$200,000 Total Settlement for Motor Vehicle Accident

In February 2018 Plaintiff 1 was a passenger in a motor vehicle operated by her husband, Plaintiff 2 which was fully stopped in traffic when the Defendant negligently failed to maintain proper observations, failed to maintain reasonably following distance, and/or otherwise failed to take evasive action when he struck Plaintiffs' fully stopped vehicle in the rear at an excessive rate of speed without warning. As contained on the business record of the police report the defendant admitted to responding Police Officer that he attempted to slow down for traffic stopped ahead of him and change into the left lane, but he was unable to stop in time and struck the rear of Plaintiffs' vehicle. The force of the impact was so great that Plaintiffs' vehicle sustained property damage in excess of $4450.

With regard to Plaintiff 1:

Plaintiff 1 initially did not present to the hospital because she was under the mistaken impression that she was merely suffering from some soreness that it would resolve on its own. The next day, she presented to the hospital and complained of severe neck pain radiating down both arms. Physical exam revealed pain throughout her neck and back. She was diagnosed with a neck strain of muscle, fascia, and tendon. She was given pain medication, and discharged with instruction to follow up with an orthopedic specialist. In March 2018, she presented to the chiropractor and in response to her complaints of neck pain radiating down her arms bilaterally with associated numbness and tingling accompanied by severe headaches, she commenced a course of conservative treatment consisting of chiropractic care, physical therapy, and acupuncture therapy. During the course of her treatment she was recommended diagnostic testing. The cervical spine x-ray test revealed straightening of the lordotic curve due to muscle spasm. In May 2018, she underwent an MRI to her cervical spine MRI which revealed a considerable-sized central and right-sided disc herniation at C5-C6 impressing upon the right anterior margin of the dural sleeve as well as upon the right anterior aspect of the cervical cord with significant encroachment upon the exiting right-sided C6 nerve root sleeve and right-sided foraminal narrowing. During the course of her treatment, she also underwent an upper extremity EMG/NCV test which revealed positive findings for right C6 radiculopathy. Given the severe nature of

her injuries and their failure to respond to physical modalities, she consulted a pain management specialist. Based on physical exam, it was confirmed that Plaintiff 1 has a 25% loss in range of motion to her cervical spine as well as tenderness upon palpation at C5-C6 and C6-C7. She was recommended a transforaminal epidural steroid injection at C6-C7. She concluded her chiropractic care and physical therapy in October 2018.

In November 2018, Plaintiff 1 underwent the following surgery: C5-C6 interbody Arthrodesis and diskectomy with decompression of spinal cord and nerve root; C6 corpectomy with decompression of spinal cord; Anterior instrumentation; Placement of C5-C6 intervertebral PEEK cage; Application of cranial tongs; Fluoroscopic guidance for localization; Bone marrow harvesting for transplantation; Reconstruction of ilium; Harvesting of right morselized anterior iliac crest autograft; Harvesting of right structural anterior iliac crest autograft; Harvesting of local bone autograft; Placement of Actifuse; Use of microscope for microdissection and the corpectomy; Placement of right iliac crest On-Q local anesthetic catheter.

At this time Plaintiff 1 is being seen post-operatively. No further treatment has been recommended.

With regard to Plaintiff 2:

Plaintiff 2 initially did not present to the hospital because he was under the mistaken impression that he was merely suffering from some soreness that would resolve on its own. When his pain began to increase in terms of frequency and intensity, he immediately sought medical attention. Specifically, his lower back into his lower extremities with associated numbness and tingling in addition to left shoulder pain with loss in range of motion. In response to those complaints, he was recommended and commenced a conservative course of treatment consisting of chiropractic case and physical therapy. In July 2018, he underwent MRI tests to his lumbar spine which revealed the following: (1) central disc herniation at L4-L5 with extruded fragments extending inferior to the disc space with associated compressive deformity of the dural sac in addition to spinal canal stenosis; and (2) central disc herniation at L5-S1 with large disc fragment extending posterior and inferior to the disc space with associated compression of the dural sac and spinal canal stenosis. Based on these findings, during the course of his treatment he was referred to a pain management doctor and based on his

complaints and examination, he was recommended a lumbar epidural steroid injection at L5-S1. In addition to the foregoing, in connection to his left shoulder injuries he was referred to an orthopedic surgeon which he consulted in June 2018 and was recommended a left shoulder MRI which revealed diffuse tendinopathy of the distal rotator cuff tendon and a partial thickness tear of the supraspinatus tendon along the bursal surface distally. He returned to the orthopedic surgeon in July 2018 and underwent a left shoulder subacromial cortisone steroid injection. His chiropractic care and physical therapy concluded in October 2018. He thereafter consulted a neurosurgeon in November 2018 and was recommended surgery.

In January 2019, Plaintiff underwent Left L4 hemilaminectomy, facetectomy and foraminotomy with decompression of the nerve roots; Left L5 hemilaminectomy, facetectomy and foraminotomy with decompression of the nerve roots; Left S1 lateral recess decompression and foraminotomy with decompression of the nerve root; Open L4-L5 diskectomy; Open L5-S1 diskectomy; Harvesting of fat grafts; Use of microscope for microdissection; Fluoroscopic guidance for localization; and Placement of left On-Q local anesthetic catheter.

At this time Plaintiff, Ivan Marrero is being seen post-operatively. No further treatment has been recommended.

The case settled as to Plaintiff 1 for the $100,000.00 policy limit and to Plaintiff 2 for $100,000.00. As such the case settled for a total amount of $200,000.00, prior to the scheduling of a trial.