

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Luminex BK LLC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-24-1347-2984
Applicant's File No.	DK24-440162
Insurer's Claim File No.	8752061740000001
NAIC No.	22063

ARBITRATION AWARD

I, Yael Aspir, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: EIP

1. Hearing(s) held on 06/23/2025
Declared closed by the arbitrator on 06/23/2025

Evan Polansky from Korsunskiy Legal Group, P.C. participated virtually for the Applicant

Diana Gonzalez from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,826.70**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The EIP, FT, a 36 year old male driver, was injured by a motor vehicle involved in an accident on 07/12/23.

In dispute is the Applicant's claim for \$2,826.70 for treatment provided to the EIP on 11/25/23. Respondent raises a defense of policy exhaustion.

The issue to be determined is whether Applicant's claim should be denied based upon exhaustion of the PIP policy.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the Parties as contained in the Electronic Case Folder maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in Modria for both parties and make my decision in reliance thereon.

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form reflecting the amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case.

Respondent contends that the policy of insurance has been exhausted. In support of this defense, Respondent submits evidence of payment of the policy limits, including the NF10 dated 08/02/24, payment log noting medical bills and lost wage claims with applied offsets, and insurance policy with declarations page. Respondent relies on its evidence to establish a total PIP payment of \$50,000.00 which includes offsets noted in the ledger.

New York Insurance Law § 5102 Insurance Law 5102(a) and (a)(2) provides as follows: (a) "Basic economic loss" means, up to fifty thousand dollars per person of the following combined items, subject to the limitations of section five thousand one hundred eight of this article: (1) All necessary expenses incurred for: (i) medical, hospital (including services rendered in compliance with article forty-one of the public health law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services; (ii) psychiatric, physical and occupational therapy and rehabilitation; (iii) any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and (iv) any other professional health services; all without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury.

For the purpose of determining basic economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section five thousand one hundred eight of this article. Additionally, 11 NYCRR 65-3.15 states that: "[w]hen claims aggregate to more than \$50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred provided claims therefore were made to the insurer prior to the exhaustion of the \$50, 000 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same time, the

payments shall be made in the order of rendition of services." Herein, the Respondent provided documentation of their payments for health care services to various providers and lost wage compensation, which indicated that \$50,000 was paid.

When an insurer "has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease." Countrywide Ins. Co. v. Sawh, 272 A.D.2d 245 (1st Dept. 2000). See also Allstate Insurance Company v. Demoura, 30 Misc.3d 145(A), 2011 N.Y. Slip Op. 50430(U) (App. Term 1st Dept. 2011); Hospital For Joint Diseases v. State Farm Mutual Automobile Insurance Company, 8 A.D.3d 533, 779 N.Y.S.2d 534 (2nd Dept. 2004). Timely denied claims do not hold a place on the priority of payment line to subsequently filed claims that were paid by the Respondent. Harmonic Physical Therapy v. Praetorian Insurance Company, 47 Misc.3d 137(A), 2015 N.Y. Slip Op. 50525(U) (App. Term 1st Dept. 2015).

At the hearing, Applicant's counsel asserted that since there was money left on the policy when the Applicant's bills were received by Respondent, Applicant's bills should have been paid ahead of any bills subsequently received. In support of this argument, Applicant's counsel relies upon the decision of the Appellate Term, Second Department in Alleviation Medical Services, P.C. v Allstate, 2017 N.Y. Slip Op.27097 (App. Term 2nd, 11th and 13th Jud. Dists. 2017), where the Court held that policy exhaustion was not a defense when an insurer is required to pay a previously denied verified claim after the no-fault insurance policy coverage had been exhausted, thereby stating a strict interpretation of the priority of payment rule as it applies to verified claims regardless of whether such claims are initially denied.

However, I decline to follow the decision in Alleviation, and I choose to follow the decision of the Appellate Term, First Department in Harmonic Physical Therapy v. Praetorian Insurance Company, 47 Misc.3d 137(A), 2015 N.Y. Slip Op. 50525(U) (App. Term 1st Dept. 2015) which states "Contrary to plaintiff's contention, defendant was not precluded by 11 NYCRR 65-3.15 from paying other providers' legitimate claims subsequent to the denial of plaintiff's claims. Adopting plaintiff's position, which would require defendant to delay payment on uncontested claims, or, as here, on binding arbitration awards - pending resolution of plaintiff's disputed claim - 'runs counter to the no-fault regulatory scheme, which is designed to promote prompt payment of legitimate claims'. (Nyack Hosp. v General Motors Accept. Corp., 8 NY3d at 300)."

I find that the reasoning set forth in the Harmonic case is more rational, more persuasive and more consistent with the goals of the no-fault system - specifically that of prompt payment of verified claims. The Regulations do not require an insurer to set aside funds for denied claims pending anticipated litigation. Once the insurer pays out the full amount of its no-fault insurance coverage proceeds (\$50,000 as determined by the facts of the herein matter), the EIP has received the full benefit of the contracted for insurance policy.

Applicant further argued that the Court of Appeals granted further appeal to Allstate in the Alleviation matter and recently determined in 2021 NY Slip Op 08159, 2/24/21, that while the insurer submitted records indicating that the subject no-fault policy had been exhausted in 2013, the defendant's admissions failed to establish its prima facie

entitlement to judgment as a matter of law. Specifically, an affidavit submitted by Allstate failed to detail information regarding the claim at issue, and Allstate failed to submit relevant documents associated with this claim. Therefore, the Court, without ruling on the merits of the priority of payment rule, found that Allstate could not sustain its defense based upon exhaustion.

Upon review of the caselaw and upon the arguments of counsel at the hearing, I find the holding from the Court of Appeals inapplicable to the matter herein. The Court's holding is very case specific and has no bearing on the fact pattern established in the instant matter. I do not find any relevant authority providing an Arbitrator with discretion to exceed the specifically enumerated policy limitations.

Since the Respondent exhausted its policy limits prior to the hearing of this matter, I find that there are no available funds to satisfy the Applicant's claim. Accordingly, the Respondent's defense of policy exhaustion is sustained, and Applicant's claim is denied. All remaining issues are moot.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. I find as follows with regard to the policy issues before me:

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY

SS :

County of Nassau

I, Yael Aspir, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

07/07/2025
(Dated)

Yael Aspir

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form

Unique Modria Document ID:

76d2be00ddc63e199fc43fe58105f6ff

Electronically Signed

Your name: Yael Aspir
Signed on: 07/07/2025