No. 24-

IN THE

Supreme Court of the United States

KIMBERLY K. SISIA,

Petitioner,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Did the June 6, 2024, decision of the Eleventh Circuit fail to comply with the rule that a federal court, in a case in which jurisdiction is founded upon diversity of citizenship, is required to apply the substantive law of the state in which the action arose?

2. Does the decision of the Eleventh Circuit panel impermissibly allow State Farm to deny medical payments coverage, not only to Petitioner, but to perhaps thousands of other State Farm insureds who have incurred medical expenses in an auto accident?

STATEMENT OF RELATED CASES

- *Sisia v. State Farm Mutual Automobile Insurance Company*, State Court of Cobb County, Georgia, No. 12-A-1738-2 (May 14, 2012) (Voluntarily Dismissed Feb. 10, 2021).

- *Sisia v. State Farm Mutual Automobile Insurance Company*, United States District Court for the Northern District of Georgia, Atlanta Division, No. 1:21-CV-02376-ELR, 588 F. Supp. 3d 1320 (N.D. Ga. Jan. 5, 2022).

- *Sisia v. State Farm Mutual Automobile Insurance Company*, United States Court of Appeals for the Eleventh Circuit, No. 22-12833 (April 18, 2023) (unpublished).

- *Sisia v. State Farm Mutual Automobile Insurance Company*, United States District Court for the Northern District of Georgia, Atlanta Division, No. 1-21-CV-02376-ELR (N.D. Ga. Dec. 1, 2023).

- *Sisia v. State Farm Mutual Automobile Insurance Company*, United States Court of Appeals for the Eleventh Circuit, No. 23-14201 (11th Cir. June 6, 2024) (unpublished).

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PETITION FOR WRIT OF CERTIORARI

Petitioner Kimberly K. Sisia respectfully requests the issuance of a writ of certiorari to review the June 6, 2024, judgment of the United States Court of Appeals for the Eleventh Circuit.

DECISIONS BELOW

The January 5, 2022 Order of the United States District Court for the Northern District of Georgia, which denied State Farm's motion to dismiss Petitioner's renewal complaint on the basis of res judicata and the statute of limitations, is reported at 588 F. Supp. 3d 1320 (N.D. Ga. 2022).

The April 18, 2023 opinion of the United States Court of Appeals for the Eleventh Circuit, No. 22-12833, which affirmed the dismissal of an illusory policy claim, which Petitioner never made, and which reversed the dismissal of Petitioner's medical expenses and duty of good faith claims, was not published, but can be found on Lexis, Westlaw or Casetext.

The December 1, 2023 Order of the District Court which granted the motion of State Farm to dismiss Plaintiff's Complaint with prejudice, No. 1:21-CV-02376-ELR. This opinion was not published, but is reproduced in the Appendix to this petition.

The June 6, 2024 Opinion of the Eleventh Circuit panel affirmed the District Court's December 1, 2023 Order which had granted the motion of State Farm to dismiss Petitioner's Complaint with prejudice, No. 23-14201.

That opinion is not published, but is reproduced in the Appendix, and can be found on Lexis, Westlaw or Casetext.

JURISDICTION

The Eleventh Circuit entered judgment on June 6, 2024. *See* Pet. App. 1a. A petition for rehearing was denied on July 25, 2024, which extended the time in which to file this petition until October 23, 2024. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254 (1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

There are no constitutional provisions, statutes, ordinances or regulations involved in this petition.

STATEMENT OF THE CASE

"Want of mutuality is a want of justice." *Dutilh v. Gathiff*, 4 U.S. 446, 450 (1806).

THE MEDICAL PAYMENTS PROVISION AT ISSUE

This case began as a civil action to recover medical expenses incurred by the Petitioner for treatment of injuries sustained in an auto accident. This petition is addressed to the proper construction to be given the optional medical payments insurance provision found in the State Farm automobile insurance policy which insured Petitioner. That provision states:

> We will pay reasonable medical expenses incurred for bodily injury caused by accident

> for services furnished within three years of the date of the accident. These expenses are for necessary medical, surgical, x-ray, dental, ambulance, hospital, professional nursing and funeral services, eyeglasses, hearing aids, and prosthetic devices. Doc. 60, p.10.

Medical payments insurance is an optional form of insurance coverage for which a separate premium is paid. In May, 2009, Petitioner was involved in a rear end collision auto accident, and incurred medical expenses for chiropractic and physical therapy care in the approximate amount of $8,000.00. State Farm paid about $1,250.00 of those expenses, but then declined to pay any remaining expenses incurred on the basis that the expenses were not "reasonable medical expenses" incurred for "necessary medical" or other covered care. Doc. 1, ¶ 21.

THE RULING SOUGHT TO BE REVIEWED

The District Court granted State Farm's motion to dismiss for failure to state a claim, finding that "the policy terms are plain and unambiguous; they require Defendant to pay for 'reasonable' and 'necessary' medical expenses and also grant Defendant the authority to determine which expenses qualify as such through its 'right to make or obtain utilization review[s].'" Doc. 60, p. 14. The Eleventh Circuit panel affirmed the District Court's order, finding that "the policy explicitly contemplates the possibility that State Farm will not pay for medical expenses that it deems unreasonable or unnecessary. Sisia's reading would impermissibly render those parts of the policy meaningless." *Sisia v. State Farm Mutual Auto Ins. Co.*, No. 23-14201 (11th Cir. June 6, 2024) (Doc.

67, p. 3). Petitioner argues, conversely, that the panel's opinion renders the medical payments section of the State Farm auto insurance policy unenforceable, in derogation of well established principles of contract construction, and specifically in contravention of the Georgia Court of Appeal's unanimous opinion in *Travelers Indemnity Co. v. Watson*, 111 Ga. App. 98, 140 S.E.2d 505 (1965).

The medical payments section of the State Farm auto insurance policy contains what is described as a "utilization review" procedure, with an avowed purpose to help the decision maker, whomever that may be, determine whether any medical expenses incurred by an insured from an auto accident are "reasonable" for "necessary" medical or other covered care? Doc. 60, p. 10. The utilization review procedure reads to be optional at State Farm's election. It was not used by State Farm to determine the reasonableness or necessity of any medical expenses incurred by Mrs. Sisia. As the panel's opinion acknowledged and approved, State Farm simply determined for itself what expenses incurred by Mrs. Sisia were, in its estimation, "reasonable" for "necessary" covered care, and only paid those expenses. "But the language of Sisia's insurance policy plainly does not require State Farm to reimburse all medical expenses – only those expenses that it deems 'reasonable' and 'necessary . . . ." (Doc. 67, p. 4). The State Farm policy contains no explanation, nor sets out any criteria for making those decisions. The insured has no input. There are no definitions. The medical payments provision does not designate who has the authority to make any such decisions, or explain how any such decisions are to be made.

The Eleventh Circuit panel found that "Sisia's argument (that the medical payments provision unambiguously requires State Farm to pay all of Plaintiff 's medical expenses (within the limits of her coverage)) ignores the plain text of the policy, which unambiguously states that State Farm must pay only for expenses that are 'reasonable' and 'necessary.'" (Doc. 67, p. 3). The panel explained that "the policy explicitly contemplates the possibility that State Farm will not pay for medical expenses that it deems unreasonable or unnecessary." Id. To arrive at that conclusion, the panel omitted the Georgia Court of Appeals' ruling in *Travelers Indemnity* that the insurer was liable for its insured's medical expenses "up to the limitation of liability provided." 111 Ga. App., p. 103. The panel's decision "unambiguously" means that the State Farm policy, as interpreted by the panel, is unenforceable by Mrs. Sisia or any other insured. State Farm gets paid a premium but is provided an escape from any contractual responsibility by the Eleventh Circuit panel's decision.

REASON FOR GRANTING THE WRIT

The reason for granting the writ is that if the Eleventh Circuit panel incorrectly decided the contractual effect of the State Farm medical payments provision, which State Farm drafted, then that erroneous decision allows State Farm to impermissibly deny medical payments benefits, not only to Petitioner, but to most likely thousands of other insureds who have also paid State Farm a separate premium for that coverage. The magnitude of harm engendered by the panel's opinion justifies the writ being granted.

THE PANEL'S OPINION DISREGARDS CONTROLLING PRINCIPLES OF APPLICABLE LAW

The panel's decision was in derogation of Georgia law and established principles of contract construction followed in most all states. It is fundamental jurisprudence that a federal court, exercising diversity of citizenship jurisdiction, must apply state substantive law to decide the case. "There is no federal common law." *Erie Railroad Corp. v. Tompkins*, 304 U.S. 64, 78, 58 S. Ct. 817 (1938). Under *Erie*, "in rendering a decision based on state substantive law, a federal court must decide the case in a way it appears the state's highest court would. (cases cited). Where the state's highest court has not spoken to an issue, a federal court must adhere to the decisions of the state's intermediate appellate courts absent some persuasive indication that the state's highest court would decide the issue otherwise." *Ernie Hale Ford, Inc. v. Ford Motor Company*, 260 F.3d 1285, 1290 (11th Cir. 2001), quoting *Insurance Co. of North America v. Lexow*, 937 F.2d 569, 571 (11th Cir. 1991).

In *Travelers Indemnity Co. v. Watson*, *supra*, the Georgia Court of Appeals unanimously found that an almost identical medical payments provision was "plain and unambiguous" and "unequivocally" required the insurer to pay its insured's medical expenses "up to the limitation of liability provided." 111 Ga. App., p. 103. In undertaking to distinguish *Travelers Indemnity*, the panel opined that "Sisia misconstrues the facts and holding of that case." Id. The panel then found that "the issue in [*Travelers Indemnity*] was whether the 'family automobile policy' required the insurer to pay for the

insured's wife's medical expenses?" Id. The panel found that the court in *Travelers Indemnity* "held that the policy 'unequivocally' required the insurer to pay the insured's wife's medical expenses," but then qualified that finding by stating "not that it had to pay for all expenses regardless of their reasonableness or necessity." Id., p. 3. On that distinction, one might ask, "what's the difference?" The panel declined to acknowledge that the Georgia Court of Appeals in *Travelers* had found the insurer was required to pay the wife's medical expenses "up to the limitation of liability provided." Id. So the Georgia Court of Appeals in *Travelers Indemnity* did find that the insurer had to pay all of its insured's covered medical expenses, which is the same result urged by Petitioner in this case. The panel simply omitted the complete holding in *Travelers* to accomplish its erroneous decision.

The panel's decision also fails to explain how the policy authorizes State Farm to pay any expenses. The policy does not clearly state who is to pay medical expenses, or provide any direction on how any decisions on what medical expenses are "reasonable" for "necessary" medical or other covered care are to be made. Nor does the panel's opinion comply with other rules of construction which sustain the construction provided essentially identical terms by the Georgia Court of Appeals in *Travelers Indemnity Co. v. Watson*. The interpretation of the medical payments provision by the panel, first and foremost, ignores the cardinal rule of contract construction that the court is to ascertain the intent of the parties. *Emanuel Tractor Sales v. Department of Transportation*, 257 Ga. App. 360, 364, 571 S.E.2d 150 (2002); *Franklin v. Unum Ins. Co.*, 297 Ga. App. 468, 677 S.E.2d 334 (2009). "In ascertaining that intent, the test

in not what the insurer intended its words to mean, but what a reasonable person in the position of the insured would understand the terms to mean." *Auto Owners Ins. Co. v. Aaa Disc.*, No. CV – 622-043 (S.D. Ga. 2024), citing *Giddens v. Equitable Assurance Soc. of the U.S.*, 445 F.3d 1286, 1297 (11th Cir. 2006). Any reasonable person in the position of Petitioner would read the medical payments section of the policy to require payment of the insured's actual medical expenses incurred from an auto accident. The panel's opinion disregards the complete holding in *Travelers Indemnity* to find that the medical payments section of the policy plainly and unambiguously permits State Farm to decide whether an insured's medical expenses are reasonable and necessary, and thus avoid coverage. "The policy should be read as a layman would read it and not as it might be analyzed by an insurance expert or an attorney." *Georgia Farm Bureau Mutual Ins. Co. v. Huncke*, 240 Ga. App. 580, 581, 524 S.E.2d 302 (1989). "When it is possible to do so without contravening any rule of law, the courts will construe a contract as binding on both the parties." *Sheridan v. Crown Capital Corp.*, 251 Ga. App. 314, 554 S.E.2d 296 (2001). "Except where the terms are clear and unambiguous, the law will not construe the contract so that one party has the right to destroy the contract simply in their discretion." *Emanuel Tractor Sales*, *supra*, p. 365. "The trial court must give a fair and reasonable construction to the contract that upholds the contract rather than to cause it to have no binding effect, because the intent of the parties is to enter a valid contract. . . . " *Sheridan v. Crown Capital Corp.*, *supra*, p. 316. State Farm's construction of its policy, approved by the Eleventh Circuit panel, renders the medical payments section of the policy unenforceable by the insured.

THE PANEL'S OPINION RENDERS THE MEDICAL PAYMENTS PROVISION UNENFORCEABLE

In actuality, it is the panel's opinion which renders the medical payments section of the policy meaningless for the insured. According to the panel, "the policy explicitly contemplates the possibility that State Farm will *not* pay for medical expenses that it deems unreasonable or unnecessary." Doc. 67, p. 3. Accordingly, in the panel's opinion, it is completely left to State Farm's discretion to decide whether to pay for any medical expenses incurred by its insured as a result of a car wreck. Under the panel's opinion, therefore, there is no contract because State Farm is not bound to do anything. The medical payments section of the Policy, as construed by the panel, is unenforceable under Georgia law. As in *Clayton McClendon, Inc. v. McCarthy*, 125 Ga. App. 76, 77, 185 S.E.2d 452 (1971), State Farm is only bound to perform "if in its uncontrolled judgment," the medical expenses incurred by Petitioner are "reasonable" for "necessary" medical or other covered care. The contract is thus "contingent upon the event which may or may not happen at the pleasure of [State Farm]. Until that contingency has occurred there is no obligation on the part of [State Farm to perform]." Id. The medical payments contractual provision, as construed by the panel, is thus unenforceable. "It is well settled that contracts conditioned upon discretionary contingencies lack mutuality." *Stone Mountain Properties v. Helmer*, 139 Ga. App. 865, 229 S.E.2d 779 (1976). Under the panel's construction, State Farm is the sole judge of whether a medical expense is "reasonable" or "necessary" which deprives the contractual provision of mutuality, *id*., p. 868, and renders it unenforceable.

As the panel observed, the medical payments section of the Policy plainly and unambiguously states that State Farm must pay the "reasonable" expenses incurred for "necessary" medical or other covered care. "Indeed, Georgia public policy encourages insurance coverage which assures no less than full compensation to the insured, while at the same time preventing the insured from recovering more than is necessary to make him whole." *Duncan v. Integon Gen. Ins. Corp.* 267 Ga. 646, 647, 482 S.E.2d 325 (1997). The Court of Appeal's decision in *Travelers Indemnity* correctly applied Georgia law to the facts which are the same facts as exist in this appeal. It was the Eleventh Circuit panel's erroneous construction of the medical payments section of the policy which rendered it meaningless.

CLASS CERTIFICATION

It should be clear that if State Farm incorrectly denied Petitioner's claim for medical expenses incurred in her May, 2009 auto accident, it has also incorrectly denied claims for medical expenses by each and every other State Farm insured for the same reasons. The proposed class of State Farm insureds have claims identical to the claim asserted by Petitioner. The only difference is the amount of medical expenses which were denied each class member by State Farm which, of course, can be easily calculated. The requisites for class certification are satisfied. The same conduct is challenged. *Jones v. American General Life & Accident Ins. Co.*, 213 F.R.D. 689, 695 (S.D. Ga. 2002).

Counsel has served as class counsel in other class actions which were actually tried. See *Del Rosario v. King & Prince Seafood Corp.*, No. 10-11967-cc (11th Cir. 2011).

Common questions of law and fact predominate over any questions affecting only individual members, and a class action is superior for other individual members of the class who would most likely be financially deterred from bringing their individual claims. Petitioner thus requests that this Honorable Court direct the district court to consider and grant her motion for class certification so that complete relief can be afforded.

CONCLUSION

If allowed to stand, the panel's opinion not only erroneously deprives Petitioner of reimbursement for her medical expenses she actually incurred, but provides an open invitation for State Farm to deny medical payments coverage to most likely thousands of its other insureds who are left with no say in the matter. State Farm gets to pocket the premiums paid by its many insureds but has no enforceable obligation to pay for any of its insureds' medical or other covered expenses. The Eleventh Circuit panel did not properly construe the medical payments provision at issue.

For the same reasons expressed in this petition regarding Petitioner's claim for recovery of her medical expenses, Petitioner urges that the court agree to also review her derivative claim against State Farm for breach of its covenant of good faith and fair dealing.

Mrs. Sisia respectfully requests that this Court issue a writ of certiorari.

Respectfully submitted,

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APPENDIX

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APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT, FILED JUNE 6, 2024

IN THE
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 23-14201

Non-Argument Calendar

KIMBERLY K. SISIA,

Plaintiff-Appellant,

versus

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Georgia
D.C. Docket No. 1:21-cv-02376-ELR

Before JILL PRYOR, BRANCH, and GRANT, Circuit Judges.

PER CURIAM:

Kimberly Sisia appeals the district court's dismissal with prejudice of her amended complaint against State Farm Mutual Automobile Insurance Company, as well

as the district court's denial of her motion for conditional class certification. We assume the parties are familiar with the factual and procedural details of this matter, which has been ongoing in one form or another since 2012. *See Sisia v. State Farm Mut. Auto. Ins. Co.*, No. 22-12833, 2023 U.S. App. LEXIS 9185, 2023 WL 2989832 (11th Cir. Apr. 18, 2023) (unpublished). In short, Sisia seeks reimbursement from State Farm for medical expenses allegedly incurred because of an automobile accident that occurred in 2009. She claims that her automobile insurance policy requires State Farm to pay all of her medical expenses stemming from the accident up to the policy limit. She seeks relief not just for herself, but for "all other State Farm insureds who have been denied medical payments coverage for the same reason."

We review de novo the district court's decision to dismiss a complaint for failure to state a claim. *Lisk v. Lumber One Wood Preserving, LLC*, 792 F.3d 1331, 1334 (11th Cir. 2015). We review the district court's decision to deny class certification for abuse of discretion. *Hines v. Widnall*, 334 F.3d 1253, 1255 (11th Cir. 2003).

Sisia's automobile insurance policy states that State Farm "will pay reasonable medical expenses incurred, for bodily injury caused by accident," and that "[t]hese expenses are for necessary medical, surgical, X-ray, dental, ambulance, hospital, professional nursing and funeral services, eyeglasses, hearing aids and prosthetic devices." (emphasis omitted). It further explains that

State Farm has the right to review "medical expenses and services to determine if they are reasonable and necessary for the bodily injury sustained." (emphasis omitted). Sisia argues that this policy "unequivocally requires State Farm to pay all of Plaintiff's medical expenses" incurred from her automobile accident. But Sisia's argument ignores the plain text of the policy, which unambiguously states that State Farm must pay only for expenses that are "reasonable" and "necessary." The policy explicitly contemplates the possibility that State Farm will *not* pay for medical expenses that it deems *un*reasonable or *un*necessary. Sisia's reading would impermissibly render those parts of the policy meaningless. *See Ace Am. Ins. Co. v. Wattles Co.*, 930 F.3d 1240, 1260 n.22 (11th Cir. 2019).

Sisia relies heavily on *Travelers Indemnity Company v. Watson*, an opinion from the Court of Appeals of Georgia. 111 Ga. App. 98, 140 S.E.2d 505 (Ga. Ct. App. 1965). But Sisia misconstrues the facts and holding of that case. True, the court there considered a policy that similarly covered "reasonable" and "necessary" medical expenses. *Id.* at 506. But the court did not interpret the meaning of those words in the policy. Rather, the issue in the case was whether the "family automobile policy" required the insurer to pay for injuries sustained by the insured's wife. *See id.* The court held that the policy "unequivocally" required the insurer to pay for the insured's wife's medical expenses, *not* that it had to pay for all expenses, regardless of their reasonableness or necessity. *Id.* at 508.

Because the language of Sisia's insurance policy plainly does not require State Farm to reimburse all medical expenses—only those expenses that it deems "reasonable" and "necessary"—the district court did not err in concluding that Sisia's claim for breach of contract against State Farm could not survive a motion to dismiss. Likewise, the district court did not err in dismissing her claim that State Farm breached its duty of good faith and fair dealing. Such a claim is not actionable unless the allegations of breach are specifically tied to the breach of a contract provision. *See Alan's of Atlanta, Inc. v. Minolta Corp.*, 903 F.2d 1414, 1429 (11th Cir. 1990). "There can be no breach of an implied covenant of good faith where a party to a contract has done what the provisions of the contract expressly give him the right to do." *Automatic Sprinkler Corp. of Am. v. Anderson*, 243 Ga. 867, 257 S.E.2d 283, 284 (Ga. 1979).

Finally, the district court did not err in denying Sisia's motion for class certification when it dismissed her complaint. Because her underlying claims lacked merit, it was not an abuse of discretion for the court to find her request for certification of those claims moot. *See Telfair v. First Union Mortg. Corp.*, 216 F.3d 1333, 1343 (11th Cir. 2000).

Accordingly, the well-reasoned order of the district court is **AFFIRMED**.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA, ATLANTA DIVISION, FILED DECEMBER 1, 2023

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA ATLANTA DIVISION

1:21-CV-02376-ELR

KIMBERLY K. SISIA, INDIVIDUALLY AND ON BEHALF OF OTHERS SIMILARLY SITUATED,

Plaintiff,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant.

ORDER

Presently before the Court are Defendant State Farm Mutual Automobile Insurance Company's "Motion to Dismiss Plaintiff's Amended Complaint" [Doc. 52] and Plaintiff Kimberly K. Sisia's "Renewed Motion for Conditional Class Certification." [Doc. 56]. The Court sets forth its reasoning and conclusions below.

Appendix B

I. Background[1]

This action arises from Defendant's purported breach of its insurance contract with Plaintiff (the "Policy"). *See generally* Compl. [Doc. 1]. Plaintiff submitted a claim to Defendant for medical expenses related to chiropractic treatment and physical therapy she allegedly required as a result of a May 19, 2009 car accident (the "May 2009 Accident"). *See id.* ¶¶ 4-5, 16-17. In total, Plaintiff alleges she incurred $8,048.00 in medical expenses for her injuries stemming from the May 2009 Accident. *See id.* ¶ 21; [*see also* Docs. 5-3 ¶ 8; 5-4 ¶¶ 11-13]. Defendant reviewed Plaintiff's claim and determined that certain of Plaintiff's medical expenses did not qualify as "reasonable medical expenses," as required for coverage pursuant to the Policy's medical payment coverage provision. *See* Compl. ¶¶ 5, 21. In total, Defendant paid only $1,254.00 of Plaintiff's claimed medical expenses. *See id.* ¶ 21; [*see also* Docs. 5-3 ¶ 8; 5-4 ¶¶ 11-13].

On May 14, 2012, Plaintiff filed suit in the State Court of Cobb County, Georgia ("*Sisia I*"), alleging that Defendant breached the Policy by failing to provide coverage for all of the approximately $8,000.00 in medical expenses Plaintiff incurred as a result of the May 2009 Accident. [*See* Docs. 5-3, 5-5]. In October 2013, Plaintiff amended her complaint in *Sisia I*. [*See generally* Doc. 5-4]. After several years of pretrial litigation and various state court rulings, Plaintiff voluntarily dismissed *Sisia I* without prejudice on February 10, 2021. [*See* Doc. 5-5].

1. For additional factual and procedural background, the Court refers to its Orders dated January 5, 2022; July 25, 2022; and August 16, 2023. [Docs. 25, 31, 53].

Appendix B

Several months after voluntarily dismissing *Sisia I*, Plaintiff filed the instant putative class action case in this Court alleging three (3) state law claims against Defendant, all of which stem from Defendant's refusal to pay the full amount of Plaintiff's claimed medical expenses associated with the May 2009 Accident. *See generally* Compl. Specifically, Plaintiff alleged claims for: (1) breach of contract (the Policy), (2) breach of private duty, and (3) breach of the duty of good faith and fair dealing. *Id.* The crux of Plaintiff's Complaint was that "[Defendant] took advantage of ambiguous Policy terms to deny medical payments coverage to Plaintiff" and others similarly situated. *See id.* ¶ 7. On August 9, 2021, Defendant moved to dismiss this action, and by an Order dated January 5, 2022, the Court found that Plaintiff's claims were time-barred and dismissed the Complaint without prejudice. [*See generally* Docs. 5, 5-1, 25]. Plaintiff appealed the Court's January 5, 2022 Order, and the United States Court of Appeals for the Eleventh Circuit affirmed this Court's dismissal of any claim based on an "illusory policy" theory as time-barred. *See generally Sisia v. State Farm Mut. Auto. Ins. Co.*, No. 22-12833, 2023 U.S. App. LEXIS 9185, 2023 WL 2989832 (11th Cir. Apr. 18, 2023). However, the Eleventh Circuit reversed the Court's dismissal of Plaintiff's other claims and remanded for further proceedings. *See id.* In reversing that portion of this Court's ruling, the Eleventh Circuit reasoned:

> [Plaintiff's] original and amended complaints are not models of clarity—if anything, they are models of confusion. The complaints often conflate causes of action and argument, forgo common pleading conventions, and

> haphazardly deploy legal vocabulary. Yet [Plaintiff] dismissed her medical expenses claim voluntarily. The merits of [Plaintiff's] case—whether [Defendant] owed her money under the [Policy]—were *never* adjudicated. Given the "remedial" nature of O.C.G.A. § 9-2-61(a) and its liberal construction, [Plaintiff] could thus renew her claim for medical expenses using the three theories of recovery, ["Breach of Contract," "Breach of Private Duty," and "Breach of the Duty of Good Faith and Fair Dealing"], explicitly set forth in her federal complaint.

Id. at *2 (emphasis in original). The Eleventh Circuit panel noted that "[t]he legal sufficiency of these three theories" was not the issue before it on appeal. *Id.* at n.3.

Following the Eleventh Circuit's opinion, Defendant filed a renewed motion to dismiss the original Complaint on July 11, 2023. [*See* Doc. 47]. Seventeen (17) days later, on July 28, 2023, Plaintiff filed an Amended Complaint on behalf of herself and a putative class. *See generally* Am. Compl. [Doc. 49]. Thus, the Court denied as moot Defendant's renewed motion to dismiss the original Complaint. [*See* Doc. 53]. On August 11, 2023, Defendant filed the present motion to dismiss Plaintiff's Amended Complaint, which Plaintiff opposes. [*See* Docs. 52-1, 54, 57]. Having been fully briefed, that motion is now ripe for the Court's review. The Court begins by setting forth the pertinent legal standard.

II. Legal Standard

To survive a Rule 12(b)(6) motion to dismiss, a complaint must "contain sufficient factual matter, accepted as true, 'to state a claim to relief that is plausible on its face.'" *See Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S. Ct. 1937, 173 L. Ed. 2d 868 (2009) (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007)). Put differently, a plaintiff must plead "factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *See id.* This so-called "plausibility standard" is not akin to a probability requirement; rather, the plaintiff must allege sufficient facts such that it is reasonable to expect that discovery will lead to evidence supporting the claim. *See id.*

When considering a Rule 12(b)(6) motion to dismiss, the Court must accept as true the allegations set forth in the complaint, drawing all reasonable inferences in the light most favorable to the plaintiff. *See Twombly*, 550 U.S. at 555-56; *United States v. Stricker*, 524 F. App'x 500, 505 (11th Cir. 2013) (per curiam). Even so, a complaint offering mere "labels and conclusions" or "a formulaic recitation of the elements of a cause of action" is insufficient. *See Ashcroft*, 556 U.S. at 678 (quoting *Twombly*, 550 U.S. at 555); *accord Fin. Sec. Assur., Inc. v. Stephens, Inc.*, 500 F.3d 1276, 1282-83 (11th Cir. 2007). Rather, "a pleading must contain a short and plain statement of the claim showing that the pleader is entitled to relief" so as to satisfy "the pleading requirements of Rule 8." *See Parker v. Brush Wellman, Inc.*, 377 F. Supp. 2d 1290, 1294 (N.D. Ga. 2005) (citing FED. R. CIV. P. 8(a)(2)).

III. Discussion

Plaintiff presently alleges two (2) Counts against Defendant: (1) breach of contract (the Policy) and (2) breach of the duty of good faith and fair dealing.[2] *See generally* Am. Compl. The Court first addresses Plaintiff's breach of contract claim.

A. Breach of Contract

In the Amended Complaint, Plaintiff abandons her previous theory that Defendant "took advantage of ambiguous Policy terms to deny medical payments[.]" *Compare* Compl. ¶ 7, *with* Am. Compl. Instead, Plaintiff now alleges that the Policy terms at issue regarding medical payments are "plain and unambiguous" and therefore "unequivocally require [Defendant] to pay *all* the medical expenses incurred by its insureds up to the limitation of liability provided for each insured." *See* Am. Compl. ¶ 25 (emphasis added); [*see also* Doc. 54 at 2] ("Other than to correct the legal issue that the terms of the medical payments section of the Policy are plain and unambiguous, Plaintiff's Amended Complaint contains exactly the same allegations as the allegations in her original [C]omplaint."). Specifically, as to breach of contract, Plaintiff alleges, in full:

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2. In the Amended Complaint, Plaintiff initially alleged a third claim for "breach of private duty," but in her response brief in opposition to Defendant's instant motion to dismiss, she withdrew that claim as duplicative. [*See* Doc. 54 at 14] ("As Plaintiff['s] claim[] for breach of private duty mirrors her claim for breach of contract, Plaintiff withdraws that claim."); *see generally* Am. Compl. Accordingly, the Court does not further discuss it.

> [Defendant] breached the plain and unambiguous terms of the Policy by denying or limiting medical payments claims by its insured based upon its subjective, self-serving determinations that such claims were not, "reasonable medical expense[s] incurred for bodily injury caused by accident" . . . for "necessary medical, surgical" or other covered services or devices incurred as a result of bodily injury caused by an accident.
>
> Defendant is liable to Plaintiff and each member of the [putative] class for the amount of medical expenses that have been denied each of them on the basis that their otherwise covered medical expenses were not "reasonable medical expenses" for "necessary medical, surgical" or other covered services, plus legal interest from the dates each insured's claim was denied.

Id. ¶¶ 36-37. In its motion to dismiss, Defendant conversely argues that "[n]othing in the Policy or Georgia law[] requires [Defendant] to pay the entirety of Plaintiff's allegedly incurred medical expenses, because the Policy only requires payment of 'reasonable' and 'necessary' medical expenses." [Doc. 52-1 at 11].

Under Georgia law, insurance contracts "are interpreted by ordinary rules of contract construction."[3] *Boardman Petrol., Inc. v. Federated Mut. Ins. Co.*, 269 Ga. 326, 498 S.E.2d 492, 494 (Ga. 1998). The "[c]onstruction

3. The Parties agree that Georgia law governs the Policy. *See generally* Am. Compl.; [Doc. 52-1].

and interpretation of an insurance contract are matters of law for the court." *Landmark Am. Ins. Co. v. Khan*, 307 Ga. App. 609, 705 S.E.2d 707, 710 (Ga. Ct. App. 2011) (internal punctuation and citation omitted). "The cardinal rule of contractual construction is to ascertain the intent of the parties." *Knott v. Knott*, 277 Ga. 380, 589 S.E.2d 99, 101 (Ga. 2003) (citing O.C.G.A. § 13-2-3). Georgia law requires that courts interpret contracts pursuant to the following process:

> First, the trial court must decide whether the language is clear and unambiguous. If it is, the court simply enforces the contract according to its clear terms; the contract alone is looked to for its meaning. Next, if the contract is ambiguous in some respect, the court must apply the rules of contract construction to resolve the ambiguity. Finally, if the ambiguity remains after applying the rules of construction, the issue of what the ambiguous language means and what the parties intended must be resolved by a jury.

City of Baldwin v. Woodard & Curran, Inc., 293 Ga. 19, 743 S.E.2d 381, 389 (Ga. 2013) (internal citation omitted).

An insurance contract is considered ambiguous "only if its terms are subject to more than one reasonable interpretation." *State Farm Mut. Auto. Ins. Co. v. Staton*, 286 Ga. 23, 685 S.E.2d 263, 265 (Ga. 2009). "Any ambiguities in the contract are strictly construed against the insurer as drafter of the document; . . . insurance

contracts are to be read in accordance with the reasonable expectations of the insured where possible." *Boardman Petrol., Inc.*, 498 S.E.2d at 494. In contrast, "[w]here the terms are clear and unambiguous, and capable of only one reasonable interpretation, the court is to look to the contract alone to ascertain the parties' intent." *Id.* "The contract is to be considered as a whole and each provision is to be given effect and interpreted so as to harmonize with the others." *Id.*; *see also* O.C.G.A. § 13-2-2 ("[T]he whole contract should be looked to in arriving at the construction of any part."). Unambiguous terms "must be given effect, even if 'beneficial to the insurer and detrimental to the insured.'" *Jefferson Ins. Co. of N.Y. v. Dunn*, 269 Ga. 213, 496 S.E.2d 696, 699 (Ga. 1998) (quoting *Woodmen of World Life Ins. Soc. v. Etheridge*, 223 Ga. 231, 154 S.E.2d 369, 372 (Ga. 1967)). "The 'natural, obvious meaning' of a term 'is to be preferred over any curious, hidden meaning which nothing but the exigency of a hard case' would suggest." *Henry's La. Grill, Inc. v. Allied Ins. Co. of Am.*, 35 F.4th 1318, 1320 (11th Cir. 2022) (quoting *Payne v. Middlesex Ins. Co.*, 259 Ga. App. 867, 578 S.E.2d 470, 472 (Ga. Ct. App. 2003)). Courts applying Georgia law "will not strain to extend coverage where none was contracted or intended." *Id.*; *see also Staton*, 685 S.E.2d at 266-67 ("[T]his court may not strain the construction of the policy so as to discover an ambiguity. . . . [T]he rule of liberal construction of an insurance policy cannot be used to create an ambiguity where none, in fact, exists." (internal citation omitted)).

As noted, the Parties here do not dispute that the relevant terms of the Policy are plain and unambiguous.

See Am. Compl. at 1 (Plaintiff stating that "under the rules of contract construction governing this action, the medical payments section of [the Policy] at issue is plain and unambiguous"); [Doc. 52-1 at 16] (Defendant stating "there is no question the Policy is unambiguous"). However, because the Parties argue that different results should flow from the Policy's "plain and unambiguous" language, "a thorough analysis of the relevant provisions is required here." *See Henry's La. Grill, Inc. v. Allied Ins. Co. of Am.*, 495 F. Supp. 3d 1289, 1292 (N.D. Ga. 2020), *aff'd*, 35 F.4th 1318 (11th Cir. 2022). Thus, the Court sets forth the disputed Policy provisions in full below.[4]

> We will pay reasonable medical expenses incurred for bodily injury caused by accident, for services furnished within three years of the date of the accident. These expenses are for necessary medical, surgical, X- ray, dental, ambulance, hospital, professional nursing and funeral services, eyeglasses, hearing aids, and prosthetic devices.
>
> REASONABLE MEDICAL EXPENSES DO NOT INCLUDE EXPENSES:
>
> 1. FOR TREATMENT, SERVICES, PRODUCTS OR PROCEDURES THAT ARE:

4. Plaintiff "does not seek to recover any expenses which are specifically and unambiguously excluded from coverage in the subsection of the Policy" quoted herein. *See* Am. Compl. ¶ 20.

Appendix B

A. EXPERIMENTAL IN NATURE, FOR RESEARCH, OR NOT PRIMARILY DESIGNED TO SERVE A MEDICAL PURPOSE; OR

B. NOT COMMONLY AND CUSTOMARILY RECOGNIZED THROUGHOUT THE MEDICAL PROFESSION AND WITHIN THE UNITED STATES AS APPROPRIATE FOR THE TREATMENT OF THE **BODILY INJURY**; OR

2. INCURRED FOR:

A. THE USE OF THERMOGRAPHY OR OTHER RELATED PROCEDURES OF A SIMILAR NATURE; OR

B. THE PURCHASE OR RENTAL OR EQUIPMENT NOT PRIMARILY DESIGNED TO SERVE A MEDICAL PURPOSE.

We have the right to make or obtain a utilization review of the medical expenses and services to

> determine if they are reasonable and necessary for the **bodily injury** sustained.
>
> The **bodily injury** must be discovered and treated within one year of the date of the accident.

Am. Compl. ¶¶ 17, 19 (emphasis in original); [*see also* Doc 49-1 at 11].

In her Amended Complaint, Plaintiff argues that "[a]s a matter of law, the terms of the medical payments section of the Policy are plain and unambiguous and unequivocally require that [Defendant] pay *all* of its insureds' medical expenses up to the limitation of liability provided." Am. Compl. ¶ 30(e) (emphasis added). Throughout her response brief, Plaintiff repeatedly emphasizes her allegation that "[Defendant] is liable, as a matter of law, to pay *all* of Plaintiff's medical expenses incurred as a result of the May [2009 Accident], 'up to the limitation of liability provided.'" [*See, e.g.*, Doc. 54 at 3 (emphasis added); *see also id.* at 2 ("[Plaintiff] allege[s] that the terms of the [Policy] . . . are 'plain and unambiguous,' and 'unequivocally' required [Defendant] to pay *all* of Plaintiff's medical expenses . . . not just those expenses [Defendant] considered to be 'reasonable' or 'necessary[.']" (emphasis added)); Doc. 51 at 18 ("[I]t is [Defendant's] duty, as a matter of law, to pay *all* the actual medical expenses Plaintiff and the potential class incurred." (emphasis added))]. In support of her interpretation, Plaintiff relies almost exclusively on a single decision from the Georgia Court of Appeals, *Travelers Indemnity Company v. Watson. See, e.g.*, Am.

Compl. ¶ 30(e) (citing 111 Ga. App. 98, 140 S.E.2d 505 (Ga. Ct. App. 1965)); [*see also* Docs. 51 at 13-19 (same); 54 at 2, 7, 9-12 (same)]. The Court finds that Plaintiff's proposed interpretation of the Policy is unreasonable for two (2) reasons.

First, Plaintiff misconstrues the holding and facts of *Travelers*. According to Plaintiff, in *Travelers* the Georgia Court of Appeals considered a medical payments insurance policy "almost identical" to the Policy terms at issue here. [*See* Doc. 51 at 13]. Specifically, Plaintiff notes that the medical payments terms in *Travelers* required the insurer "to pay all reasonable expenses incurred . . . for necessary medical" services. [*Id.*] (quoting *Travelers Indemnity Co.*, 140 S.E.2d at 506). Plaintiff argues that the Georgia Court of Appeals held that those policy terms "required the insurer, 'unequivocally,' to pay *all* of the insured's medical expenses 'up to the limitations of liability provided.'" [Doc. 51 at 13-14] (quoting *Travelers Indemnity Co.*, 140 S.E.2d at 508) (emphasis added). Without citation, Plaintiff then asserts that this "unanimous holding . . . has been uniformly followed amongst the states." [*Id.* at 14].

However, Plaintiff incorrectly characterizes both the facts before the Georgia Court of Appeals in *Travelers* and that court's holding. At issue in *Travelers* was whether a "family automobile policy" required the insurer to provide medical payment coverage to the insured's wife as opposed to only the insured. *See Travelers Indemnity Co.*, 140 S.E.2d at 506. In its analysis of that contract, the Georgia Court of Appeals quoted a significant portion of the policy that included four (4) relevant sections: (1) an

introductory paragraph, (2) a "Division 1" paragraph, (3) a "Division 2" paragraph, and (4) a definitions section. *See id.* at 506-07. Although the introductory paragraph contained some similar language to the Policy at issue here—namely a requirement to pay for "reasonable expenses" and "necessary" medical services—the Georgia Court of Appeals' analysis focused on the Division 1 and Division 2 paragraphs, which both concerned whether the named insured's relatives were covered under the policy. *See id.* at 506, 508-09. After analyzing the relevant terms, the Georgia Court of Appeals held:

> The terms of the policy are plain and unambiguous and therefore must be construed as written . . . [D]ivision 1[] provides for payment of [medical service] expenses "[t]o and for the named insured and each relative who sustains bodily injury, caused by the accident . . . ." The undertaking in Division 1, except for exclusions hereafter discussed, is *unequivocally to pay medical expenses incurred by either the named insured or his wife, or both* . . . .

Id. at 508 (emphasis added). Put differently, the Georgia Court of Appeals held that the policy at issue in *Travelers* "unequivocally" required coverage of the named insured's wife. *See id.* The court did not interpret the meaning of "reasonable" or "necessary" medical expenses or articulate any holdings to that effect. *See generally id.* Therefore, contrary to Plaintiff's argument, *Travelers* does not stand for the proposition that the Policy at issue in this case requires Defendant to "unequivocally" pay for

"all" of Plaintiff's claimed medical expenses as a matter of law.

Second, Plaintiff's interpretation of the Policy ignores the plain text of the Policy at bar. Plaintiff argues that "[t]he Policy gave [Defendant] no authority to decide what medical expenses are reasonable or necessary." [Doc. 51 at 16]. In making her argument, Plaintiff appears to posit that Defendant had no "authority" to deny or limit medical expense payments and must therefore pay for "all" her claimed medical expenses.[5] However, contrary to Plaintiff's theory, the Policy unambiguously states that Defendant must pay for "reasonable" and "necessary" medical expenses "incurred for bodily injury," and further, grants Defendant the "right to make or obtain a utilization review of the medical expenses and services to determine if they are reasonable and necessary for the bodily injury sustained." *See* Am. Compl. ¶¶ 17, 19 (emphasis omitted); [Doc. 49-1 at 11].

Read together, the Court finds that the Policy's terms are plain and unambiguous; they require Defendant to pay for "reasonable" and "necessary" medical expenses and also grant Defendant the authority to determine which

5. The Court again notes that any "illusory policy" theory or claims by Plaintiff are foreclosed as time barred. *See Sisia*, 2023 WL 2989832 at *3. Thus, the Court does not consider Plaintiff's alternative arguments that the Policy's language "nullif[ies]" the medical payments coverage section or that Defendant's ability to declare some medical expenses unreasonable constitutes an "unlawful" scheme, as these are merely attempts to repackage the "illusory policy" theory. [*See* Docs. 51 at 8-10; 54 at 8, 10].

expenses qualify as such through its "right to make or obtain utilization review[s]." *See* Am. Compl. ¶¶ 17, 19. Nowhere does the Policy require Defendant to pay for "all" claimed medical expenses (even if those claimed expenses fall below the Policy coverage limits). *See generally id.* To accept Plaintiff's broad interpretation would render meaningless the conditional words "reasonable" and "necessary" and the language allowing Defendant to make or obtain utilization reviews—a result directly counter to Georgia law. *Ace Am. Ins. Co. v. Wattles Co.*, 930 F.3d 1240, 1260 n.22 (11th Cir. 2019) ("Georgia law prefers a construction that 'will not render any of the policy provisions meaningless or mere surplusage.'" (quoting *Nat'l Cas. Co. v. Ga. Sch. Boards Ass'n-Risk Mgmt. Fund*, 304 Ga. 224, 818 S.E.2d 250, 253 (Ga. 2018) and O.C.G.A. § 13-2-2(4))); *see also Johnson v. Hartford Fin. Servs. Grp., Inc.*, 510 F. Supp. 3d 1326, 1334 (N.D. Ga. 2021).

In sum, the Court finds that the plain, unambiguous language in the Policy does not impose a duty on Defendant to "unequivocally" pay for "all" of Plaintiff's claimed medical expenses. Rather, the Policy language clearly contemplates that Defendant can deny or limit medical payments coverage based on reasonableness and necessity. Therefore, because Defendant owed Plaintiff no duty to "unequivocally" pay for "all" claimed expenses up to the limitation of liability pursuant to the Policy, Plaintiff's breach of contract claim does not survive Defendant's motion to dismiss.[6]

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6. Plaintiff does not bring a bad faith denial claim in the Amended Complaint. *See generally* Am. Compl. Accordingly, the Court makes no findings as to whether such a claim would survive a motion to dismiss.

B. Breach of Duty of Good Faith and Fair Dealing.

In her second claim, Plaintiff alleges that Defendant "breached its duty of good faith and fair dealing by denying coverage for medical expenses incurred by Plaintiff[] and other members of the putative class." Am. Compl. ¶ 47. Plaintiff further alleges that Defendant's interpretation that it could "deny medical payments coverage based on its determination that the expense was not a reasonable medical expense created a conflict of interest for [Defendant], and thus amounted to bad faith." *Id.* ¶ 49.

A breach of the covenant of good faith and fair dealing is not an independent cause of action under Georgia law. *See Ahmed v. Air France-KLM*, 165 F. Supp. 3d 1302, 1314 (N.D. Ga. 2016) (quoting *Alan's of Atlanta, Inc. v. Minolta Corp.*, 903 F.2d 1414, 1429 (11th Cir. 1990)). To state a claim for breach of the covenant of good faith and fair dealing, the plaintiff "must set forth facts showing a breach of an actual term of an agreement. General allegations of breach of the implied duty of good faith and fair dealing not tied to a specific contract provision are not actionable." *Am. Casual Dining L.P. v. Moe's Sw. Grill, L.L.C.*, 426 F. Supp. 2d 1356, 1370 (citing *Alan's of Atlanta*, 903 F.2d at 1429). "[T]here can be no breach of an implied covenant of good faith where a party to a contract has done what the provisions of the contract expressly give him the right to do." *Ameris Banks v. Alliance Inv. & Mgmt. Co.*, 739 S.E.2d 481, 486 (Ga. Ct. App. 2013) (quoting *Automatic Sprinkler Corp. of Am. v. Anderson*, 243 Ga. 867, 257 S.E.2d 283 (Ga. 1979)).

In the matter at bar, because Plaintiff's breach of contract claim fails, her claim for breach of the covenant of good faith and fair dealing based on the same Policy terms fails as well. *See id.* Plaintiff points to no other purported breaches of the Policy. *See generally* Am. Compl. As explained above, the Policy gives Defendant authority to deny or limit medical payment coverage based on a utilization review and to limit coverage to "reasonable" and "necessary" medical expenses. [*See* Doc 49-1 at 11]. Thus, the Court grants Defendant's motion to dismiss Plaintiff's claim for breach of the covenant of good faith and fair dealing.

IV. Conclusion

For the foregoing reasons, the Court **GRANTS** Defendant's "Motion to Dismiss Plaintiff's Amended Complaint" [Doc. 52] and **DISMISSES WITH PREJUDICE** this action. Additionally, the Court **DENIES AS MOOT** Plaintiff's "Renewed Motion for Conditional Class Certification." [Doc. 56]. Finally, the Court **DIRECTS** the Clerk to close this case.

SO ORDERED, this 1st day of December, 2023.

/s/ Eleanor L. Ross
Eleanor L. Ross
United States District Judge
Northern District of Georgia

APPENDIX C — DENIAL OF REHEARING OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT, FILED JULY 25, 2024

IN THE
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 23-14201

KIMBERLY K. SISIA,

Plaintiff-Appellant,

versus

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Georgia
D.C. Docket No. 1:21-cv-02376-ELR

Before JILL PRYOR, BRANCH, and GRANT, Circuit Judges.

PER CURIAM:

The Petition for Panel Rehearing filed by Appellant Kimberly K. Sisia is DENIED.