STATE OF MICHIGAN

COURT OF APPEALS

KENDRA WRIGHT,

Plaintiff-Appellant,

v

AAA INSURANCE COMPANY,

Defendant-Appellee.

UNPUBLISHED
April 25, 2000

No. 212270
Wayne Circuit Court
LC No. 97-720564-NF

Before: Gribbs, P.J., and Hoekstra and Markey, JJ.

PER CURIAM.

In this action for first-party no-fault benefits, plaintiff appeals as of right from the trial court's order granting defendant's motion for summary disposition under MCR 2.116(C)(10). We reverse and remand.

Plaintiff argues that the trial court erred in granting summary disposition in defendant's favor because defendant failed to provide documentary evidence to support its argument that because plaintiff elected to coordinate benefits with her primary health care insurer, Health Alliance Plan (HAP), pursuant to MCL 500.3109a; MSA 24.13109(1) (hereinafter § 3109a), defendant was not obligated to provide coverage which HAP was required, under its contract, to either pay for or provide. We review a trial court's grant of summary disposition de novo. *Spiek v Dep't of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998); *Russell v Dep't of Corrections*, 234 Mich App 135, 136; 592 NW2d 125 (1999).

The parties agree that *Tousignant v Allstate Ins Co*, 444 Mich 301; 506 NW2d 844 (1993), is the controlling legal authority with respect to the coordination of medical benefits and no-fault insurance coverage under § 3109a of the no-fault act. In *Tousignant*, the defendant refused to pay for the medical care provided by a physician and dentist not within the plaintiff's health care coverage, arguing that any necessary services were required to be provided by the plaintiff's health care provider. *Id.* at 305. Our Supreme Court stated:

> The question presented concerns the liability of a no-fault automobile insurer when the insured purchases a policy of no-fault automobile insurance coordinated with

> other health coverage. We hold that a no-fault insurer is not subject to liability for medical expense that the insured's health care insurer is required, under its contract, to pay for or provide. [*Id.* at 303 (footnotes omitted.)]

The Court concluded, as a matter of legislative policy, that an insured who elects to coordinate no-fault and health coverage is required "to obtain payment and services from the health insurer to the extent of the health coverage available from the health insurer." *Id.* at 307. According to *Tousignant*, to determine if coverage for a given service is available under the health care provider's policy, the terms of the policy must be analyzed:

> In deciding whether health care was available from HAP [the plaintiff's health care insurer/provider], the focus should be on the HAP contract as it is applied in practice. Section 3109a does not require a health insurer to provide particular benefits. The availability of services thus depends on what the contract means as applied in practice, a question of fact as well as of legal construction of a contract document.
>
> Tousignant does not contend that HAP would not or could not provide the medical care she needed. Nor is this a case in which it is claimed that the quality of the available care was such that it can be said that the benefit was not available.
>
> Where there is no claim that the health insurer would not or could not provide the necessary medical treatment, there is no basis for a finding that the benefits were not available--not "payable" or "required to be provided"--from the health insurer. [*Id.* at 312-313 (footnotes omitted.)]

Thus, resolution of the question whether benefits or services were available from the primary health care provider turns on the terms of the provider's contract. This involves a question of fact. *Touisignant, supra*.

To be entitled to summary disposition under MCR 2.116(C)(10), defendant, as the moving party, was required to come forward with documentary evidence establishing that there was no genuine issue of material fact and that it was entitled to judgment as a matter of law. *Smith v Globe Life Ins Co*, 460 Mich 446, 455; 597 NW2d 28 (1999). MCR 2.116(G) provides in relevant part:

> (3) Affidavits, depositions, admissions, or other documentary evidence in support of the grounds asserted in the motion are required
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> (a) when the grounds asserted do not appear on the face of the pleadings, or
>
> (b) when judgment is sought based on subrule (C)(10).
>
> (4) A motion under subrule (C)(10) must specifically identify the issues as to which the moving party believes there is no genuine issue as to any material fact. When a motion under subrule (C)(10) is made and supported as provided in this rule, 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. If the adverse party does not so respond, judgment, if appropriate, shall be entered against him or her.

Affidavits offered in support of a motion under MCR 2.116(C)(10) must be based on personal knowledge and "must set forth with particularity such facts as would be admissible as evidence to establish or deny the grounds stated in the motion." *SSC Associates Ltd Partnership v General Retirement System of Detroit*, 192 Mich App 360, 364; 480 NW2d 275 (1991). Also, documentary evidence offered in support of the motion must consist of evidence that would be admissible at trial. *Id*. The party opposing the motion has no obligation to submit evidence until the moving party has first come forward with documentary evidence regarding a dispositive fact. *Id*.

In the context of this case, defendant had the burden of showing that plaintiff could have obtained treatment for her injuries with her health care provider, i.e., it was necessary for defendant to show that the disputed medical services were available or covered by HAP. To do this, defendant was required to produce evidence on the terms of HAP's coverage. See *Tousignant, supra*. The affidavit submitted by defendant's attorney in support of the motion fails to establish that there is no genuine issue of material fact and that defendant is thereby entitled to judgment as a matter of law. No evidence was submitted regarding the scope of plaintiff's HAP coverage, thus precluding any determination whether the disputed services were available under plaintiff's health care coverage. Therefore, the trial court erred in granting defendant's motion for summary disposition.

We decline to address the issue whether plaintiff is entitled to an award of costs and attorney fees under MCR 2.114, because that issue was not decided by the trial court. The trial court is free to consider that issue on remand.

Reversed and remanded. We do not retain jurisdiction.

/s/ Roman S. Gribbs
/s/ Joel P. Hoekstra
/s/ Jane E. Markey