STATE OF MICHIGAN

COURT OF APPEALS

EVELYN BLANFORD, ALICE D. BOWEN, WANDA CADY, ELAINE CASE, MYRTLE CLINE, PATRICIA COLLINS, CHRISTOPHER DANKO, RYAN DYBDAHL, MARILYN GRAFF, VERTIS HALL, SUSAN HIGASHI, JOHN HOWELL, KATHRYN JACOBSON, GEOFFREY KENNEDY, CAROLE KERBY, NANCY KREGER-AILLS, DENNIS LEE, KIM LEWANOWICZ, NICHOLAS LOPEZ, SR., MATTHEW MARX, GLENNA MCPEAKE, BARBARA MOREA, EILEEN NAGY, STEVEN RODGERS, JOANNE SCHILLING, RICHARD SECORD, GEORGE SHAW, DAWN SHURTER, PRISCILLA TATE, DONALD THOMPSON, ELNA THOMPSON, JOHN TURNER, JR., WENDELL WOODARD, PAUL ZICK, and all those unnamed parties former retirees of Genesee County Community Mental Health, whether union or nonunion employees,

Plaintiffs-Appellants,

v

GENESEE COUNTY COMMUNITY MENTAL HEALTH,

Defendant-Appellee.

UNPUBLISHED
December 26, 2019

No. 346205
Genesee Circuit Court
LC No. 11-096574-CL

Before: TUKEL, P.J., and SAWYER and RIORDAN, JJ.

PER CURIAM.

Plaintiffs[1] appeal as of right the trial court's order granting summary disposition to defendant, Genesee County Community Mental Health.[2] On appeal, union plaintiffs argue that defendant breached its collective bargaining agreements with them by failing to provide them with Blue Cross/Blue Shield health insurance. Union plaintiffs additionally argue that the trial court erred by failing to hold an evidentiary hearing. We agree that defendant breached the collective bargaining agreements as to those union plaintiffs who are under 65 years old and hold that these union plaintiffs are entitled to at least nominal damages.[3] Furthermore, we hold that defendant did not breach the collective bargaining agreements as to those union plaintiffs who are over 65 years old and that union plaintiffs' evidentiary hearing argument is abandoned.

I. UNDERLYING FACTS

This case arises out of the 1996, 1999, and 2002 collective bargaining agreements (the CBAs) that defendant negotiated with Teamsters State, County and Municipal Workers, Local 214 (Teamsters) and the American Federation of State, County, and Municipal Employees

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[1] All of the named plaintiffs remaining when the trial court entered its order granting summary disposition to defendant, which is the subject of this appeal, were retirees at the time the complaint was filed. Evelyn Blanford, Ryan Dybdahl, Nancy Kreger-Aills, Matthew Marx, Barbara Morea, and Elna Thompson were members of Teamsters State, County and Municipal Workers, Local 214 (together, "Teamsters plaintiffs"). Marilyn Graff, John Howell, Carole Kerby, Dennis Lee, Glenna McPeake, Joanne Schilling, Richard Secord, and Dawn Shurter were all members of the American Federation of State, County, and Municipal Employees (collectively, AFSCME plaintiffs, and together with Teamsters plaintiffs "union plaintiffs"). Union plaintiffs are the only plaintiffs with claims at issue in this appeal.

[2] As noted by defendant in its brief on appeal, Genesee County Community Mental Health changed its name to Genesee Health System since the time plaintiff filed its complaint. We refer to defendant as "defendant" throughout this opinion, but use the name "Genesee County Community Mental Health" rather than "Genesee Health System" when it is necessary to refer to defendant by name.

[3] Elna L. Thompson, Marilyn Graff, Carol Kerby, Blenna McPeake, Joanne Schilling, and Richard Secord were over 65 years old as of February 1, 2017 and retired while the 1996 and 1999 collective bargaining agreements at issue on appeal were in effect. Nancy Kreger-Aills, John Howell, and Dawn Shurter were all under 65 years old as of February 1, 2017. Nancy Kreger-Aills was 59 years old, John Howell was 62 years old, and Dawn Shurter was 61 years old on that date. Evelyn Blanford, Ryan Dybdahl, Barbara Morea, and Dennis Lee were over 65 years old as of February 1, 2017 and retired when the 2002 collective bargaining agreements at issue on appeal were in effect. Matthew Marx, however, was 58 years old on February 1, 2017 and retired when the 2002 collective bargaining agreement at issue on appeal was in effect.

(AFSCME).[4] Specifically, the issue in this case is health insurance provided by defendant to retirees under the CBAs.

The provisions of the 1996 and 1999 CBAs between Teamsters and defendant as well as the 1999 CBA between AFSCME and defendant (together, "the 1996 and 1999 CBAs") regarding retiree health insurance benefits were identical and stated that retirees would be "provided with fully paid Blue Cross/Blue Shield, dental and optical benefits" after retirement. The 2002 CBA between AFSCME and defendant as well as the 2002 CBA between Teamsters and defendant (together "the 2002 CBAs") changed the health insurance offered to retirees. Instead of offering "fully paid" Blue Cross/Blue Shield health insurance, the 2002 CBAs allowed retirees to choose between four specified health insurance options: HealthPlus Plan MN, "BC/BS Community Blue," "BC Network I," and Traditional Blue Cross/Blue Shield. The 2002 CBAs additionally stated:

> The Employer will pay the full premium cost for retirees who select the lowest premium coverage plan. Retirees who select the higher premium coverage plan are required to pay the difference in premiums. Said retirees shall remain on the active employee's hospital/medical benefit plan until attaining the age of sixty-five (65). Thereafter retirees (and their eligible spouse) are required to enroll and pay for Medicare Supplemental Plan B and are required to select either complementary Health Plus [sic] coverage or complementary Blue Cross/Blue Shield Traditional coverage. Only employees who retire with at least eight (8) years of credited service will be provided with hospital/medical coverage.

At some point after 2002, Blue Cross/Blue Shield stopped offering Traditional Blue Cross/Blue Shield and its "flex blue" health insurance plan. Raymond Knott (Knott), the individual who negotiated on defendant's behalf for each of the CBAs, opined that this was because these plans "cost [themselves] out of business." Furthermore, beginning in 2007, most of defendant's then-current employees chose to no longer select Blue Cross/Blue Shield as an option for their health insurance because it was too expensive. As a result, Blue Cross/Blue Shield notified defendant that it would not offer health insurance, other than complementary Medicare coverage, to defendant's retirees because less than five of defendant's employees chose Blue Cross/Blue Shield for their health insurance. Blue Cross/Blue Shield had two business rules or internal practices which caused that decision: first, Blue Cross/Blue Shield would insure active employees, as opposed to retirees, only if at least five of them chose to have Blue Cross/Blue Shield health insurance. Additionally, Blue Cross/Blue Shield would not insure retirees under 65 years old if it did not also insure an employer's current employees, because retirees under 65 years old represented a high-risk group to insure. Thus, after most of defendant's active employees opted out of Blue Cross/Blue Shield health insurance, leaving fewer than five who sought Blue Cross/Blue Shield coverage, defendant's retirees could only obtain Blue Cross/Blue Shield health insurance if they were at least 65 years old and enrolled in

[4] The 1996 CBA between AFSCME and defendant is not at issue in this case. Accordingly, any reference to the 1996 CBA refers solely to the 1996 CBA between defendant and Teamsters.

Medicare. Since at least 2007, however, defendant has offered and provided the same health insurance to union plaintiffs that it offers and provides to its current employees.

This case has a lengthy procedural history, most of which is not relevant to this appeal. In relevant part, union plaintiffs filed a complaint in August 2011. In June 2012, the trial court entered a consent order bifurcating the issues of liability and damages. The consent order stated that the issue of liability would be determined before the issue of damages. Union plaintiffs then filed an amended complaint in February 2017 alleging that under the CBAs, they each were entitled to a specific type of health insurance, Traditional Blue Cross/Blue Shield, following retirement. Plaintiffs did not seek monetary damages because "while the damages are real to Plaintiffs, they have been difficult to record and organize and thus, speculative in nature, requiring Plaintiffs to abandon previous claims for money damages."

Defendant answered in March 2017, asserting that it did not breach the CBAs. Defendant moved for summary disposition in March 2017, arguing that it did not breach the CBAs. Defendant additionally argued that it could not provide Blue Cross/Blue Shield health insurance to union plaintiffs unless they were enrolled in Medicare, due to Blue Cross/Blue Shield's business rules and internal practices previously discussed. Accordingly, defendant argued that, even if it had breached the CBAs, no relief was available to union plaintiffs because relief would have required a change in business rules and internal practices on the part of Blue Cross/Blue Shield. Union plaintiffs responded that defendant did breach the CBAs and that plaintiffs were entitled to Traditional Blue Cross/Blue Shield health insurance under the CBAs. Union plaintiffs also stated, however, that they were unable to prove any monetary damages based on defendant's breach.

Additional briefing by the parties continued these same arguments, and the trial court held a motion hearing in November 2017. At the motion hearing, the parties repeated the arguments raised in their briefs and union plaintiffs reiterated that they could not prove any monetary damages. The trial judge then reopened discovery and stated that she would hold an additional evidentiary hearing if necessary to determine the cost of Blue Cross/Blue Shield's health insurance policies. Ultimately, however, no such hearing was held. In September 2018, defendant refiled its motion for summary disposition. Union plaintiffs responded that defendant breached the CBAs. Defendant replied that, because union plaintiffs failed to specify the equitable remedy to which they were entitled, the trial court should not award any equitable remedy to union plaintiffs. The trial court then granted summary disposition to defendant under MCR 2.116(C)(8) and (10) because it found that any breach by defendant was not a material breach of the CBAs. This appeal followed.

II. STANDARD OF REVIEW

The trial court granted summary disposition to defendant under MCR 2.116(C)(8) and (10). "A motion under MCR 2.116(C)(8) tests the legal sufficiency of the complaint." *Maiden v Rozwood*, 461 Mich 109, 119; 597 NW2d 817 (1999). When deciding a motion for summary disposition brought under MCR 2.116(C)(8), "a court considers only the pleadings." *Id*. at 120. The trial court considered the CBAs when granting summary disposition to defendant. The CBAs, however, were not attached to the pleadings. Thus, the trial court considered information outside the pleadings and erred to the extent that it granted summary disposition to defendant

under MCL 2.116(C)(8). See *Maiden*, 461 Mich at 119-120. Nevertheless, we may consider the propriety of the grant of summary disposition under MCR.2.116(C)(10).

A motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of the complaint, *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 205-206; 815 NW2d 412 (2012), and we review a trial court's summary disposition ruling de novo. *Walters v Nadell*, 481 Mich 377, 381; 751 NW2d 431 (2008). This Court "reviews a motion brought under MCR 2.116(C)(10) "by considering the pleadings, admissions, and other evidence submitted by the parties in the light most favorable to the nonmoving party." *Patrick v Turkelson*, 322 Mich App 595, 605; 913 NW2d 369 (2018). Summary disposition "is appropriate if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law." *Id*. "There is a genuine issue of material fact when reasonable minds could differ on an issue after viewing the record in the light most favorable to the nonmoving party." *Allison v AEW Capital Mgt, LLP*, 481 Mich 419, 425; 751 NW2d 8 (2008). "Only the substantively admissible evidence actually proffered may be considered." *1300 LaFayette East Coop, Inc v Savoy*, 284 Mich App 522, 525; 773 NW2d 57 (2009) (quotation marks and citation omitted). "Circumstantial evidence can be sufficient to establish a genuine issue of material fact, but mere conjecture or speculation is insufficient." *McNeill-Marks v Midmichigan Med Ctr-Gratiot*, 316 Mich App 1, 16; 891 NW2d 528 (2016). "This Court is liberal in finding genuine issues of material fact." *Jimkoski v Shupe*, 282 Mich App 1, 5; 763 NW2d 1 (2008).

The moving party has the initial burden of supporting its claim with documentary evidence, but once the moving party has met this burden the burden then shifts to the nonmoving party to establish that a genuine issue of material fact exists. *AFSCME v Detroit*, 267 Mich App 255, 261; 704 NW2d 712 (2005). Additionally, if the moving party asserts that the nonmovant lacks evidence to support an essential element of one of his or her claims, the burden shifts to the nonmovant to present such evidence. *Lowrey v LMPS & LMPJ, Inc*, 500 Mich 1, 7; 890 NW2d 344 (2016). Furthermore, "questions involving the proper interpretation of a contract or the legal effect of a contractual clause are also reviewed de novo." *Rory v Continental Ins Co*, 473 Mich 457, 464; 703 NW2d 23 (2005).

III. ANALYSIS

A. PRELIMINARY ISSUES

Union plaintiffs assert that the trial court erred by failing to hold an evidentiary hearing prior to granting summary disposition to defendant, but in this Court, plaintiffs failed to make any argument regarding how the trial court erred by failing to hold such a hearing. "An appellant may not merely announce a position then leave it to this Court to discover and rationalize the basis for the appellant's claims; nor may an appellant give an issue only cursory treatment with little or no citation of authority." *Cheesman v Williams*, 311 Mich App 147, 161; 874 NW2d 385 (2015). Because this state's courts do not serve as the research assistants of the litigants before them, *Walters*, 481 Mich at 388, "[t]his Court will not search for authority to sustain or reject a party's position," *Phillips v Deihm*, 213 Mich App 389, 401; 541 NW2d 566 (1995). "If a party fails to adequately brief a position, or support a claim with authority, it is abandoned." *MOSES, Inc v SEMCOG*, 270 Mich App 401, 417; 716 NW2d 278 (2006). Thus, the argument is abandoned.

B. THE CBAS

"In ascertaining the meaning of a contract, we give the words used in the contract their plain and ordinary meaning that would be apparent to a reader of the instrument." *Rory*, 473 Mich at 464. "A dictionary may be consulted to ascertain the plain and ordinary meaning of words or phrases used in the contract." *Auto Owners Ins Co v Seils*, 310 Mich App 132, 145; 871 NW2d 530 (2015). "[C]ontracts must be read as a whole," *Kyocera Corp v Hemlock Semiconductor, LLC*, 313 Mich App 437, 447; 886 NW2d 445 (2015), giving "effect to every word, phrase, and clause," while taking pains to "avoid an interpretation that would render any part of the contract surplusage or nugatory," *Klapp v United Ins Group Agency, Inc*, 468 Mich 459, 468; 663 NW2d 447 (2003). Accordingly, "[t]he construction or interpretation of written contracts consists in ascertaining the meaning of the parties, as expressed in the terms of the writing, according to the rules of grammar." *Pendill v Maas*, 97 Mich 215, 218; 56 NW 597 (1893).

"A fundamental tenet of our jurisprudence is that unambiguous contracts are not open to judicial construction and must be enforced as written." *Rory*, 473 Mich at 468. Contracts are enforced "according to their unambiguous terms because doing so respects the freedom of individuals freely to arrange their affairs via contract." *Id.* "However, if the contractual language is ambiguous, extrinsic evidence can be presented to determine the intent of the parties." *In re Smith Trust*, 480 Mich 19, 24; 745 NW2d 754 (2008).

A "contract is ambiguous when its provisions are capable of conflicting interpretations. Accordingly, if two provisions of the same contract irreconcilably conflict with each other, the language of the contract is ambiguous." *Klapp*, 468 Mich at 467 (citation and quotation marks omitted). Furthermore, "courts cannot simply ignore portions of a contract in order to avoid a finding of ambiguity or in order to declare an ambiguity. Instead, contracts must be construed so as to give effect to every word or phrase as far as practicable." *Id*. (citation and quotation marks omitted). "[A]mbiguity is a finding of last resort" that "is to be reached only after all other conventional means of interpretation have been applied and found wanting." *Kendzierski v Macomb Co*, 503 Mich 296, 311; 931 NW2d 604 (2019) (citations and quotation marks omitted). Accordingly, this Court "will not create ambiguity where the terms of the contract are clear." *Id*. (citation and quotation marks omitted).

Unambiguous contracts should be enforced as written because "doing so respects the freedom of individuals freely to arrange their affairs via contract." *Rory*, 473 Mich at 468. Furthermore, "[w]hen a court abrogates unambiguous contractual provisions based on its own independent assessment of 'reasonableness,' the court undermines the parties' freedom of contract." *Id*. at 468-469. Permitting a court to make its own determination of reasonableness and to rewrite a contract accordingly, even when it is unambiguous "is contrary to the bedrock principle of American contract law that parties are free to contract as they see fit, and the courts are to enforce the agreement as written absent some highly unusual circumstance, such as a contract in violation of law or public policy." *Kendzierski*, 503 Mich at 312 (citation and quotation marks omitted).

When a contract is ambiguous, the ambiguity "may either be patent or latent." *Shay v Aldrich*, 487 Mich 648, 667; 790 NW2d 629 (2010). Patent ambiguities appear "from the face of

the document." *Id.* Accordingly, "extrinsic evidence may not be used to identify a patent ambiguity." *Id*. Latent ambiguities, however, do "not readily appear in the language of a document, but instead arise[] from a collateral matter when the document's terms are applied or executed." *Id*. at 668. "A latent ambiguity exists when the language in a contract appears to be clear and intelligible and suggests a single meaning, but other facts create the necessity for interpretation or a choice among two or more possible meanings." *Id*. (citation and quotation marks omitted). Courts should consider extrinsic evidence to determine whether a contract is latently ambiguous. *Id*. "[I]f a contract is ambiguous, then extrinsic evidence is admissible to determine the actual intent of the parties." *Id*. at 667 (citation and quotation marks omitted). Finally, "[w]here the contract language is unclear or susceptible to multiple meanings, interpretation becomes a question of fact." *Port Huron Ed Ass'n, MEA/NEA v Port Huron Area Sch Dist*, 452 Mich 309, 323; 550 NW2d 228 (1996).

1. THE 1996 AND 1999 CBAS

The 1996 and 1999 CBAs stated that union plaintiffs would be "provided with fully paid Blue Cross/Blue Shield, dental and optical benefits" after retirement. On its face, this statement is not ambiguous because it states that union plaintiffs will receive Blue Cross/Blue Shield health insurance, paid for by defendant, after retirement. When actually implemented, however, this provision of the 1996 and 1999 CBAs becomes ambiguous because the specific health insurance coverage to which union plaintiffs were entitled is unclear. See *Klapp*, 468 Mich at 467. Because the actual terms of this provision of the 1996 and 1999 CBAs are clear, this ambiguity is latent and not patent.

Union plaintiffs argue that the "fully paid Blue Cross/Blue Shield" health insurance promised to union plaintiffs referred to the Traditional Blue Cross/Blue Shield health insurance plan. The 1996 and 1999 CBAs, however, did not specify that union plaintiffs were entitled to Traditional Blue Cross/Blue Shield health insurance. Rather, the 1996 and 1999 CBAs only stated that union plaintiffs were entitled to "fully paid Blue Cross/Blue Shield" health insurance. Accordingly, defendant was required to provide union plaintiffs with Traditional Blue Cross/Blue Shield health insurance only if that was the only health insurance offered by Blue Cross/Blue Shield at the time of contracting, because in that circumstance "fully paid Blue Cross/Blue Shield" health insurance would necessarily have referred to Traditional Blue Cross/Blue Shield health insurance.

Union plaintiffs argue that when the 1996 and 1999 CBAs were executed, Blue Cross/Blue Shield only offered Traditional Blue Cross/Blue Shield health insurance. Defendant disagrees. Raymond Knott testified, in his deposition, that the only health insurance policy Genesee County had as an option in the 1990s through Blue Cross/Blue Shield was Traditional Blue Cross/Blue Shield.[5] Knott additionally testified, however, that in the 1970s and 1980s Blue Cross/Blue Shield had "basically one" health insurance policy: Traditional Blue Cross/Blue

[5] Genesee County "was the administrator" of defendant's health insurance policies until about 2003.

Shield. This statement implied that Blue Cross/Blue Shield offered multiple health insurance plans in the 1970s and 1980s. Furthermore, the 1996 and 1999 CBAs listed multiple health insurance policies from Blue Cross/Blue Shield that employees could choose from such as Blue Cross/Blue Shield of Michigan Preferred Provider Organization and Traditional Blue Cross/Blue Shield. Consequently, reasonable minds cannot differ as to whether Blue Cross/Blue Shield offered only Traditional Blue Cross/Blue Shield policies in 1996 and 1999, because the 1996 and 1999 CBAs clearly show that Blue Cross/Blue Shield offered multiple health insurance plans at those times.

Because the record shows that Blue Cross/Blue Shield offered multiple health insurance policies in 1996 and 1999, the 1996 and 1999 CBAs cannot be read as necessarily meaning that "fully paid Blue Cross/Blue Shield" health insurance could only have meant Traditional Blue Cross/Blue Shield health insurance; rather, the plain language of the 1996 and 1999 CBAs only entitled union plaintiffs to some type of "fully paid Blue Cross/Blue Shield" health insurance. Thus, defendant would have fulfilled its obligations to union plaintiffs under the 1996 and 1999 CBAs so long as it provided union plaintiffs with *any* type of fully paid Blue Cross/Blue Shield health insurance policy.

In 2007, defendant's then-current employees chose to no longer select Blue Cross/Blue Shield health insurance. As a result, Blue Cross/Blue Shield discontinued offering any health insurance to union plaintiffs unless those employees were over 65 years old and enrolled in Medicare. Rather, beginning in 2007, Blue Cross/Blue Shield offered only complementary Medicare health insurance to defendant's retirees if the retirees were both over 65 years old and enrolled in Medicare; if those conditions were met, defendant would fully pay for such policies. Thus, as to those union plaintiffs over 65 years old and enrolled in Medicare, defendant has not breached the 1996 and 1999 CBAs because defendant provided those individuals with fully paid Blue Cross/Blue Shield health insurance policies (albeit not Traditional Blue Cross/Blue Shield policies). For those union plaintiffs under 65 years old and not enrolled in Medicare, however, Blue Cross/Blue Shield refused to provide health insurance as a matter of business because an insufficient number of defendant's current employees chose Blue Cross/Blue Shield health insurance. Thus, for those union plaintiffs covered by the 1996 and 1999 CBAs and who were under 65 years old, Nancy Kreger-Aills (Kreger-Aills), John Howell (Howell), and Dawn Shurter (Shurter), it is beyond defendant's capacity to provide them with Blue Cross/Blue Shield health insurance, even though the CBAs contractually obligated defendant to do so.[6]

Defendant argues that because it became impossible for it to provide Kreger-Aills, Howell, and Shurter with any type of Blue Cross/Blue Shield health insurance (due to Blue Cross/Blue Shield's business decisions), defendant did not breach the 1996 and 1999 CBAs. "A promisor's liability may be extinguished in the event his or her contractual promise becomes objectively impossible to perform." *Roberts v Farmers Ins Exch*, 275 Mich App 58, 73; 737 NW2d 332 (2007). Impossibility, however, is only an effective defense to a breach of contract

[6] As addressed in note 3, Kreger-Aills, Howell, and Shurter were all under 65 years old on February 1, 2017.

claim if the supervening event making it impossible for the promisor to preform was not reasonably foreseeable. *Id*. at 74. Changes in the health insurance industry, however, were reasonably foreseeable in 1996 and 1999, when the 1996 and 1999 CBAs were executed. In fact, the 1996 and 1999 CBAs stated that the health insurance offered to current employees was only "offered subject to continued availability through each carrier."[7] Accordingly, defendant, Teamsters, and AFSCME reasonably foresaw that the health insurance available to defendant's employees could change and, therefore, it also was reasonably foreseeable that the health insurance available to retirees could change; consequently, defendant breached the 1996 and 1999 CBAs as to Kreger-Aills, Howell, and Shurter when it failed to provide them with any type of Blue Cross/Blue Shield health insurance.

Defendant additionally argues that it did not breach the 1996 and 1999 CBAs because it provided Kreger-Aills, Howell, and Shurter with comparable health insurance. Defendant's argument is unpersuasive. The 1996 and 1999 CBAs specifically required defendant to provide union plaintiffs covered by the 1996 and 1999 CBAs with Blue Cross/Blue Shield health insurance. The rule of reasonable expectations, establishing that a contract is not breached as long as a party's reasonable expectations have been met, is not recognized in Michigan. See *Wilkie v Auto-Owners Ins Co*, 469 Mich 41, 62-63; 664 NW2d 776 (2003) (discussing the rule of reasonable expectations and holding that "the rule of reasonable expectations has no application in Michigan, and those cases that recognized this doctrine are to that extent overruled."). Furthermore, similar doctrines, such as the doctrine of substantial performance, are not full defenses to breach of contract claims. See *Antonoff v Basso*, 347 Mich 18, 32; 78 NW2d 604 (1956) (holding that even though the breaching party substantially performed under the contract it still was required to pay compensatory damages); *Black's Law Dictionary* (11th ed) (defining substantial performance as "[t]he rule that if a good-faith attempt to perform does not precisely meet the terms of an agreement or statutory requirements, the performance will still be considered complete if the essential purpose is accomplished, subject to a claim for damages for the shortfall."). Thus, defendant breached the 1996 and 1999 CBAs as to Kreger-Aills, Howell, and Shurter. Consequently, Kreger-Aills, Howell, and Shurter are entitled to a remedy.

[7] The provision in the 1996 and 1999 CBAs stating that health insurance was "offered subject to continued availability through each carrier" was only included in the section of the 1996 and 1999 CBAs addressing health insurance for current employees. The section of the 1996 and 1999 CBAs addressing health insurance for retirees, however, failed to include this limitation on health insurance coverage. Thus, based on the continued availability of Blue Cross/Blue Shield health insurance, the plain and ordinary meaning of the section of the 1996 and 1999 CBAs did not limit the health insurance offered to retirees. See *Rory*, 473 Mich at 464 ("In ascertaining the meaning of a contract, we give the words used in the contract their plain and ordinary meaning that would be apparent to a reader of the instrument.").

2. THE 2002 CBAS

The 2002 CBAs stated that defendant would provide retirees with "paid hospital/medical insurance" and provided four health insurance plan options from which retirees could choose. Specifically, the 2002 CBAs stated:

> Employees have the option of selecting hospital/medical Insurance [sic] through Health Plus [sic] Plan MN (no office copay, $5/15 drug copay until June 1, 2004, then increase to $10 office copay), BC/BS Community Blue ($10 office visit copay, $10/$20 drug copay), BC Network I ($10 office visit copay, $5/$15 drug copay), or Traditional BC/BS ($10/$20 drug copay). The Employer will pay the full premium cost for retirees who select the lowest premium coverage plan. Retirees who select the higher premium coverage plan are required to pay the difference in premiums. Said retirees shall remain on the active employee's hospital/medical benefit plan until attaining the age of sixty-five (65).

The 2002 CBAs additionally stated that after retirees turned 65 years old they were required to enroll in Medicare. After retirees enrolled in Medicare, defendant would pay the entire cost of a Blue Cross/Blue Shield complementary Medicare health insurance plan. Defendant offered Blue Cross/Blue Shield complementary Medicare health insurance to all retirees, including union plaintiffs covered by the 2002 CBAs. Thus, defendant did not breach the 2002 CBAs as to any union plaintiffs over 65 years old who were covered by the 2002 CBAs.

In 2007, defendant's current employees chose to no longer select Blue Cross/Blue Shield health insurance. As a result, Blue Cross/Blue Shield discontinued offering any health insurance to union plaintiffs unless they were both over 65 years of age and enrolled in Medicare. Thus, defendant is incapable of providing Matthew Marx (Marx) with Blue Cross/Blue Shield health insurance.[8] Whether retirees were entitled to Blue Cross/Blue Shield health insurance after 2007, however, is less clear.

The 2002 CBAs listed multiple Blue Cross/Blue Shield health insurance plans retirees could choose. The 2002 CBAs then included the following language:

> The Employer will pay the full premium cost for retirees who select the lowest premium coverage plan. Retirees who select the higher premium coverage plan are required to pay the difference in premiums. Said retirees shall remain on the active employee's hospital/medical benefit plan until attaining the age of sixty-five (65).

The first two sentences created separate classes of retirees: (1) those retirees who choose "the lowest premium coverage plan," and (2) those retirees who choose "the higher premium

[8] As discussed in note 3, Matthew Marx is the only union plaintiff covered by the 2002 CBAs less than 65 years old as of February 1, 2017.

coverage plan." The language used in the 2002 CBAs, however, contains an inherent inconsistency. The phrase "the lowest" implies at least three options, while the term "the higher" implies only two options. Under the 2002 CBAs, retirees were given the choice between four health insurance plans. Accordingly, what was meant by "the higher premium coverage plan" is unclear on its face. For example, was "the highest premium coverage plan" meant, meaning that only one health insurance plan qualifies for this distinction? Or was simply "a higher premium coverage plan" meant, meaning any health insurance plan with a premium higher than the lowest cost premium coverage plan qualifies for this distinction? We do not know, and the rules of contract interpretation have failed to provide us with an answer. Thus, the 2002 CBAs are patently ambiguous.

When a contract is ambiguous, the meaning of the contract becomes a question of fact. See *Port Huron Ed Ass'n*, 452 Mich at 323. Accordingly, we remand to the trial court to determine what the parties intended for the following portion of the 2002 CBAs:

> The Employer will pay the full premium cost for retirees who select the lowest premium coverage plan. Retirees who select the higher premium coverage plan are required to pay the difference in premiums.

The trial court may rely on extrinsic evidence to interpret this portion of the 2002 CBAs. See *Shay*, 487 Mich 667. Our finding that this portion of the 2002 CBAs is patently ambiguous, however, should not be taken as an indication that any other portions of the 2002 CBAs are either patently or latently ambiguous. In fact, the remainder of the 2002 CBAs are unambiguous.

Specifically, by stating that "said retirees" would remain on the current employees' health insurance plan, the phrase "said retirees" seemingly refers only to those retirees who selected "the higher premium coverage plan" because that was the class of retirees addressed in the immediately preceding sentence. See *Sun Valley Foods Co v Ward*, 460 Mich 230, 237; 596 NW2d 119 (1999) ("It is a general rule of grammar . . . that a modifying word or clause is confined solely to the last antecedent, unless a contrary intention appears."); *Garner's Modern American Usage* (3rd ed) (stating that "said" is often used as a synonym for "the, this, that, these, or those") (emphasis omitted). Accordingly, after considering the extrinsic evidence in this case, if the trial court should conclude that if Marx falls into the category of retirees who selected "the lowest premium coverage plan" he is entitled to Blue Cross/Blue Shield health insurance. In contrast, if Marx falls into the category of retirees who selected "the higher premium coverage plan" then he is one of "said retirees." Consequently, Marx would only be entitled to the health insurance plans defendant offers its current employees.

Defendant, therefore, might not have breached the 2002 CBAs at all. As discussed earlier, defendant did not breach the 2002 CBAs as to union plaintiffs older than 65 years old. Defendant also did not breach the 2002 CBAs if the trial court concludes that Marx is one of "said retirees" who selected "the higher premium coverage plan." If, however, the trial court concludes that Marx falls into the category of retirees who selected "the lowest premium coverage plan" he is entitled to Blue Cross/Blue Shield health insurance. As discussed earlier, however, defendant is unable, because of decisions made by Blue Cross/Blue Shield, to provide any Blue Cross/Blue Shield policy to any of its retirees unless they are enrolled in Medicare (i.e., at age 65). Furthermore, as discussed earlier, because a change in the health care industry was

foreseeable, impossibility is not an effective defense for defendant in this case. Thus, Marx only is entitled to a remedy if he falls into the category of retirees who selected "the lowest premium coverage plan."

C. REMEDIES

As addressed earlier, Kreger-Aills, Howell, Shurter, and possibly Marx are entitled to a remedy because defendant breached the CBAs by failing to provide them with Blue Cross/Blue Shield health insurance. Defendant argues that, despite any potential breach of the CBAs, the trial court's grant of summary disposition to it should be affirmed because union plaintiffs conceded that they could not prove any damages. According to defendant, union plaintiffs could not fulfill all the elements of a breach of contract action: "(1) that there was a contract, (2) that the other party breached the contract, and (3) that the party asserting breach of contract suffered damages as a result of the breach." *Doe v Henry Ford Health Sys*, 308 Mich App 592, 601-602; 865 NW2d 915 (2014).

The trial court entered a consent order bifurcating the issues of liability and damages. Under the bifurcation order, the issue of liability was to be determined before the issue of damages. We are unaware of any subsequent order rescinding or otherwise altering the bifurcation order. Union plaintiffs, however, conceded on two separate occasions subsequent to the entry of the bifurcation order that they could not prove any damages.[9] Additionally, union plaintiffs stated in their reply brief on appeal that they "were *only* seeking equitable relief as a result of their amended complaint."

While union plaintiffs have conceded that they cannot prove their damages with any level of certainty, they were not required to do so at the time the trial court granted summary disposition to defendant because, under the bifurcation order, the issue of damages would only be addressed after the issue of liability was decided. Furthermore, "the law infers some damage—at least nominal damage—from the breach of a contract." *4041-49 W Maple Condo Ass'n v Countrywide Home Loans, Inc*, 282 Mich App 452, 460; 768 NW2d 88 (2009); see also *Vandenberg v Slagh*, 150 Mich 225, 229; 114 NW 72 (1907) (holding that "[i]n actions for breach of contract, nominal damages are recoverable upon proof of the breach."). In order to recover "substantial damages," however, "the plaintiff must offer evidence from which the loss can be computed with reasonable certainty." *Vandenberg*, 150 Mich at 229.

> A plaintiff asserting a cause of action has the burden of proving damages with reasonable certainty, and damages predicated on speculation and conjecture are not recoverable. Damages, however, are not speculative simply because they cannot be ascertained with mathematical precision. Although the result may only

[9] First, in their October 25, 2017 response to defendant's motion for summary disposition, union plaintiffs conceded that, given the state of the record, they could not prove what their damages were. Second, at the November 21, 2017 motion hearing, union plaintiffs again conceded that they could not prove any damages.

> be an approximation, it is sufficient if a reasonable basis for computation exists. Moreover, the law will not demand that a plaintiff show a higher degree of certainty than the nature of the case permits. Thus, when the nature of a case permits only an estimation of damages or a part of the damages with certainty, it is proper to place before the jury all the facts and circumstances which have a tendency to show their probable amount. Furthermore, the certainty requirement is relaxed where damages have been established but the amount of damages remains an open question. Questions regarding what damages may be reasonably anticipated are issues better left to the trier of fact. [*Health Call of Detroit v Atrium Home & Health Care Servs, Inc*, 268 Mich App 83, 96-97; 706 NW2d 843 (2005) (citations and quotation marks omitted).]

Finally, "[a]lthough breach-of-contract damages need not be precisely established, uncertainty as to the fact of the amount of damage caused by the breach of contract is fatal[.]" *Van Buren Charter Twp v Visteon Corp*, 319 Mich App 538, 551; 904 NW2d 192 (2017) (citation and quotation marks omitted; alteration in original).

Kreger-Aills, Howell, Shurter, and possibly Marx have established that defendant breached the CBAs. Accordingly, they are entitled to at least nominal damages. See *4041-49 W Maple Condo Ass'n*, 282 Mich App at 460. Additionally, those plaintiffs need not prove their damages with absolute mathematical precision. See *Health Call of Detroit*, 268 Mich App at 96-97. Rather, Kreger-Aills, Howell, Shurter, and possibly Marx may prove their damages by an estimation based on the facts available in this case. See *id*. Furthermore, the trial court's bifurcation order was not rescinded or otherwise altered. While the parties may have forgotten about this order, possible or actual oversight does not change the fact that it appears to still be in effect. Additionally, the trial court did not reach the issue of damages when it granted summary disposition to defendant, and we decline to address the damages issue in the first instance. Thus, because defendant breached the CBAs as to Kreger-Aills, Howell, Shurter, and possibly Marx, we remand to the trial court for a determination of the damages as to those plaintiffs, and for it to decide in the first instance whether, and how, the various concessions affect the issue.

Finally, union plaintiffs sought an equitable remedy in this case. The powers of equity, however, cannot fashion a remedy for union plaintiffs. Equitable remedies have "traditionally been reserved for 'unusual circumstances' such as fraud or mutual mistake." *Devillers v Auto Club Ins Ass'n*, 473 Mich 562, 590; 702 NW2d 539 (2005). Even when the other prerequisites to equitable relief are satisfied, however, injunctions can only be ordered against parties or their agents. See MCR 3.310(C)(4) (stating that injunctions and restraining orders are "binding only on the parties to the action, their officers, agents, servants, employees, and attorneys, and on those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise"). Accordingly, Blue Cross/Blue Shield is not subject to equitable relief in this case because it is not a party to the case. Furthermore, Kreger-Aills, Howell, Shurter, and possibly Marx have not requested any specific equitable remedy. Accordingly, because this state's courts do not serve as the research assistants of the litigants before them, *Walters*, 481 Mich at 388, we decline to fashion any other potential equitable remedy for Kreger-Aills, Howell, Shurter, and possibly Marx. Our decision to refrain from awarding an equitable remedy at this time does not prohibit the trial court from doing so in the future.

IV. CONCLUSION

Defendant breached the CBAs as to Kreger-Aills, Howell, Shurter, and possibly Marx, but it did not breach the CBAs as to union plaintiffs who are older than 65. Accordingly, Kreger-Aills, Howell, Shurter, and possibly Marx are entitled, at a minimum, to nominal damages. We remand to the trial court for a determination of damages in light of all the circumstances, including the various concessions. Finally, union plaintiffs' argument that the trial court should have held an evidentiary hearing before granting summary disposition to defendant is abandoned.

Affirmed in part, reversed in part, and remanded for further proceedings. We do not retain jurisdiction.

/s/ Jonathan Tukel
/s/ David H. Sawyer
/s/ Michael J. Riordan