED.

All Citations

Not Reported in Fed. Supp., 2005 WL 8160053

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MOA App'x 15: Chainey v Street-3

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2005 WL 696883
Only the Westlaw citation is currently available.
United States District Court,
E.D. Pennsylvania.

Nannie CHAINEY, et al. Plaintiffs,
v.
John STREET, et al. Defendants.

No. Civ.A. 03-6248.
|
March 22, 2005.

Attorneys and Law Firms

Adrian J. Moody, Moody & Anderson P.C., Robert T. Vance, Jr., Law Offices of Robert T. Vance, Jr., Philadelphia, PA, for Plaintiffs.

Gerald E. Wallerstein, City of Philadelphia Law Dept Labor & Employment Unit, Philadelphia, PA, for Defendants.

ORDER

NEWCOMER, J.

***1** AND NOW, this 22nd day of March, 2005, upon consideration of Defendants' Motion for Summary Judgment (Doc. 19), Plaintiffs' Response, Defendants' Reply, and the Parties' Motions to Exceed Page Limits and file Replies (Doc. 22, 23), it is hereby ORDERED that Defendants' Motion for Summary Judgment is DENIED, and the Parties' Motions to File Replies and Exceed Page Limits are GRANTED. The Court's reasoning follows.

The Court writes only for the Parties, and will thus avoid a lengthy discussion of the background of this case and the familiar standards for judgment under FED. R. CIV. P. 56. Defendants seek summary judgment on Plaintiffs' common law conspiracy claims, their § 1983 conspiracy claims, their breach of contract claims, and on the issue of qualified immunity. The Court will deal with each issue in turn.

1. *Plaintiffs' Civil Conspiracy and § 1983 Conspiracy Claims*

Defendants Motion for Summary Judgment on Plaintiffs' conspiracy claims must be rejected. First, there is a dispute between the Parties as to whether Defendants request summary judgment on Plaintiffs' federal § 1983 claims (Counts I, II, and III of the Amended Complaint), or merely their state civil conspiracy claim (Count VI). Plaintiffs argue that they have not, and Defendants submit in a Reply brief that they have. The Court has examined Defendants' Motion, and must resolve this somewhat unusual dispute with the conclusion that Defendants only sought judgment as to the conspiracy portion of Plaintiffs' § 1983 claims, and as to Plaintiffs' civil conspiracy claim. Defendants' Motion does not give any substantive treatment to Plaintiffs' § 1983 claims, beyond its discussion of the ambiguous conspiracy charges. The Court's conclusion is reinforced by the extensive discussion of substantive federal constitutional law in Defendants' Reply Brief, and the total absence of any such discussion in the brief supporting their Motion. It is now less than two weeks to trial; when Defendants filed their Reply, there were less than four weeks remaining to trial. In this case the Parties consented to an abbreviated briefing and trial schedule. Defendants are surely forthright in their position, but it would be unfair to allow a party to sneak substantive legal argument into a Reply brief, when the exact same argument could have (and should have) been raised in the brief supporting the initial motion. Although reply briefs can be extremely helpful to the Court, their utilization in this manner deprives the adverse party of the guarantee of a response. Trial is now less than two weeks away, and both sides must hunker down and prepare. In other words, were the Court to accept Defendants' representation, it would necessarily mean depriving Plaintiffs of the opportunity to respond to the substance of Defendants' Motion. This would be manifestly unfair.

Defendants seek relief from Plaintiffs' conspiracy claim, and from the § 1983 claims to the extent they are premised exclusively on this conspiracy claim. [1] Turning to the merits, the Court must deny this request. The record does not show that there is no genuine issue as to any material fact in this case such that Defendants would be entitled to judgment. *See* FED. R. CIV. P. 56(c)). A jury could, based on the record, find for Plaintiffs based on legitimate inferences drawn from circumstantial evidence.

***2** Defendants argue that Plaintiffs' § 1983 conspiracy claims are time-barred. Defendants did not plead the statute of limitations as an affirmative defense to Plaintiffs' Complaint, and have therefore waived the opportunity to claim it. *See Fassett v. Delta Kappa Epsilon,* 807 F.2d 1150, 1167 (3d Cir.1986) ("A statute of limitations time bar is not

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jurisdictional; rather, it constitutes an affirmative defense that the defendant must raise in the answer or else waive."); FED. R. CIV. P. 8(c)).

2. *Defendants' Qualified Immunity*

The Court denies Defendants' Motion for Summary Judgment on the individual Defendants' qualified immunity. On this issue, the Court must engage in a two-step inquiry. *See Saucier v. Katz,* 533 U.S. 194, 201, 121 S.Ct. 2151, 150 L.Ed.2d 272 (2001). First the Court asks whether, "in the light most favorable to the party asserting the injury, do the facts alleged show the officer's conduct violated a constitutional right?" *Id.* Here, the individual Defendants are alleged to have violated the Due Process Clause of the Fourteenth Amendment by seizing Plaintiffs' houses in a malicious and irrational manner, the Fifth Amendment by taking Plaintiffs' homes without just compensation, and the Equal Protection Clause. As the first step of the *Saucier* inquiry is met, the Court proceeds to the next step. Here the Court's attention shifts to whether the right alleged to be violated was clearly established at the time of violation. *Id.* at 201. That the rights alleged to have been violated were clearly established at the time of the alleged violation is so obvious as to obviate the need for any serious discussion. The record presents, at best, a mixed picture of what happened during the events leading up to this case. Given the facts as they are known to the Court at this time, qualified immunity is inappropriate. Defendants' Motion is denied.

3. *Plaintiffs' Breach of Contract Claim*

Finally, Defendants' Motion for Summary Judgment on Plaintiffs' Breach of Contract Claim is denied. Defendants bring a Motion to limit the amount of damages Plaintiffs can seek for their breach of contract claims, rather than a motion seeking judgment that Defendants did not breach a contract. Defendants argue that Plaintiffs must use the diminished-market-value method to value their damages, rather than the cost-to-perform method. Defendants argue that this is necessary because the amount needed to repair the homes in question is disproportionately higher than the difference in market value caused by not performing the repairs. The Court cannot rule on this issue at this time. First, both the market value of the homes and the cost of repairing them are disputed issues of material fact. Second, even assuming that this was not the case, Defendants seek to condemn Plaintiffs' homes, reducing their value to (a potential of) zero-rendering Defendants' arithmetic somewhat improper. There is no doubt that some mitigation of damages may be called for-but at this stage such consideration is premature. Defendants' Motion is denied.

***3** AND IT IS SO ORDERED.

All Citations

Not Reported in F.Supp.2d, 2005 WL 696883

Footnotes

1 The Court is not so sure that Plaintiffs plead only § 1983 conspiracy-even a narrow reading of the Amended Complaint reveals that Plaintiffs claim both that each Defendant violated their federal constitutional rights, and that all Defendants conspired to do so. *See* Am. Compl. at ¶¶ 74, 75, 77, 84, 90.

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MOA App'x 16: 3 Damages in Tort Actions 16.01

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§ 16.01 Duty to Mitigate Damages

[1] General Rule

[a] Common Law Rule

The common law rule is that an injured party may not recover damages from a tortfeasor for any consequences of the injury which the party could have reasonably avoided.[1] This is known as the "mitigation of damages" rule or "the doctrine of avoidable consequences." The mitigation rule imposes a common law duty upon the injured party to use ordinary care and reasonable diligence to minimize damages and to avoid aggravating damages.[2] Where it is found that a reasonable person in similar circumstances would have attempted mitigation, the plaintiff's failure to do so does not bar his or her cause of action but will reduce the damages award by the amount that the plaintiff could have avoided with reasonable diligence.[3]

In various jurisdictions and circumstances, such "self-inflicted wounds" may include failure to seek medical treatment or undergo surgery;[4] failure to wear a seat belt;[5] failure to return to work where feasible;[6] and

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[1] Chesapeake & O. R. Co. v. Kelly, 241 U.S. 485, 36 S. Ct. 630, 60 L. Ed. 1117 (1916) ("Ordinarily a person seeking to recover damages for the wrongful act of another must do that which a reasonable man would do under the circumstances to limit the amount of the damages").

See § 16.01[5] Multi-Jurisdictional Survey of the Duty to Mitigate Damages.

See also Restatement (Second) of Torts § 918(1).

[2] *See* § 16.01[5] Multi-Jurisdictional Survey of the Duty to Mitigate Damages.

[3] *See, e.g.*:

FDIC v. Dosland, 2013 U.S. Dist. LEXIS 179429 (D. Iowa 2013) (mitigation is not a "duty" imposed on a plaintiff by Iowa law, but rather the failure to mitigate is a basis for reduction of a plaintiff's damages based on the plaintiff's failure to avoid the consequences of another's conduct); Simmons v. Erie Insurance Exchange, 891 N.E.2d 1059, 1069–1070 (Ind. Ct. App. 2008) (in an action arising out of a vehicular accident, concluded that a "reasonable person" analysis is required to determine whether a plaintiff has a duty to submit to a medical procedure to overcome an affirmative defense of failure to mitigate damages); Covino v. Peck, 233 N.J. Super. 612, 617, 559 A.2d 868 (App. Div. 1989) (damages will be curtailed only when the claimant is unreasonable in refusing or failing to take action to prevent further loss).

[4] *See* § 16.03 discussing the duty to seek and follow medical treatment.

[5] *See* § 16.04[1] discussing the seat belt defense.

[6] Doherty v. Wilson, 356 F. Supp. 35 (M.D. Ga. 1973); Oil, Chemical & Atomic Workers, Local 6-10 v. Amoco Oil Co., 653 F. Supp. 300, 123 L.R.R.M. (BNA) 2934 (E.D. Wis. 1987), applying Wisconsin law; Tosti v. Ayik, 400 Mass. 224, 508 N.E.2d 1368 (1987); Beatty v. Davis, 224 Neb. 663, 400 N.W.2d 850 (1987); Robinson v. Gonzalez, 213 N.J. Super. 364, 517 A.2d 479, 483 (App. Div. 1986).

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failure to wear protective gear.[7] A plaintiff cannot stand by and watch his or her losses accumulate when it would be reasonable under the circumstances to undertake some action.[8]

[b] Application of Doctrine in Tort versus Contract Action

The mitigation rule applies whether the injury is to a person[9] or to property.[10] Moreover, the mitigation of damages applies with equal force whether the action is in tort or for breach of contract.[11] Mitigation of damages is not as strict a doctrine in tort as it is in contract. The goal in torts cases is to make the plaintiff whole again.[12] In contrast, in a contract action, mitigation of damages would be stopping performance or making substitute arrangements following a breach of contract.[13]

[c] Application to Intentional Torts and Claims Based on Statutory Duty

Generally, the doctrine of mitigation will not operate against an injured party where the failure to minimize damages occurs subsequent to some intentional or reckless act on defendant's part, [14] or where the tort is positive and continuous, or constitutes a nuisance.[15]

A plaintiff may have a statutory duty to mitigate damages. For example, a statutory duty may arise from a duty to wear a seat belt or protective gear.[16]

Under title VII of the federal law, [17] a claimant has a statutory duty to use reasonable and diligent efforts to secure suitable employment in order to mitigate damages. Although the plaintiff has this duty, the defendant

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See also § 16.01[1][c] regarding the application of mitigation of damages to claims based on a statutory duty.

[7] *See* § 16.04[2] discussing protective gear.

[8] *See* § 16.02 discussing the reasonableness standard.

[9] Tanberg v. Ackerman Inv. Co., 473 N.W.2d 193 (Iowa 1991), *overruled in part by* Greenwood v. Mitchell, 621 N.W.2d 200 (Iowa 2001) (plaintiff failed to mitigate damages when he unreasonably failed to lose weight after he injured his back); Waterson v. General Motors Corp., 111 N.J. 238, 544 A.2d 357 (1988).

[10] 1900 Partnership v. Bubber, Inc., La. App. 27475, 662 So. 2d 808 (La. Ct. App. 1995); Burnham v. Mark IV Homes, Inc., 387 Mass. 575, 441 N.E.2d 1027 (1982).

[11] *See* § 16.01[5] Multi-Jurisdictional Survey of the Duty to Mitigate Damages.

[12] Bohannon v. Tandy Transp. Co., 402 F. Supp. 783, 787 (N.D. Tex. 1975); Hood v. Neil, 502 So. 2d 749, 751 (Ala. 1987).

[13] DW Data, Inc. v. C. Coakley Relocation Sys., Inc., 951 F. Supp. 2d 1037, 1056 (N.D. Ill. 2013) (the court rejected the defendant's conclusory mitigation argument because the prophylactic action the defendant claimed the plaintiff should have taken in 2002 when the servers went into storage long antedated the loss; the court also rejected the defendant's argument that the plaintiff's failure to have paid support fees between 2002 and 2009 is another cause of the plaintiff's harm; the victim of a breach is only required to " 'exercise reasonable diligence and ordinary care in attempting to minimize the damages after injury has been inflicted' " and need not take action that involves undue risk or burden).

[14] Dziadek v. Charter Oak Fire Ins. Co., 2014 U.S. Dist. LEXIS 26703 (D. S.D. March 3, 2014) (failure to mitigate punitive damages is not an affirmative defense in South Dakota); Clark Operating Corp. v. Yokley, 120 Misc. 2d 631, 466 N.Y.S.2d 204 (1983) (duty of mitigation not required in case of intentional or malicious injuries nor to case of positive, continuing torts such as nuisance or trespass).

See Restatement (Second) of Torts § 918(2).

[15] Fischer v. Hendler, 121 P.2d 792 (Cal. Ct. App. 1942); Allen v. Morris Bldg. Co., 360 Mich. 214, 103 N.W.2d 491 (1960); Clark Operating Corp. v. Yokley, 120 Misc. 2d 631, 466 N.Y.S.2d 204 (1983); Desimone v. Mutual Materials Co., 162 P.2d 808 (Wash. 1945).

[16] *See* § 16.04 regarding seat belt and protective gear use.

[17] 42 U.S.C. § 2000e-5.

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bears the burden of proving the affirmative defense of failure to mitigate. Specifically, the defendant must prove (1) that the plaintiff did not exercise reasonable diligence in seeking comparable employment; and (2) that comparable employment actually was available had the plaintiff exercised reasonable diligence.[18] However, Title VII claimants do not have a duty to mitigate emotional damages.[19]

Under some statutes, for example the Fair Labor Standards Act, [20] mitigation of damages is not a recognized defense.[21] Similarly, the mitigation of damages defense is not appropriate in copyright infringement case where the plaintiff seeks only statutory damages.[22]

The California Fair Employment and Housing Act, [23] however, recognizes that the avoidable consequences doctrine applies to damage claims under the Act. Accordingly, the plaintiff's recoverable damages do not include those damages that the plaintiff could have avoided with reasonable effort and without undue risk, expense, or humiliation.[24]

[d] Affirmative Defense

Mitigation of damages is an affirmative defense on which the defendant bears the burden of proof. The affirmative defense of mitigation of damages requires the defendant to prove that the plaintiff failed to exercise reasonable care to mitigate his or her post-injury damages.[25] Depending on the jurisdiction, the defendant must prove that the plaintiff's failure to exercise reasonable care caused the plaintiff to suffer an identifiable item of harm not attributable to the defendant's negligent conduct[26] or that the plaintiff's unreasonable post-injury conduct increased the plaintiff's harm, and if so, by how much.[27]

Most jurisdictions require the defendant to specifically plead the plaintiff's failure to mitigate damages as an affirmative defense.[28]

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[18] United States EEOC v. Gurnee Inn Corp., 914 F.2d 815, 818 (7th Cir. 1990) (rule stated).

See, e.g.:

Meyer v. United Air Lines, 950 F. Supp. 874, 876 (N.D. Ill. 1997) (by immediately accepting a part-time, lower-paying position and never seeking a full-time, higher-paying job, the plaintiff effectively refused to accept comparable employment for purposes of mitigation and therefore, failed to mitigate her damages resulting from the defendant's alleged discriminatory acts); Hite v. Peters, 2009 U.S. Dist. Lexis 51894 (D.N.J. June 19, 2009) (post-termination employment records are relevant on issue of mitigation of damages in Title VII case alleging discriminatory discharge); EEOC v. Joint Apprenticeship Comm. of the Joint Bd., 1996 U.S. Dist. LEXIS 7924 (S.D. N.Y. 1996) (the evidence taken as a whole cannot support a finding that the plaintiff demonstrated any continuing commitment to be a member of the work force during the relevant period).

[19] EEOC v. Fred Meyer Stores, Inc., 954 F. Supp. 2d 1104, 1128 (D. Or. 2013).

[20] 29 U.S.C. § 201.

[21] Rivero v. Lefeld & Son, LLC, 2014 U.S. Dist. LEXIS 69090 (S.D. Fla. May 20, 2014) (plaintiff alleged violations of the Fair Labor Standards Act).

[22] Arista Records, Inc. v. Flea World, Inc., 356 F. Supp. 2d 411, 422 (D.N.J. 2005).

[23] Cal. Gov. Code § 12900.

[24] State Dept. of Health Services v. Superior Court, 31 Cal. 4th 1026, 1047 (2003) (as the avoidable consequences doctrine may be applied to a no-fault system like workers' compensation, then there is nothing inconsistent or anomalous in applying it also to Fair Employment and Housing Act harassment claims); Rosenfeld v. Abraham Joshua Heschel Day School, Inc., 2014 Cal. App. LEXIS 465 (May 28, 2014) (the avoidable consequences doctrine enables an employer to show that reasonable use of its internal procedures would have prevented at least some of the harm the employee suffered).

[25] DW Data, Inc. v. C. Coakley Relocation Sys., Inc., 951 F. Supp. 2d 1037 (N.D. Ill. 2013).

[26] DW Data, Inc. v. C. Coakley Relocation Sys., Inc., 951 F. Supp. 2d 1037 (N.D. Ill. 2013).

See also § 16.01[3] regarding the burden of proof.

[27] Thomas v. Brinker, 2012 U.S. Dist. LEXIS 4440 (S.D. Ind. 2012).

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[2] Mitigation Distinguished From Comparative Negligence

Mitigation is sometimes confused with both contributory negligence—which bars recovery to an injured party who is at all at fault[29]—and comparative negligence—which reduces recovery to a plaintiff according to his degree of fault.[30] Since failure to mitigate damages only reduces the plaintiff's recovery and does not bar recovery completely, it is more similar to comparative negligence than to contributory negligence. However, the concepts are distinct[31] in that comparative negligence focuses on the cause of the initial injury-producing event, while mitigation of damages focuses on the injured party's conduct *subsequent* to the initial injury.[32] Nevertheless, some courts have blurred the distinction between mitigation and comparative negligence, [33] particularly with respect to an injured party's failure to use protective devices (e.g., seat belts, motorcycle helmets) prior to the occurrence of the accident.[34]

[3] Burden of Proof

The burden of proving that the injured party could have avoided some or all of his damages rests on the defendant.[35] It requires a showing that the plaintiff failed to take reasonable action to minimize damages, [36] and

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[28] Brodvin v. Hertz Corp., 487 F. Supp. 1336 (S.D.N.Y. 1980); Billings v. Boercker, 648 P.2d 172 (Colo. Ct. App. 1982); Powell v. Brady, 30 Colo. App. 406, 496 P.2d 328 (1972) (requirement stated); Rozny v. Marnul, 43 Ill. 2d 54, 250 N.E.2d 656 (1969) (requirement stated); Nancy's Home of the Stuffed Pizza, Inc. v. Cirrincione, 144 Ill. App. 3d 934, 494 N.E.2d 795 (1986) (rule stated); Kelty v. Best Cabs, Inc., 206 Kan. 654, 481 P.2d 980 (1971); Acme Cigarette Servs., Inc. v. Gallegos, 91 N.M. 577, 577 P.2d 885 (1978); Davis v. Davis, 49 App. Div. 2d 1024, 374 N.Y.S.2d 482 (1975); Peeples v. Sargent, 77 Wis. 2d 612, 253 N.W.2d 459 (1977) (requirement stated).

Contra City of Terre Haute v. Deckard, 183 N.E.2d 815 (Ind. 1962); Stipp v. Tsutomi Karasawa, 318 S.W.2d 172 (Mo. Ct. App. 1958); Zimmerman v. Ausland, 266 Or. 427, 513 P.2d 1167 (1973); Moulton v. Alamo Ambulance Serv., Inc., 414 S.W.2d 444 (Tex. 1967) (rule stated).

[29] Only a few states still follow contributory negligence. Most states have adopted some form of comparative negligence. *See* Ch. 48, § 48.02[4] Multi-Jurisdictional Survey of Comparative Negligence Law.

[30] *See* Ch. 48, *Comparative Negligence.*

[31] Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970); Kirby v. Larson, 400 Mich. 585, 256 N.W.2d 400 (1977).

[32] *See* § 16.01[5] Multi-Jurisdictional Survey of the Duty to Mitigate Damages.

See also Komlodi v. Picciano, 2014 N.J. LEXIS 485 (2014) (the doctrine of avoidable consequences applies when a plaintiff's carelessness that occurs *after* the defendant's tortious act causes the plaintiff additional harm).

[33] McCarthy Well Co. v. St. Peter Creamery, Inc., 389 N.W.2d 514 (Minn. Ct. App. 1986), *rev'd in part on other grounds*, 410 N.W.2d 312 (1987).

See Grier, *Rethinking the Treatment of Mitigation of Damages Under the Iowa Comparative Fault Act in Light of Tanberg v. Ackerman Inv. Co.*, 77 Iowa L. Rev. 1913 (1992).

[34] *See* § 16.04[1] regarding the seat belt defense.

See § 16.04 regarding seat belts and other protective gear.

[35] *See* § 16.01[5] Multi-Jurisdictional Survey of the Duty to Mitigate Damages.

[36] Tennessee Valley Sand & Gravel Co. v. M/V Delta, 598 F.2d 930 (5th Cir. 1979); Fuches v. S.E.S. Co., 459 N.W.2d 642 (Iowa Ct. App. 1990); 1900 Partnership v. Bubber, Inc., La. App. 27475, 662 So. 2d 808 (La. Ct. App. 1995); Tibbetts v. Dairyland Ins. Co., 2010 ME 61, 999 A.2d 930; Hurlbut v. Landgren, 200 Neb. 413, 264 N.W.2d 174 (1978); Waterson v. General Motors Corp., 111 N.J. 238, 544 A.2d 357 (1988); Ainsworth v. Progressive Cas. Ins. Co., 322 P.3d 6 (Wash. Ct. App. 2014) (the

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that such failure either prevented improvement or correction of the initial injury or enhanced damages beyond what they otherwise would have been.[37]

Where appropriate facts can be developed, this defense can be very effectively utilized by counsel. If the evidence is strongly presented, it may have the effect of reducing damages to an extent even greater than expected, since it tends to cast doubt and suspicion on plaintiff's entire damage claim.

In addition, the tortfeasor must establish with reasonable certainty the amount of damages that might have been avoided.[38]

For example, in an Iowa action, the trial court properly concluded that the record contained insufficient evidence to support a mitigation of damages instruction where the defendant had failed to present any evidence that the plaintiff's decision to forego additional counseling, as recommended by his treating psychologists, had been against sound medical advice or that additional counseling would have mitigated damages sustained.[39] Similarly, in an Indiana action, the trial court erroneously gave a failure to mitigate instruction where the defendant had failed to prove that the plaintiff's post-injury disregard of advice as to medical treatment had increased her harm, and if so, by how much.[40] However, this burden of proof in no way relieves the injured party of the initial burden of proving the damages claimed.

In order for the issue to be submitted to the jury, there must be competent evidence that the injured party: (1) had the opportunity or ability to mitigate;[41] and (2) failed to take reasonable efforts to avoid or minimize his or her damages.[42] For example, in a South Dakota action, the trial court properly refused a defendant's proposed jury instruction on mitigation of damages where the record was replete with evidence that the plaintiff had taken reasonable steps to improve his condition, including enrolling in a six-year pharmacy program at a state university to ensure that he did not lost more money by being forced to take a lower paying substitute job.[43] In a

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defendant raised no genuine material issues of fact that the plaintiff unreasonably failed to mitigate damages related to his medical appointments).

See also § 16.02 discussing the reasonableness standard.

[37] Tennessee Valley Sand & Gravel Co. v. M/V Delta, 598 F.2d 930 (5th Cir. 1979); Glenn McClendon Trucking Co. v. Williams, 183 Ga. App. 508, 359 S.E.2d 351 (1987); Jones v. Abriani, 350 N.E.2d 635 (Ind. Ct. App. 1976); Mullen v. Jacobs, 58 Misc. 2d 64, 294 N.Y.S.2d 636 (Sup. Ct. 1968).

[38] Pool v. City of Oakland, 42 Cal. 3d 1051, 232 Cal. Rptr. 528, 728 P.2d 1163 (1986); T.J. Morris Co. v. Dykes, 197 Ga. App. 392, 398 S.E.2d 403 (1990); Waterson v. General Motors Corp., 111 N.J. 238, 544 A.2d 357 (1988); Ecksel v. Orleans Constr. Co., 360 Pa. Super. 119, 519 A.2d 1021 (1987).

But see Johnson v. Farmers Union Cent. Exch., Inc., 414 N.W.2d 425 (Minn. Ct. App. 1987).

[39] Vasconez v. Mills, 651 N.W.2d 48, 53–54 (Iowa 2002).

[40] Willis v. Westerfield, 839 N.E.2d 1179, 1189–1190 (Ind. 2006).

[41] Jones v. Scarborough, 194 Ga. App. 468, 390 S.E.2d 674 (1990); 1900 Partnership v. Bubber, Inc., La. App. 27475, 662 So. 2d 808 (La. Ct. App. 1995); Tosti v. Ayik, 400 Mass. 224, 508 N.E.2d 1368 (1987); Last v. MSI Constr. Co., 305 S.C. 349, 409 S.E.2d 334 (1991).

[42] Fitzpatrick v. United States, 754 F. Supp. 1023 (D. Del. 1991); Keans v. Bottiarelli, 35 Conn. App. 239, 645 A.2d 1029 (1994); Ga. Farm Bureau Mut. Ins. Co. v. Turpin, 294 Ga. App. 63, 668 S.E.2d 518, 521 (2008) (in a personal-injury action, an award of $165,000 was proper and would not be reduced for plaintiff's failure to mitigate damages where defendants presented no evidence that plaintiffs had engaged in activities that had aggravated their conditions, that they had stopped medical treatment for their injuries or that they had failed to exercise ordinary care and diligence); Fuches v. S.E.S. Co., 459 N.W.2d 642 (Iowa Ct. App. 1990); Jackson v. Safeway Ins. Co., 2004-211 (La. App. 3 Cir. 6/30/04), La. App. 2004-0211, 879 So. 2d 364, 367–368 (the appellate court concluded that an award of $10,000 to the plaintiff was appropriate where his delay in seeking professional medical treatment had not been unreasonable and had not aggravated his injury since he had continued to self-treat his back pain by using over-the-counter drugs; the plaintiff had started working a new shift and did not want to miss work; although the plaintiff had not sought professional medical treatment for his back pain until nearly two years after the injury-causing accident, his medical expert testified that no serious complications had resulted from the delay); Crews v. Workmen's Comp. Appeal Bd., 554 A.2d 190 (Pa. 1989); Last v. MSI Constr. Co., 305 S.C. 349, 409 S.E.2d 334 (1991).

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Louisiana action, however, the trial court inappropriately entered judgment awarding the plaintiff $100,000 in compensatory damages where evidence revealed that she had not only failed to mitigate her damages but had aggravated them by disregarding one of her physician's orders to curb her narcotics intake and by withholding from two other physicians information regarding her receipt of prescriptions for the narcotics from more than one physician. Inasmuch as the plaintiff's primary treating physician was of the opinion that her abuse of the prescribed narcotic, hydrocodone, had contributed to her chronic headaches, the award of general damages was excessive and was reduced to $45,000.[44]

Expert testimony may be necessary to prove that the plaintiff failed to take reasonable efforts to avoid or minimize damages, For example, in an Indiana personal-injury action, the appellate court noted that the state requires that expert testimony that the plaintiff's injuries have been aggravated or increased before a jury may be instructed on the affirmative defense of failure to mitigate damages. Inasmuch as the defendant failed to elicit any testimony from the plaintiff's medical expert that she had aggravated or increased her injuries by failing to follow the course of treatment prescribed, the trial court improperly instructed the jury on the affirmative defense of failure to mitigate.[45]

[4] Recovery of Costs Expended in Effort to Mitigate Damages

[a] Reasonable Efforts to Minimize Damages

Since the mitigation doctrine imposes upon the plaintiff a duty to undertake reasonable measures to minimize damages, a plaintiff who does so may recover reasonable costs expended in mitigation efforts.[46]

When reviewing the bills claimed by the plaintiff, counsel should note any unique expenses which indicate unusual efforts to affect a cure. Counsel should carefully question the plaintiff as to the circumstances surrounding this item of damage. Certainly most jurors appreciate extraordinary efforts on a plaintiff's part to improve his or her plight. Expenses for treatments such as acupuncture, even if not affecting a cure, may convincingly establish the plaintiff's genuine desire to be cured.

For example, interest charges on loans, [47] attorney and other professional fees not associated with the litigation, [48] and charges for repairs to damages property[49] may be recovered from the tortfeasor.

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[43] Jurgensen v. Smith, 2000 SD 73, 611 N.W.2d 439, 441.

[44] Adams v. Chenault, 36729 (La. App. 2 Cir. 1/29/2003), 836 So. 2d 1193.

[45] Willis v. Westerfield, 839 N.E.2d 1179, 1187 (Ind. 2006) (expert testimony is often, but not always, required to establish that the plaintiff's conduct caused any additional harm, and if so, how much); Jackson v. Safeway Ins. Co., 2004-211 (La. App. 3 Cir. 6/30/04), La. App. 2004-0211, 879 So. 2d 364, 367–368 (the appellate court concluded that an award of $10,000 was appropriate where the plaintiff's delay in seeking professional medical treatment had not been unreasonable and had not aggravated his injury inasmuch as he had continued to self-treat his back pain by using over-the-counter drugs; the plaintiff had started working a new shift and did not want to miss work; although the plaintiff had not sought professional medical treatment for his back pain until nearly two years after the injury-causing accident, his medical expert testified that no serious complications had resulted from the delay).

[46] Robbins v. Farmers Union Grain Terminal Ass'n, 552 F.2d 788 (8th Cir. 1977); Orkin Exterminating Co. v. Lesassier, 688 S.W.2d 651 (Tex. App. 1985); Smith v. Gore, 728 S.W.2d 738 (Tenn. 1987).

See Restatement (Second) of Torts § 912(2).

[47] Rodrigues v. State, 52 Haw. 156, 472 P.2d 509 (1970).

[48] *See, e.g.*, Tulsa Municipal Airport Trust v. National Gypsum Co., 551 P.2d 304 (Okla. Ct. App. 1976).

[49] *See, e.g.*, Elgin, J. & E. Ry. v. American Commercial Line, Inc., 317 F. Supp. 175 (N.D. Ill. 1970); City of Jackson v. Keane, 502 So. 2d 1185 (Miss. 1987).

But see McDonald v. American Fire & Indem. Ins. Co., 378 So. 2d 1013 (La. Ct. App. 1979).

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Importantly, recovery of costs may be had even where the effort to minimize damages proves unsuccessful, [50] or actually increases the loss, [51] or where less costly alternatives might later be shown to have been available.[52] While proof of the expenditures alone is prima facie evidence of an attempt to mitigate, [53] recovery of such expenses will be denied where the defendant can establish that they were not reasonably related to the goal of minimizing damages.[54]

[b] No Requirement of Financial Outlay

The requirement that the victim of a breach exercise reasonable diligence and ordinary care in attempting to minimize the damages after injury has been inflicted does not involve the need not take action that involves "undue risk or burden." Thus, for example, in one case involving computers, the doctrine of mitigation of damages would not require the plaintiff to pay support fees of approximately $2 million, thus far exceeding the $200,000 for updated software and accompanying license.[55] Likewise, in a Texas case involving water damage to a home, the plaintiffs were not required to remove water damaged sheetrock because its removal would have required more than mere "trifling expense" or "reasonable exertions."[56]

If counsel is in doubt as to the wisdom of claiming an item of expense which may be viewed with suspicion by the jury, it is generally better to advise the client not to advance that particular item of expense. Typical of such claims are travel expenses to a warm climate, even if recommended by a physician; jurors may consider the claim as a subterfuge for trying to recover damages for what in reality was a vacation. Counsel must always consider whether a given item of expense will detract from rather than advance the plaintiff's claim.

[c] Insurance and the Collateral Source Rule

Under the collateral source rule, a tortfeasor has no right to any mitigation of damages because of payments or compensation received by the injured person from an independent source.[57] Furthermore, a tort victim is not required to obtain insurance to cover the loss. Evidence that a plaintiff has received compensation for injuries from insurance is not admissible in support of mitigation of damages.[58]

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[50] City of Jackson v. Keane, 502 So. 2d 1185 (Miss. 1987).

[51] Tulsa Municipal Airport Trust v. National Gypsum Co., 551 P.2d 304 (Okla. Ct. App. 1976).

[52] *See, e.g.*, Elgin, J. & E. Ry. v. American Commercial Line, Inc., 317 F. Supp. 175 (N.D. Ill. 1970).

But see McDonald v. American Fire & Indem. Ins. Co., 378 So. 2d 1013 (La. Ct. App. 1979).

See also Sutherland on Damages § 155, at 477 (4th ed. 1916).

[53] Sedgwick on Damages § 227 (9th ed. 1913).

[54] Sedgwick on Damages § 227 (9th ed. 1913).

[55] DW Data, Inc. v. C. Coakley Relocation Sys., Inc., 951 F. Supp. 2d 1037 (N.D. Ill. 2013) (the defendant's conclusory mitigation argument fails, since the prophylactic action the defendant claims the plaintiff should have taken in 2002 when the servers went into storage long antedated the loss; as to the plaintiff's failure to have paid support fees those fees would have been 22% of the purchase price of the original software and license for each year between 2002 and 2009; that would be approximately $2 million, thus far exceeding the $200,000 for updated software and accompanying license).

[56] Vien v. Del Buono, 2010 Tex. App. LEXIS 10011 (Dec. 15, 2010) (reasonable and fair-minded people could have found that: (1) the plaintiffs could not afford to have the sheetrock removed as the defendant contended they should have; (2) they reasonably followed instructions regarding the treatment of the water damaged sheetrock; and (3) they were not equipped to remove the sheetrock themselves).

[57] *See* Ch. 17 discussing the collateral source rule in greater detail.

[58] Aquino v. Watts, 2014 U.S. Dist. LEXIS 73309 (D. Vt. 2014); Parker Towing Co. v. Triangle Aggregates, Inc., 2013 Ala. LEXIS 177 (Dec. 13, 2013) (the sum received from insurance cannot be shown in mitigation of damages for the injury); Council of Unit Owners of Windswept Condo Ass'n v. Schumm, et al., 2014 Del. Super. LEXIS 261 (May 19, 2014) (there is no right to any

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[5] Multi-Jurisdictional Survey of the Duty to Mitigate Damages

	Duty Not Imposed	Duty Imposed
Federal		Wiegand v. Royal Caribbean Cruises, 2020 U.S. Dist. LEXIS 129634 (S.D. Fla. 2020). Maritime law recognizes the doctrine of comparative negligence. Any assumption of risk in admiralty, whatever its scope, must be applied in conjunction with the established admiralty doctrine of comparative negligence, to ensure that the assumption of risk defense in admiralty cases is not a bar to recovery, but only mitigates damages.
Alabama		CSX Transp., Inc. v. Miller, 46 So. 3d 434 (Ala. 2010). A Federal Employer's Liability Act (FELA) plaintiff claiming lost wages has a duty to reasonably mitigate his damages.
Alaska		Irving v. Bullock, 549 P.2d 1184 (Alaska 1976). The plaintiff was injured in two separate rear-end accidents and suffered coughing, headaches, numbness in the fingers of one hand, and pain in the neck, chest, and shoulder. The trial court did not err in giving a jury instruction that the plaintiff had the duty to prevent aggravation of injuries and to accomplish healing, because it appeared that many of the plaintiff's symptoms were related to his carpal tunnel syndrome, which could have been alleviated by a relatively easy operation that had a good record of success. Instead, the plaintiff waited four years before he submitted to the surgery, and the instruction allowed the jury to consider

mitigation of damages because a party contracted for insurance and paid the insurance premiums); Strasburg v. Union Pac. R.R. Co., 286 Neb. 743, 746 (2013) (the fact that the party seeking recovery has been wholly or partially indemnified for a loss by insurance or otherwise cannot be set up by the wrongdoer in mitigation of damages); Houghton v. Leinwohl, 376 A.2d 733, 737 (Vt. 1977) (trial court did not abuse its discretion by excluding from evidence for purposes of mitigating damages the pension benefits received by the appellee under the Railroad Retirement Act).

	Duty Not Imposed	Duty Imposed
		the possibility that the plaintiff acted reasonably in waiting to have the operation. The judgment for the plaintiff was affirmed in part, reversed in part, and remanded.
Arizona	University of Ariz. Health Sciences Center v. Superior Court of State in and for Maricopa County, 136 Ariz. 579, 667 P.2d 1294 (1983). The parents in a wrongful-pregnancy action were not forced to mitigate damages by choosing abortion or adoption. Rules requiring mitigation of damages require only that reasonable measures be taken.	
California		Maher v. County of Alameda, 223 Cal. App. 4th 1340, 1354 (2014). The plaintiff had a duty to mitigate damages by promptly initiating a proceeding to enforce his access rights and could not recover alleged consequential costs that could have been avoided by timely pursuing such a remedy.
California (*continued*)		Withrow v. Becker, 6 Cal. App. 2d 723, 45 P.2d 235 (1935). The plaintiff alleged that it would be necessary for him to undergo an operation for the correction and cure of a hernia. No reason appeared in the record why this was not done, and where it further appeared that the operation would have greatly reduced the damage, the court stated that the defendant was entitled to a new trial on the issue of damages.
Colorado	Stone v. Satriana, 41 P.3d 705 (Colo.	Bonidy v. Vail Valley Ctr. for Aesthetic Dentistry,

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	Duty Not Imposed	Duty Imposed
	2002). A plaintiff's failure to appeal a judgment can never be a failure to mitigate damages caused by malpractice at trial. The law does not require a person to take affirmative legal action to prevent the tortfeasor from suffering the result of the tortious act. Litigation is too uncertain and costly to impose such a duty on a party.	P.C., 232 P.3d 277, 284 (Colo. Ct. App. 2010). The wrongfully terminated employees have an affirmative duty to use all reasonable efforts to mitigate damages.
Connecticut		Preston v. Keith, 20 Conn. App. 656, 570 A.2d 214 (1990), *aff'd in part*, 217 Conn. 12, 584 A.2d 439 (1991). It is well settled that one who is injured by the negligence of another must use reasonable care to promote recovery and prevent any aggravation or increase of the injuries.
Delaware	Miller v. State Farm Mut. Auto. Ins. Co., 993 A.2d 1049, 1051 (Del. 2010). The collateral source rule provides that a tortfeasor has no right to any mitigation of damages because of payments or compensation received by the injured person from an independent source.	Meding v. Robinson, 52 Del. 299, 157 A.2d 254 (1959), *aff'd*, 52 Del. 578, 163 A.2d 272 (Del. 1960). The rule was applied where the claimant unreasonably failed to continue treatment after 17 months.
District of Columbia	McCord v. Green, 362 A.2d 720, 725 (D.C. 1976). The court stated that: "the doctrine of avoidable consequences, like the last clear chance doctrine, comes into play only after the defendant has committed the	

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	Duty Not Imposed	Duty Imposed
	wrongful act but at a time when the plaintiff still has an opportunity to avoid the consequences in whole or in part."	
Florida	M.I. Windows & Doors, LLC v. Liberty Mut. Fire Ins. Co., 2018 U.S. Dist. LEXIS 83918 (M.D. Fla. 2018). Alabama law recognizes failure to mitigate damages as an affirmative defense. An insured's duty to mitigate damages does not terminate when the insurer breaches a duty to timely settle a claim. However, the insurer failed to establish a general rule that failure to mitigate is a defense to a Florida bad faith claim.	
	Insurance Co. of North America v. Pasakarnis, 451 So. 2d 447, 454 (Fla. 1984). The jury may consider non-use of a seat belt, long with all other facts in evidence, in deciding whether the damages for which defendant may otherwise be liable should be reduced. Ballard & Ballard v. Pelaia, 73 So. 2d 840 (Fla. 1954). The plaintiff was not required to submit to an operation to minimize damages, even though it was shown that such operations were 65% successful	

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	Duty Not Imposed	Duty Imposed
	and completely relieved the affliction.	
Georgia		Ga. Code Ann. § 51-12-11. When a person is injured by the negligence of another, he must mitigate his damages as far as is practicable by the use of ordinary care and diligence. However, this duty to mitigate does not apply in cases of positive and continuous torts. Doherty v. Wilson, 356 F. Supp. 35 (M.D. Ga. 1973). Reinstated teacher was disallowed back pay because of a lack of effort to find employment during the pendency of case. Ga. Farm Bureau Mut. Ins. Co. v. Turpin, 294 Ga. App. 63, 668 S.E.2d 518 (2008). In a personal injury action, there was no evidence to justify a charge on mitigation of damages under Ga. Code Ann. § 51-12-11.
Hawaii		Uy v. Spencer Homes, Inc., 135 Haw. 533, 354 P.3d 186 (2015). Admission of insurance evidence addressing failure to mitigate damages was not contrary to Haw. Rev. Evid. 403, 411 or the collateral source rule.
Idaho		McCormick Int'l USA, Inc. v. Shore, 152 Idaho 920, 924, 277 P.3d 367 (2012). The doctrine of avoidable consequences was imposed, but the defendant did not prove that the proposed means of mitigation were reasonable under the circumstances.
		Weinstein v. Prudential Prop. & Cas. Ins. Co., 149 Idaho 299, 327, 233 P.3d 1221 (2010). The plaintiff is ordinarily denied recovery for damages that could have been avoided by reasonable acts, including reasonable expenditures, after actionable conduct has taken place. Here, the

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	Duty Not Imposed	Duty Imposed
		defendant failed to prove that the plaintiff did not act reasonably to mitigate their damages.
Illinois	Passafiume v. Jurak, 2024 Ill. LEXIS 465. In a claim brought under the Wrongful Death Act, 740 Ill. Comp. Stat. 180/0.01, the plaintiff's remarriage after the death of his wife did not limit his damages against medical providers for loss of material services. Material services remained an element of damages recoverable under the Act and, therefore, did not end upon plaintiff's remarriage. A plaintiff's remarriage cannot be considered in mitigation of damages in a wrongful death case.	Karahodzic v. JBS Carriers, Inc., 881 F.3d 1009 (7th Cir. 2018), applying Illinois law. A mitigation of damages jury instruction was proper because the jury was informed that it should reduce the amount it awarded to plaintiff if he failed to reduce his damages by obtaining medical treatment. Holland v. Schwan's Home Serv., Inc., 992 N.E.2d 43, 88 (Ill. App. Ct. 2013). The duty to mitigate damages requires an injured party to exercise reasonable diligence and ordinary care in trying to minimize damages. The plaintiff mitigated damages by applying for numerous positions with other companies, attending job fairs, filling out 8 to 10 applications per week, and attending interviews with several potential employers.
		Wagner v. Zboncak, 111 Ill. App. 3d 268, 66 Ill. Dec. 922, 443 N.E.2d 1085 (1982). In an action to recover for personal injuries sustained in automobile accident evidence of use or nonuse of seat belts is irrelevant to issue of the defendant's liability or the plaintiff's contributory negligence, but is relevant only in determining the extent of injuries for which the plaintiff may recover. The trial court erred in failing to instruct the jury that evidence of nonuse of seat belts may only be considered in calculating damages. Reversed and remanded.
Indiana		Harris v. Jones, 2020 Ind. App. LEXIS 107. In a personal injury case, the

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		trial court committed reversible error because it gave a failure to mitigate jury instruction when there was a complete lack of any evidence, expert or otherwise, that additional harm was caused by the plaintiff's post-injury conduct. The erroneous instruction could have formed the basis for the compensatory damages award, because the jury issued a general verdict and the appellate court could not discern whether the plaintiff's damages were reduced due to her alleged failure to mitigate.
Iowa	Vasconez v. Mills, 651 N.W.2d 48, 53–54 (Iowa 2002). The court affirmed the judgment for the plaintiff-bicyclist who suffered injuries when struck from behind by the defendant's truck. The plaintiff's injuries included cognitive impairment and general fatigue that allegedly prevented his pursuing an advanced teaching degree. The plaintiff refused to continue psychological counseling despite his treating psychologists' recommendations, preferring to attempt to manage his own problems. In the absence of proof on the essential elements of the mitigation claim, the district court correctly refused to give the jury such an instruction.	Dix v. Casey's Gen. Stores, Inc., 961 N.W.2d 671 (Iowa 2021). Under Iowa law, the burden of proof in asserting that a party has failed to mitigate damages is on the party asserting that claim. In the context of employment discrimination cases, an employer can meet its burden of establishing the plaintiff failed to mitigate damages by showing (1) the availability of suitable jobs that the employee could have discovered and for which the employee was qualified, and (2) that the employee failed to seek such a position with reasonable care and diligence. A person is not obligated to accept employment that is not comparable to their previous employment, but recovery may be reduced if the person failed to mitigate their damages. Mitigation thus turns on the reasonableness of the employee's efforts.
Kansas		Miller v. Hartman, 140 Kan. 298, 36 P.2d 965 (1934). The trial court did not err in

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	Duty Not Imposed	Duty Imposed
		admitting evidence tending to show that the plaintiff's shoulder injury would have been temporary had it been promptly treated. The lack of treatment for several months went to a factual question concerning the plaintiff's having taken reasonably appropriate action, which was readily available, to mitigate the damages.
Kentucky	Carney v. Scott, 325 S.W.2d 343 (Ky. 1959). The trial court erred in mitigating damages because the plaintiff left the hospital of his own volition, because the plaintiff had been subject to financial pressure and the physician not only did not advise him it would be unsafe to go home but cooperated with the plaintiff so that he could leave the hospital.	Deskins v. Estep, 314 S.W.3d 300, 305 (Ky. Ct. App. 2010). A party claiming damages for a breach of contract is obligated to use reasonable efforts to mitigate its damages occasioned by the other party's breach.
Louisiana	Jacobs as Tutor of Jacobs v. New Orleans Pub. Serv., Inc., 432 So. 2d 843 (La. 1983). An accident victim has a duty to exercise reasonable diligence and ordinary care to minimize his damages after the injury has been inflicted, but he need not make extraordinary or impractical efforts. Rondeno v. Vincent, 012-1203 (La. App. 4 Cir. 03/13/13), 111 So. 3d 515, 524. The plaintiff's duty to mitigate his damages encompassed only	Young v. First Nat'l Bank, 34, 214 (La. App. 2 Cir. 08/22/01), 794 So. 2d 128. The jury was adequately instructed on the law governing reduction of damages under the doctrines of mitigation and avoidable consequences. Soileau v. LaFosse, 558 So. 2d 294 (La. Ct. App. 1990). The doctrine of unavoidable consequences bars recovery of those damages that occurred after the initial injury and that might have been averted by reasonable conduct on the part of the plaintiff. The standard is that of a reasonable man under like circumstances.

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	Duty Not Imposed	Duty Imposed
	what a reasonably prudent man would have done to lessen his damages, given the facts known to him at the time and avoiding the temptation to view the case through hindsight.	
Maine	Macomber v. Dillman, 505 A.2d 810 (Me. 1986). The court noted that "parents should not be forced to mitigate their damages [resulting from medical malpractice] by resorting to abortion or to adoption." The court then noted that "most courts that have considered the matter have held, as a matter of law, neither course of action would be reasonable."	*In re* Hannaford Bros. Co. Customer Data Sec. Breach Litig., 2010 ME 93, 4 A.3d 492, 498. The doctrine of mitigation of damages, or avoidable consequences, encourages plaintiffs to take reasonable steps to minimize losses caused by a defendant's negligence by prohibiting recovery for any damages that the plaintiff could reasonably have avoided. However, Maine law of negligence and implied contract does not recognize time and effort alone, spent in a reasonable effort to avoid or remediate reasonably foreseeable harm, as a cognizable injury in the absence of physical harm or economic loss or identity theft.
Maryland		Cave v. Elliott, 190 Md. App. 65, 988 A.2d 1 (2010). The duty to mitigate damages is employed in the areas of tort and contract law. Even if a duty existed in this case involving wrongful termination, the defendant never adduced any evidence that the plaintiff failed to use reasonable efforts to mitigate the losses he sustained as a result of his termination.
Massachu setts	Sheriff of Suffolk County v. Jail Officers & Emples., 465 Mass. 584, 990 N.E.2d 1042, 1051 (2013). The plaintiff had no duty to mitigate his damages by seeking	

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	Duty Not Imposed	Duty Imposed
	comparable employment.	
	Baglio v. New York C. R. Co., 344 Mass. 14, 180 N.E.2d 798 (1961). If the condition of a person claiming damages would be improved by having an ordinary operation, which the reasonably prudent man in like circumstances would submit to, a refusal would be evidence of an unreasonable failure to lessen the amount of damages. However, a person is not obliged to have a serious surgical operation when the outcome as to relief and the reduction of damages is uncertain. Such a person has an obligation to be reasonable with respect to having the operation and to exercise care in effecting a cure and diminishing the damages, which a person of ordinary prudence would exercise in like circumstances.	
Michigan	Allen v. Morris Bldg. Co., 360 Mich. 214, 103 N.W.2d 491 (1960). The willful grading of adjoining lots led to permanent drainage of surface water onto the plaintiffs' property. The plaintiffs were not required to raise the grade of their own lot to minimize damages.	Braverman v. Granger, 303 Mich. App. 587, 599 (2014). The doctrine of avoidable consequences has not been abrogated by the adoption of comparative negligence. The defendant argued that reasonable efforts were not made to avoid the plaintiff's damages resulting from the decedent's death because the blood transfusion recommended to save the decedent's life was refused because the decedent was a Jehovah's Witness.

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	Duty Not Imposed	Duty Imposed
		Canty v. Mason, 2024 Mich. App. LEXIS 7934. The plaintiff filed an action against the defendant alleging that defendant negligently caused the accident. The plaintiff was covered by an automobile insurance policy. However, he had elected to not maintain coverage for personal injury protection (PIP) benefits because he otherwise had qualified health coverage, in the form of Medicare. The common law mitigation of damages principles also applied. Under either the Mich. Comp. Laws § 500.3109 or common-law mitigation principles, the defendant was entitled to a set-off for medical expenses that would have been covered by Medicare. The trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages.
Minnesota		Couture v. Novotny, 297 Minn. 305, 211 N.W.2d 172 (1973). The plaintiff was injured through the defendant's negligence in a head-on automobile collision. The court properly instructed the jury instruction as to the plaintiff's duty to mitigate damages by undergoing minor surgery on a knee injury that, as a matter of law, did not constitute "a major operation" and involved no grave risks to the plaintiff.
Mississippi		Munn v. Algee, 730 F. Supp. 21 (N.D. Miss. 1990), applying Mississippi law. The court referred to the familiar rule applicable to injuries generally, whether in tort or in contract, that the injured person must use

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	Duty Not Imposed	Duty Imposed
		reasonable care and effort to prevent or minimize the injury. Wright v. Royal Carpet Servs., 29 So. 3d 109, 113 (Miss. Ct. App. 2010). Evidence of homeowner's insurance which was introduced for a purpose of showing that the plaintiff did not mitigate damages did not violate the collateral source rule.
Missouri		Stipp v. Tsutomi Karasawa, 318 S.W.2d 172 (Mo. 1958). In a collision case, the plaintiff visited the doctor on the day of the accident and also two days later. Thereafter, for a period of a year, he did not visit the doctor for treatment despite his testimony that during this time he suffered intermittent pain and numbness in his arms, limitation of motion in turning his head and in raising his arms, and pain in the back of the neck. It was error to refuse to permit medical testimony that the plaintiff's whiplash injury could have been minimized or cured by the time of trial. $12,500 verdict was reversed, and the case remanded for a new trial on the issue of damages only.
Montana	Timpano v. Cent. Mont. Dist. Six Human Res. Dev. Council, 2022 MT 169. Despite the similar common law origin of the duty to mitigate damages implied in Mont. Code § 39-2-905, the statute addressing remedies for wrongful discharge, and underlying the federal Willful Loss of Earnings Doctrine (WLOED), there is no textual predicate in the mitigation of	

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	Duty Not Imposed	Duty Imposed
	damages provision of the Montana statute from which to logically imply or extrapolate the WLOED. The lower court erroneously granted summary judgment to the plaintiff's former employer on the damages element of her wrongful discharge claims due to failure to mitigate damages in accordance with Mont. Code § 39-2-905. The defendant presented no direct or circumstantial evidence that any full-time employment comparable to her employment with the defendant was actually reasonably available to the plaintiff following her discharge. Genuine issues of material fact remained on the pleadings. Covey v. Brishka, 396 Mont. 362 (2019). In an action by property owners against neighbors for damages caused by the spillover of the neighbors' 4.5-million-	
	gallon man-made pond on the side of a mountain, strict liability was properly applied to the neighbors because the pond constituted an abnormally dangerous condition and they did not exercise care to mitigate damage.	
Nebraska		Armstrong v. Clarkson Coll., 297 Neb. 595 (2017).

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	Duty Not Imposed	Duty Imposed
		A party is required only to mitigate damages that might have been avoided by reasonable efforts. Courts often consider three factors in determining the reasonableness of a party's actions to mitigate damages: (1) the cost or difficulty to the plaintiff of mitigation, (2) the plaintiff's financial ability to mitigate, and (3) the defendant's actions to inhibit the plaintiff from mitigating damages. Borley Storage & Transfer Co. v. Whitted, 271 Neb. 84, 710 N.W.2d 71 (2006). A plaintiff's failure to take reasonable steps to mitigate damages bars recovery for the damages that might have been avoided by reasonable efforts.
		Colton v. Benes, 176 Neb. 483, 126 N.W.2d 652 (1964). The plaintiff is not required to undergo an operation where the hazards are great, and the question should not be submitted to the jury in the absence of evidence showing the extent of the hazards of death or injury and of pain or suffering. However, an instruction as to whether the plaintiff should have undergone a fusion operation on the neck was proper on the basis that the evidence did not show the prospect of the plaintiff being benefited by the operation where the plaintiff's doctor indicated there was a reasonable chance of benefit.
Nevada	Automatic Merchandisers, Inc. v. Ward, 98 Nev. 282, 646 P.2d 553 (1982). It is unquestioned that an injured person cannot recover for damages that could have been avoided by the exercise of	

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	reasonable care. The passenger did not fail to mitigate damages by not undergoing surgery where the surgery had not been consistently recommended before trial and was recommended only as an elective procedure.	
New Hampshire		Chamberlain v. Palmer Lumber, Inc., 104 N.H. 221, 183 A.2d 906 (1962). The injured party could recover future damages only for injuries he could not avoid by the exercise of due care in obtaining treatment to cure his disabilities.
New Jersey	Covino v. Peck, 233 N.J. Super. 612, 559 A.2d 868 (App. Div. 1989). The doctrine of mitigation of damages or, as it is called, the doctrine of avoidable consequences, proceeds on the theory that a plaintiff who has suffered an injury as the proximate result of a tort cannot recover for any portion of the harm if, by the exercise of ordinary care, the injury could have been avoided. In a legal malpractice action, it was not reasonable to require the plaintiff to expend time and money to travel to another state and bring a legal action.	Cohen v. Community Medical Center, 386 N.J. Super. 387, 901 A.2d 445 (App. Div. 2006). The doctrine of avoidable consequences is based on the premise that a plaintiff who suffers an injury as the proximate result of a tort cannot recover for any portion of the harm that he or she could have avoided by the exercise of ordinary care. The doctrine of avoidable consequences is applicable to medical malpractice claims.
New York	Rivera v. Kolsky, 82 N.Y.S.3d 554 (App. Div. 2018). The court declined to decline to instruct the jury with respect to the plaintiff's duty to	Wachs v. Winter, 569 F. Supp. 1438 (E.D.N.Y. 1983), applying New York law. An Israeli attorney won a libel action on default against a New York client. New York law requires a defamed person to

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	mitigate damages by losing weight. A party seeking to avail itself of the affirmative defense of failure to mitigate damages must establish that the injured party failed to make diligent efforts to mitigate its damages and the extent to which such efforts would have diminished those damages. The plaintiff's expert orthopedic surgeon testified that the plaintiff's decision whether to have bariatric surgery to facilitate weight loss was a personal decision. The plaintiff's expert further testified that the plaintiff's obesity did not change the need for knee and hip replacements. The trial evidence established that the plaintiff complied with medical directives for physical therapy in an effort to mitigate damages and there was no evidence presented that his damages would have been less if he had more actively participated in physical therapy.	minimize the effects of the defamation. One who attempts to mitigate such damages is entitled to recover the reasonable expenses that are proportionate to the injury and to the consequences to be averted. In light of the tenuous original claims of the plaintiff, the plaintiff was awarded $26,550 in compensatory damages. N.Y. Veh. & Traf. § 1229-c. Non-use of safety belt is not admissible as evidence in any civil action in regard to the issue of liability but may be introduced into evidence in mitigation of damages provided the party introducing said evidence has pleaded such non-compliance as an affirmative defense.
North Carolina		Smith v. Childs, 112 N.C. App. 672, 437 S.E.2d 500, 507 (1993). In a negligence action, it is well settled that the party wronged must use due care to minimize the loss occasioned by defendant's negligence. A plaintiff is barred from recovering for those losses that could have been prevented through

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	Duty Not Imposed	Duty Imposed
		reasonable efforts.
North Dakota		Cartier v. Northwestern Elec., Inc., 2010 ND 14, 777 N.W.2d 866, 872. The jury did not abuse its discretion in giving the two failure-to-mitigate instructions to the jury.
Ohio	Woods v. City of Columbus, 23 Ohio App. 3d 163, 167, 492 N.E.2d 466 (1985). "Admission of seat belt evidence in order to mitigate damages is based upon the requirement that the failure to use the available restraint was a substantial contributing factor in increasing the harm that ensued."	
Oklahoma	Jones v. Eppler, 266 P.2d 451 (Okla. 1954). The instruction that the plaintiff was not required to submit to a major surgical operation involving the risk of life was not error.	
Oregon		Zimmerman v. Ausland, 266 Or. 427, 513 P.2d 1167 (1973). The trial court properly submitted to the jury issues as to whether the plaintiff sustained a permanent knee injury and whether the plaintiff had unreasonably failed to mitigate her damages by submission to surgery. Judgment for the plaintiff affirmed.
Pennsylvania		Hilscher v. Ickinger, 194 Pa. Super. 237, 166 A.2d 678 (1960), *aff'd*, 403 Pa. 596, 170 A.2d 595 (1961). The refusal of an injured party to submit to treatment which required no incision, but only the manipulation of the arm, raised a question for the jury as to whether or not the injured party acted

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	Duty Not Imposed	Duty Imposed
		as a reasonable person in minimizing damages.
South Carolina	Adams v. Orr, 194 S.E.2d 232, 234 (S.C. 1973). "[B]urden of proving a lack of due diligence in minimizing the damages was upon the defendants." Judgment for the plaintiff for the loss of the use of an automobile affirmed, where the defendant offered no evidence as to the plaintiff's alleged unreasonable delay in effecting repairs.	
South Dakota	W. Consol. Coop. v. Pew, 2011 SD 9, 795 N.W.2d 390, 400. Application of the doctrine of mitigation to conversion of a plaintiff's property is very limited.	
Texas		Hogan v. Zoanni, 627 S.W. 3d 163 (Tex. 2021). Under the Texas Defamation Act (DMA), Tex. Civ. Prac. & Rem. Code Ann. § 73.062, a plaintiff may maintain an action for defamation only if the plaintiff makes a timely and sufficient statutory request for correction, clarification, or retraction from the defendant or if a defendant makes a correction, clarification, or retraction. The plain language and the purpose of the Defamation Mitigation Act afforded a defendant a time-limited right to a plea in abatement if a timely and sufficient request was not provided by the plaintiff. If a plaintiff failed to provide the necessary request and a defendant timely filed a plea in abatement, the suit had to abate until the plaintiff responded with a

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	Duty Not Imposed	Duty Imposed
		written request. The plain language of the statute did not support a right to dismissal for failure to provide a sufficient request before the statute of limitations expired. The plaintiff, a pastor at a Houston church divorced his wife. After the divorce, the defendant published a litany of statements online, to the police, and to Hogan's church leadership stating he is a pedophile, pervert, and patron of child pornography. The pastor demanded that the wife cease and desist all defamation of his character and reputation. He then sued his wife alleging causes of action for defamation,
Texas (*continued*)		invasion of privacy, malicious prosecution, abuse of the child protective services process, and intentional infliction of emotional distress. Because the wife sought to have the newly added claims dismissed, rather than abated, to remedy the husband's alleged failure to provide a sufficient request, she waived any complaints about defective notice. Nabors Well Servs. v. Romero, 508 S.W.3d 512 (Tex. 2016). In a personal injury case, relevant evidence of use or nonuse of seat is admissible for the purpose of apportioning responsibility under the Texas proportionate-responsibility statute, Tex. Civ. Prac. & Rem. Code Ann. § 33.003 provided
		that the plaintiff's conduct caused or was a cause of his damages. Although failure to use a seat belt does not *cause* an accident and those who cause accidents who should pay, the legal system takes a broader view toward assigning responsibility for

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	Duty Not Imposed	Duty Imposed
		a plaintiff's damages. City of Fort Worth v. Satterwhite, 329 S.W.2d 899 (Tex. Civ. App. 1959). The failure to instruct the jury not to allow damages that could have been avoided by the wearing of a splint was reversible error. The failure to do so should be considered in determining the adequacy of the verdict.
Virginia		Brown v. Huddleston, 213 Va. 146, 191 S.E.2d 234 (1972). The trial court properly instructed the jury that if the plaintiff, who was injured in the automobile accident, "failed to exercise reasonable care to lessen her damages and such failure enhanced her claim, then she could not recover the enhanced amount."
Washington	Desimone v. Mutual Materials Co., 162 P.2d 808 (Wash. 1945). Where damage to crops and land from the flooding resulted from the defendant's sand operation, the plaintiffs need not show reasonable efforts to minimize damages in order to recover, because that requirement "does not apply to cases of nuisances." Salisbury v. City of Seattle, 2023 Wash. App. LEXIS 46. A mitigation instruction should not be given to the jury if the evidence shows that a proposed treatment might not be successful or if there is conflicting testimony as to the probability of a cure because it is not unreasonable for a plaintiff to	

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	Duty Not Imposed	Duty Imposed
	refuse treatment that offers only a possibility of relief. A "mere possibility of a benefit" from a course of medical treatment is insufficient to warrant a failure to mitigate instruction.	
West Virginia		Martinez v. Asplundh Tree Expert Co., 803 S.E.2d 582 (W. Va. 2017). W. Va. Code § 55-7E-3, requiring a plaintiff in an employment case to mitigate damages, applied retroactively to an employee's discrimination claims based on facts arising before the statute's enactment, occurring before trial of the claims. The remedial statute addressing the procedure for addressing front pay and back pay awards that did not impact a vested right because the employee had no vested right to damages. Rubin Res., Inc. v. Morris, 787 S.E.2d 641 (W. Va. 2016). A plaintiff in a legal malpractice action has a general duty to mitigate his or her damages. The plaintiff must take reasonable steps within his or her ability to minimize losses caused by the attorney's
West Virginia (*continued*)		negligence. However, a plaintiff is not required to take actions which are impractical, disproportionately expensive, or likely futile. After discovering the title defect, the plaintiff took responsible actions to minimize the liabilities arising from the problem. The plaintiff decided to settle the matter instead of pursuing litigation. Cook v. Cook, 216 W. Va. 353, 607 S.E.2d 459 (2004). According to the doctrine of avoidable consequences, a party cannot recover damages flowing from consequences

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	Duty Not Imposed	Duty Imposed
		that the party could reasonably have avoided. W. Va. Code § 55-7E-3. Duty to mitigate damages in employment cases. The plaintiff has an affirmative duty to mitigate past and future lost wages, regardless of whether the plaintiff can prove the defendant employer acted with malice or malicious intent, or in willful disregard of the plaintiff's rights. Jordan v. Jenkins, 859 S.E.2d 700 (W. Va. Ct. App. 2021). In an action arising out of an automobile accident, a new trial on damages was necessary because the jury should have been instructed on respondent's duty to mitigate the loss of use of his vehicle. As with all consequential damages, the availability of loss-of-use damages is necessarily circumscribed by commonsense rules. Whether framed as a duty of mitigation or a doctrine of avoidable consequences, the principle is the same: A plaintiff may not recover loss-of-use damages for a period longer than that reasonably needed to replace the personal property. Because the jury should have been instructed on Mr. Jenkins's duty to mitigate the loss of use of his vehicle, the court reversed the jury's verdict and remand this case for a new trial on respondents' claim for damages against the Jordans.
Wisconsin		Collova v. Mutual Serv. Casualty Ins. Co. of St. Paul, Minn., 8 Wis. 2d 535, 99 N.W.2d 740 (1959). Evidence that the plaintiff failed to follow medical advice was considered in determining the adequacy of the award.
Wyoming		Hacker Oil, Inc. v. Hacker, 2024 WY3. The plaintiff,

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	Duty Not Imposed	Duty Imposed
		the deceased employee's widow, asserted a cause of action for conversion against the defendant Hacker Oil. The plaintiff did not fail to mitigate her damages when the employer converted to its own use one-half of the life insurance proceeds because she rightfully brought a claim, asserted her rights, and when the damage had occurred, she did nothing to warrant any reduction in the amount to which she was entitled.

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MOA App'x 17: 3 Damages in Tort Actions 16.03

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§ 16.03 Duty to Seek and Follow Medical Treatment

[1] Duty to Exercise Reasonable Care in Obtaining and Following Medical Treatment

The doctrine of mitigation requires that the injured person exercise reasonable care in obtaining medical treatment of his or her injuries.[1] In some cases, medical treatment may also encompass psychological counseling.[2] The "reasonable care" standard affords plaintiffs a certain latitude in making medical decisions; an injured party need not elect the best medical treatment available[3] or a specific course of treatment where more than one proven treatments exists, [4] nor undergo treatment at a specific facility or with a specific doctor.[5] It should be noted that since the plaintiff is not charged with procuring the best treatment (whether judged prospectively or in hindsight), the defendant will generally also be liable for any aggravating injuries resulting from medical treatment necessitated by the initial injury.[6]

An injured party may be found to have failed to mitigate damages by waiting longer than a "reasonable person" would to seek initial medical attention or to seek recommended follow-up care.[7] For example, in an Indiana action, the trial court did not abuse its discretion in refusing to instruct the jury on the plaintiff's duty to mitigate damages inasmuch as his failure to schedule chiropractic sessions during a 12-day period had not aggravated

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[1] Yosuf v. United States, 642 F. Supp. 432 (M.D. Pa. 1986), applying federal law; Knauss v. City of Des Moines, 357 N.W.2d 573 (Iowa 1984); Miller v. Eichhorn, 426 N.W.2d 641 (Iowa Ct. App. 1988), *overruled in part by* Greenwood v. Mitchell, 621 N.W.2d 200 (Iowa 2001); Baio v. Haggerty, 558 So. 2d 691 (La. Ct. App. 1990); Neff v. Allvend, Inc., 474 So. 2d 1027 (La. Ct. App. 1985); Reeves v. Louisiana & A. R. Co., 304 So. 2d 370 (La. Ct. App. 1974).

[2] Vasconez v. Mills, 651 N.W.2d 48, 53–54 (Iowa 2002) (defendant had failed to present any evidence that the plaintiff's decision to forego additional counseling, as recommended by his treating psychologists, had been against sound medical advice or that additional counseling would have mitigated damages sustained); Guillot v. Doe, 2003-1754 (La. App. 3 Cir. 6/30/04), 879 So. 2d 374, 381 (the appellate court found no abuse in the trial court's award of $45,000 in general damages to a 7-year-old who was injured when struck by a pellet fired from a BB gun, concluding that the child's parents had exercised reasonable diligence in dealing with his accident-related psychological injuries and that the defendant had failed to prove to what extent they should have mitigated their damages; although they had sought advice from their pastor and friends immediately after the accident, the parents had not sought professional psychological counseling until the child reached early adolescence and first revealed the inner turmoil he was suffering as a result of the shooting; the treating psychologist testified that the minor had needed almost five years from the time of the accident to develop sufficiently expressive verbal skills).

[3] Flint v. Connecticut Hassam Paving Co., 92 Conn. 576, 103 A. 840 (1918).

[4] Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961); Cannon v. New Jersey Bell Tel., 219 N.J. Super. 304, 530 A.2d 345 (App. Div. 1987).

[5] Geer v. First Nat'l Supermarkets, Inc., 5 Conn. App. 175, 497 A.2d 999 (1985); Burke v. National Farmers Union Property & Casualty Co., 36 Wis. 2d 427, 153 N.W.2d 545 (1967).

But cf. Crews v. Workmen's Compensation Appeal Bd., 554 A.2d 190 (Pa. 1989).

[6] *See* ch. 15, *Aggravation of Injury.*

[7] Lopez v. Prestige Cas. Co., 53 Wis. 2d 25, 191 N.W.2d 908 (1971).

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or increased his injuries. Prior to the 12-day hiatus, the plaintiff had undergone chiropractic manipulations every 2–3 days for more than one year.[8] Timeliness may depend on whether a reasonable person would have realized that it was imperative to see a medical professional rather than attempting self-help or alternative remedies given the initial severity of the injury.[9] The fact that the plaintiff waited some time before seeing a doctor will not automatically entitle the defendant to a mitigation instruction; the defendant must prove that earlier treatment would have minimized the plaintiff's damages.[10]

A plaintiff may also be found to have not mitigated damages by failing to follow doctor's instructions or to submit to diagnostic testing or surgical procedures to which a reasonable person would submit. To establish that the injured party acted unreasonably in failing to follow a physician's advice or program of treatment, the adverse party must show that reasonable advice had been clearly communicated to the injured party, [11] and that the advice had been ignored without good reason.[12]

In an Ohio case, for example, a plaintiff's failure to undergo a discectomy upon the recommendation of his treating physician represented unreasonable conduct where the physician had informed him that the minor outpatient procedure would alleviate his back pain resulting from the accident in suit. The trial court was not persuaded by the plaintiff's assertion that he was not refusing, but reasonably postponing, surgery given the severity and cost of the procedure and the lack of certainty of success.[13] Likewise, in a New Jersey action, a plaintiff's failure to undergo a carpal tunnel surgery supported the submission of a jury instruction regarding her duty to mitigate damages by agreeing to appropriate medical treatment. The evidence, including the testimony of the plaintiff's own medical expert, indicated that the plaintiff was in need of the prescribed surgical procedure, that it posed no undue risk to her health or slight peril to her life and that it would involve no extraordinary suffering. Moreover, the plaintiff's expert testified that he had performed numerous carpal-tunnel release surgeries and that the procedure had "a good track record." The jury could reasonably have concluded, therefore, that a person in the plaintiff's position, exercising ordinary and reasonable care for her own health and comfort, would have agreed to undergo the proposed corrective surgery.[14]

Failure to heed medical advice that an ordinary person would likely follow may be excused where the defendant's negligent act caused the plaintiff's emotional state which prevents him from timely seeking adequate medical or surgical treatment.[15] In addition, to limit the amount of recovery, the defendant must show that the initial injuries failed to improve or had been aggravated by the failure to follow the physician's advice.[16]

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[8] Sikora v. Fromm, 782 N.E.2d 355 (Ind. Ct. App. 2002).

[9] Garrison v. Booth, 10 Cal. App. 2d 738, 52 P.2d 535 (1935); Roy v. Robin, 173 So. 2d 222 (La. Ct. App. 1965).

[10] T.J. Morris Co. v. Dykes, 197 Ga. App. 392, 398 S.E.2d 403 (1990).

[11] Smith v. Jones, 382 Mich. 176, 169 N.W.2d 308 (1969); Chamberlain v. Palmer Lumber, Inc., 183 A.2d 906 (N.H. 1962);Zimmerman v. Ausland, 266 Or. 427, 513 P.2d 1167 (1973).

[12] Rapisardi v. United Fruit Co., 441 F.2d 1308 (2d Cir. 1971); Moctezuma v. Industrial Comm'n, 19 Ariz. App. 534, 509 P.2d 227 (1973); Barsavage v. State, Dep't of Transp. & Dev., 96-0688 (La. App. 1 Cir. 12/20/96), 686 So. 2d 957; Keans v. Bottiarelli, 35 Conn. App. 239, 645 A.2d 1029 (1994); Neff v. Allvend, Inc., 474 So. 2d 1027 (La. Ct. App. 1985); Martinez v. Vigil, 105 N.M. 741, 737 P.2d 100 (Ct. App. 1987); Yost v. Union R.R., 380 Pa. Super. 236, 551 A.2d 317 (1988).

But see Yosuf v. United States, 642 F. Supp. 432 (M.D. Pa. 1986); Daniels v. Standard Oil Realty Corp., 145 Ill. App. 3d 363, 495 N.E.2d 1019, 1024 (1986); Perrette v. City of Slidell, 465 So. 2d 63 (La. Ct. App. 1985); Hurlbut v. Landgren, 200 Neb. 413, 264 N.W.2d 174 (1978).

[13] Dunn v. Maxey, 118 Ohio App. 3d 665, 693 N.E.2d 1138, 1139–1141 (1998).

[14] Simmons v. Erie Insurance Exchange, 891 N.E.2d 1059, 1065–1068 (Ind. Ct. App. 2008) (plaintiff's failure to undergo surgery to treat his plantar fascitis was insufficient to support a jury instruction on failure to mitigate damages where none of his treating physicians recommended surgery, where he had seen several doctors who prescribed a variety of non-surgical treatments, and where the defendant had failed to introduce any evidence regarding the risks, benefits, costs, or inconveniences of the surgery); Albert v. Monarch Fed. Sav. & Loan Assoc., 327 N.J. Super. 462, 743 A.2d 890, 892–893 (App. Div. 2000).

[15] Browning v. United States, 361 F. Supp. 17 (E.D. Pa. 1973); Disabatino Bros., Inc. v. Baio, 366 A.2d 508 (Del. 1976); Botek v. Mine Safety Appliance Corp., 531 Pa. 160, 611 A.2d 1174 (1992).

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A total disregard of reasonable warnings and restrictions, such as to avoid strenuous activity, [17] may be sufficient to defeat recovery of enhanced damages, as might the failure to keep appointments.[18] The doctrine of mitigation of damages would apply if the plaintiff failed to quit smoking on a doctor's advice.[19] In a wrongful death action, the trial court erred in preventing cross-examination of a family member about the family's decision to withhold allegedly life-saving treatments from the decedent.[20]

Often this defense will have its genesis in the plaintiff's treatment records—*e.g.*, hospital, clinic, or physician's records. Defense counsel should carefully review these records with particular attention to either notes of missed appointments or what seems to be irregular scheduling of appointments. To adequately do so, counsel must learn the various symbols which indicate failure to keep appointments.

The plaintiff's physician on cross-examination should be asked about these missed examinations. Moreover, if the defendant feels these missed appointments materially affected the medical result, direct medical testimony should be offered to prove this argument. Even absent direct evidence, however, defendant will do well to show the irresponsibility of plaintiff in missing numbers of scheduled medical examinations and/or treatments.

Other circumstances sufficient to defeat recovery of enhanced damages include the failure to perform exercises which might have been accomplished without unusual pain and suffering;[21] the failure to lose weight;[22] and the failure to wear a medical device, such as a supporting brace or eye patch.[23]

For example, in a Louisiana action, an award of $4,000 in general damages did not represent an abuse of the jury's discretion where the plaintiff's injuries were not severe in nature and where she had failed to mitigate her damages. Although the plaintiff complained of suffering with knee pain over the course of 10 months, evidence revealed that the pain was mild to moderate as indicated by the fact that she had complained of the pain on five visits to her physicians, using the word "bother" rather than "hurt." Moreover, the plaintiff only sporadically completed the physical therapy she was instructed to follow and she herself stated relieved much of her knee discomfort. The trial court properly concluded that the plaintiff's duty to mitigate her damages included completing 15 minutes of physical therapy exercises daily. Appellate review concurred in the determination finding that 15 minutes of light exercises daily was not unreasonable.[24]

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[16] Fitzpatrick v. United States, 754 F. Supp. 1023 (D. Del. 1991); Yosuf v. United States, 642 F. Supp. 432 (M.D. Pa. 1986); Baio v. Haggerty, 558 So. 2d 691 (La. Ct. App. 1990); Radford v. Norris, 63 N.C. App. 501, 305 S.E.2d 64 (1983).

[17] Amoco Chem. Corp. v. Hill, 318 A.2d 614 (Del. Super. Ct. 1974); Stone v. Duffy Distributors, Inc., 785 S.W.2d 671 (Mo. Ct. App. 1990); Romano v. Allstate Ins. Co., 458 A.2d 339 (R.I. 1983).

[18] *Cf.* Greene v. Mackle Co., 142 So. 2d 283 (Fla. 1962).

[19] Schifino v. Geico Gen. Ins. Co., 2013 U.S. Dist. LEXIS 174574 (W.D. Pa. Dec. 13, 2013) (the defendants met their burden in showing that the plaintiff should have taken the reasonable measure to quit smoking in order to reduce his damages).

[20] Manhattan Nursing & Rehab. Ctr., LLC v. Pace, 134 So. 3d 810, 819 (Miss. Ct. App. 2014).

[21] Sanderson v. Secrest Pipe Coating Co., 465 S.W.2d 65 (Ky. 1971); Schexnayder v. United Servs. Auto. Ass'n, 375 So. 2d 736 (La. Ct. App. 1979); Reeves v. Louisiana & A. R. Co., 304 So. 2d 370 (La. Ct. App. 1974); Martinez v. Vigil, 105 N.M. 741, 737 P.2d 100 (Ct. App. 1987); Radford v. Norris, 63 N.C. App. 501, 305 S.E.2d 64 (1983).

But see Daniels v. Standard Oil Realty Corp., 145 Ill. App. 3d 363, 495 N.E.2d 1019, 1024 (1986).

[22] Muller v. Lykes Bros. S.S. Co., 337 F. Supp. 700 (E.D. La. 1972), *aff'd*, 468 F.2d 951 (6th Cir. 1973); Moctezuma v. Industrial Comm'n, 19 Ariz. App. 534, 509 P.2d 227 (1973); Baio v. Haggerty, 558 So. 2d 691 (La. Ct. App. 1990).

But see Lewis v. Ins. Co. of N. Am., 322 So. 2d 429 (La. Ct. App. 1975); Close v. New York, 90 A.D.2d 599, 456 N.Y.S.2d 437 (1982).

[23] Rapisardi v. United Fruit Co., 441 F.2d 1308 (2d Cir. 1971); Martinez v. Vigil, 105 N.M. 741, 737 P.2d 100 (Ct. App. 1987); City of Fort Worth v. Satterwhite, 329 S.W.2d 899 (Tex. Ct. App. 1959).

[24] Lacombe v. Buras, 778 So. 2d 1181, 1185 (La. Ct. App. 2001).

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While a plaintiff has the right to refuse medical treatment on religious or other grounds, he will not be relieved of the duty to mitigate damages and cannot recover damages resulting from his refusal of reasonable medical treatment.[25]

[2] Refusal to Undergo Surgical or Medical Treatment

Failure to undergo surgery may also be deemed unreasonable, entitling the defendant to a mitigation instruction. Courts may be less willing to require that a plaintiff undergo a serious operation in order to recover full damages as opposed to one deemed routine.[26] Other factors that the court will consider in assessing the reasonableness of the failure to submit to surgery include: the actual risk or danger of such procedure;[27] the expenditure of money and effort required;[28] the likelihood of the procedure's success;[29] the availability of alternative treatment;[30] and the pain and suffering which could be expected to result from the procedure.[31]

Failure to exercise reasonable care in seeking timely medical treatment, following doctor's instructions or submitting to reasonable surgical procedures will not completely bar recovery, but damages may be limited to the extent that the plaintiff was unreasonable in neglecting his condition.[32]

In an Iowa action, however, the trial court properly refused the defendant's instruction regarding the mitigation of damages where nothing in the record suggested that the plaintiff's decision to forego additional counseling was against medical advice. Evidence in the record indicated that neither of the professionals who had

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[25] Corlett v. Caserta, 562 N.E.2d 257 (Ill. Ct. App. 1990); Braverman v. Granger, 303 Mich. App. 587, 608 (2014) (if the blood transfusion was an objectively reasonable means of avoiding or minimizing damages, then the refusal to accept the transfusion means the individual unreasonably failed to mitigate his or her damages. This is a neutral approach that does not treat anyone disparately because it eliminates all subjective factors from consideration, not just religion); Walter Nashert & Sons v. McCann, 460 P.2d 941 (Okla. 1969); Shorter v. Drury, 103 Wash. 2d 645, 695 P.2d 116 (1985), *cert. denied*, 474 U.S. 827, 106 S. Ct. 86, 88 L. Ed. 2d 70.

[26] Verrett v. McDonough Marine Serv., 705 F.2d 1437 (5th Cir. 1983).

[27] Arthur G. McKee & Co. v. Industrial Comm'n, 24 Ariz. App. 218, 537 P.2d 603 (1975); Lapidus v. Hahn, 115 Ill. App. 3d 795, 450 N.E.2d 824 (1983); Fuches v. S.E.S. Co., 459 N.W.2d 642 (Iowa Ct. App. 1990); Michaud v. Steckino, 390 A.2d 524 (Me. 1978); Cannon v. New Jersey Bell Tel., 219 N.J. Super. 304, 530 A.2d 345 (App. Div. 1987), *cert. denied*, 109 N.J. 54, 532 A.2d 1119 (1987); Zimmerman v. Ausland, 266 Or. 427, 513 P.2d 1167 (1973).

[28] Fuches v. S.E.S. Co., 459 N.W.2d 642 (Iowa Ct. App. 1990); Colton v. Benes, 176 Neb. 483, 126 N.W.2d 652 (1964) (on retrial, plaintiff's financial condition was to be shown).

[29] Stark v. Shell Oil Co., 450 F.2d 994 (5th Cir. 1971); Fitzpatrick v. United States, 754 F. Supp. 1023 (D. Del. 1991); Arthur G. McKee & Co. v. Industrial Comm'n, 24 Ariz. App. 218, 537 P.2d 603 (1975); Hildyard v. Western Fasteners, Inc., 33 Colo. App. 396, 522 P.2d 596 (1974); Disabatino Bros., Inc. v. Baio, 366 A.2d 508 (Del. 1976); Fuches v. S.E.S. Co., 459 N.W.2d 642 (Iowa Ct. App. 1990); McCormick v. Gullett, 460 S.W.2d 813 (Ky. 1970); Labit v. Setiff, 489 So. 2d 942 (La. Ct. App. 1986); Michaud v. Steckino, 390 A.2d 524 (Me. 1978); Cannon v. New Jersey Bell Tel., 219 N.J. Super. 304, 530 A.2d 345 (App. Div. 1987), *cert. denied*, 109 N.J. 54, 532 A.2d 1119 (1987).

[30] Cline v. United States, 270 F. Supp. 247 (S.D. Fla. 1967); Perrette v. City of Slidell, 465 So. 2d 63 (La. Ct. App. 1985); Automatic Merchandisers, Inc. v. Ward, 646 P.2d 553 (Nev. 1982); Cannon v. New Jersey Bell Tel., 219 N.J. Super. 304, 530 A.2d 345 (App. Div. 1987), *cert. denied*, 109 N.J. 54, 532 A.2d 1119 (1987).

[31] Fuches v. S.E.S. Co., 459 N.W.2d 642 (Iowa Ct. App. 1990); Michaud v. Steckino, 390 A.2d 524 (Me. 1978).

[32] Yosuf v. United States, 642 F. Supp. 432 (M.D. Pa. 1986) (because the plaintiff, a former prison inmate, refused the recommended surgery, refused to use the injured hand causing it to atrophy, and refused to begin physical therapy when released from prison, the damages awarded to the plaintiff would be reduced by 25%); Keans v. Bottiarelli, 35 Conn. App. 239, 645 A.2d 1029 (1994); Neff v. Allvend, Inc., 474 So. 2d 1027 (La. Ct. App. 1985), *cert. denied*, 478 So. 2d 148 (La. 1986); Dohmann v. Richard, 282 So. 2d 789 (La. Ct. App. 1973); Casimere v. Herman, 28 Wis. 2d 437, 137 N.W.2d 73 (1965).

See generally Grier, *Rethinking the Treatment of Mitigation of Damages Under the Iowa Comparative Fault Act in Light of Tanberg v. Ackerman Inv. Co.*, 77 Iowa L. Rev. 1913, 1916.

recommended further counseling had been questioned about the plaintiff's failure to heed their recommendation so as to permit the jury to assess the reasonableness of their advice or the unreasonableness of his response. Moreover, the defendant failed to tender any proof that additional counseling would have mitigated the damages sustained.[33]

[3] Wrongful Pregnancy/Birth Claims

A plaintiff cannot be required to undergo an abortion or give a child up for adoption to mitigate damages.[34] For example, in a California action based on plaintiff having become pregnant after defendant doctor had performed a bilateral tubal ligation on her for the purpose of sterilization, the plaintiff could not be required to undergo an abortion or place her unwanted child for adoption.[35]

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[33] Vasconez v. Mills, 651 N.W.2d 48, 53–54 (Iowa 2002).

[34] University of Ariz. Health Sciences Center v. Superior Court of State in and for Maricopa County, 136 Ariz. 579, 667 P.2d 1294 (1983) (the parents in a wrongful-pregnancy action were not forced to mitigate damages by choosing abortion or adoption; rules requiring mitigation of damages require only that reasonable measures be taken); Macomber v. Dillman, 505 A.2d 810 (Me. 1986) (the court noted that "parents should not be forced to mitigate their damages resulting from medical malpractice by resorting to abortion or to adoption;" the court then noted that most courts that have considered the matter have held, as a matter of law, neither course of action would be reasonable); Rivera v. State, 404 N.Y.S.2d 950, 954 (Ct. Cl. 1978) (claimant had no obligation to mitigate damages by undergoing an abortion).

[35] Morris v. Frudenfeld, 135 Cal. App. 3d 23, 31 (1982).

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