IN THE COURT OF APPEALS OF TENNESSEE
AT NASHVILLE
Assigned on Briefs November 3, 2015

RICHARD G. DAVIS v. TENNESSEE RURAL HEALTH IMPROVEMENT ASSOCIATION

Appeal from the Circuit Court for Davidson County
No. 12C1403 Joseph P. Binkley, Jr., Judge

No. M2015-00573-COA-R3-CV – Filed November 30, 2015

Plaintiff policy holder filed suit against defendant insurance company after the insurance company denied his claim for benefits. Defendant filed a motion for summary judgment based on the plaintiff's failure to utilize the appeals procedure outlined in the contract for insurance before filing a lawsuit. The trial court granted the motion for summary judgment. Plaintiff appeals. Discerning no error, we affirm.

Tenn. R. App. P. 3 Appeal as of Right; Judgment of the Circuit Court Affirmed

J. STEVEN STAFFORD, P.J.,W.S., delivered the opinion of the Court, in which ANDY D. BENNETT, J., and THOMAS R. FRIERSON, II, J., joined.

G. Kline Preston, IV, Nashville, Tennessee, for the appellant, Richard G. Davis.

Travis Swearingen and Ashonti T. Davis, Nashville, Tennessee, for the appellee, Tennessee Rural Health Improvement Association.

MEMORANDUM OPINION[1]

[1] Rule 10 of the Rules of the Court of Appeals of Tennessee provides:

> This Court, with the concurrence of all judges participating in the case, may affirm, reverse or modify the actions of the trial court by memorandum opinion when a formal opinion would have no precedential value. When a case is decided by memorandum opinion it shall be designated "MEMORANDUM OPINION", shall not be published, and shall not be cited or relied on for any reason in any unrelated case.

Background

On October 14, 2010, Richard G. Davis ("Mr. Davis" or "Appellant") contracted with Tennessee Rural Health Improvement Association ("TRH" or "Appellee") to purchase health insurance.[2] He was issued Policy #TRH800170716 ("Policy"), for which he paid monthly premiums of approximately $175.75 per month. Mr. Davis's Policy became effective on December 1, 2010.

Approximately three to four months prior to seeking health insurance, Mr. Davis became aware of a lump on the left side of his face near his jaw.[3] On December 8, 2010, Mr. Davis went to the Summit Primary Care Clinic in Hermitage, Tennessee, presenting with a "growth on [the left] side of [his] face that seems to have gotten much bigger recently but has felt a small knot there for [years]."[4] The physician's notes reported that the physician found a "ping pong sized soft lesion" near Mr. Davis's left jaw. The physician noted that he suspected the lump to be benign, and Mr. Davis was referred to a plastic surgeon. Unfortunately, after the lump was surgically removed and biopsied, Mr. Davis was diagnosed with non-Hodgkin's lymphoma.

Mr. Davis subsequently underwent treatment. TRH was notified of Mr. Davis's diagnosis, and it initially paid for his treatment. At some point into Mr. Davis's treatment, TRH declined to cover the cost of his treatment because it determined that Mr. Davis's illness constituted a pre-existing condition and was, therefore, not covered pursuant to the Policy.[5]

Mr. Davis did not appeal the denial of his claim with TRH. Rather, Mr. Davis pursued legal action and filed a civil warrant for breach of contract against TRH[6] in the Davidson

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[2] Mr. Davis had been without health insurance since early 2006, when he left his previous employer.

[3] At his deposition, Mr. Davis stated that he initially believed the knot to be a dental issue.

[4] Although the record contains conflicting reports of when Mr. Davis noticed the lump, the timing is immaterial for purposes of this appeal.

[5] The parties dispute whether Mr. Davis's lymphoma constitutes a pre-existing condition; however, this is not at issue in this appeal.

[6] Mr. Davis initially brought suit against BlueCross BlueShield of Tennessee, Inc. However, both parties subsequently agreed that TRH was the proper defendant and should be substituted. On May 14, 2013, the trial court entered an order substituting TRH as party-defendant. For purposes of this Opinion, we refer

County General Sessions Court on December 16, 2011. The case was eventually transferred to the Davidson County Circuit Court. In the circuit court, TRH filed a motion for a more definite statement seeking further description of Mr. Davis's allegations and claims. Mr. Davis filed his initial Complaint, the first formal complaint in this action, on November 14, 2012. Mr. Davis alleged that TRH breached the terms of the Policy when it refused to pay his claims related to his lymphoma treatment. Mr. Davis subsequently filed another document titled First Amended Complaint on June 3, 2013, and a Second Amended Complaint on October 1, 2013. TRH filed its answer to the Second Amended Complaint on November 5, 2013, raising, *inter alia*, the defense of exhaustion of administrative remedies.

On December 10, 2014, after discovery, TRH filed a motion for summary judgment and a statement of undisputed material facts in support of the motion. TRH argued that it was entitled to judgment as a matter of law on two bases. First, it asserted that the undisputed facts established that Mr. Davis knew about the lump near his jaw for several months prior to the effective date of the Policy. Based on this, TRH argued that it was not obligated to pay for any of Mr. Davis's related medical expenses because his illness was a pre-existing condition within the meaning of the Policy. Second, TRH asserted that Mr. Davis failed to exhaust an internal administrative appeals process prior to instituting any legal action as required by the Policy.

Mr. Davis responded to the motion for summary judgment on January 23, 2015. He claimed that TRH committed the first material breach by denying coverage, and he was excused from complying with the terms of the Policy subsequently, including those terms governing the appeals procedure. He also disputed whether his illness was a pre-existing condition within the meaning of the Policy. Mr. Davis also responded to TRH's statement of undisputed facts, providing that the only fact in dispute was at what time he began to feel the knot near his jaw.

TRH filed a supplemental brief to its motion on February 6, 2015, which expounded on its argument that Mr. Davis failed to "make use of the review and appeal procedure provided in the [Policy] before resorting to the courts." (Internal quotations omitted.)

The trial court conducted a hearing on TRH's motion for summary judgment on February 20, 2015. By written order entered February 27, 2015, the trial court granted the motion. The trial court found that Mr. Davis had failed to comply with the Policy's internal appeals process before resorting to legal action. The trial court specifically stated in its order that it did "not reach the issue of whether [Mr. Davis's] insurance coverage was properly

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only to TRH to avoid confusion.

denied because [his] medical condition was 'pre-existing' as defined by the Policy." Mr. Davis timely filed this appeal.

Issue

Appellant presents a sole issue for this Court's review, as taken from his brief and reworded: Whether the trial court erred in granting summary judgment to TRH based upon its determination that the Policy unambiguously required Mr. Davis to use the outlined appeals procedure before resorting to legal action.[7]

Standard of Review

Summary judgment is appropriate where: (1) there is no genuine issue with regard to the material facts relevant to the claim or defense contained in the motion and (2) the moving party is entitled to judgment as a matter of law on the undisputed facts. Tenn. R. Civ. P. 56.04. In cases where the moving party does not bear the burden of proof at trial, the movant may obtain summary judgment if it:

> (1) Submits affirmative evidence that negates an essential element of the nonmoving party's claim; or
>
> (2) Demonstrates to the court that the nonmoving party's evidence is insufficient to establish an essential element of the nonmoving party's claim.

Tenn. Code Ann. § 20-16-101 (applying to cases filed after July 1, 2011); *see also* ***Rye v. Women's Care Ctr. of Memphis, MPLLC***, --- S.W.3d ---, 2015 WL 6457768, at *22 (Tenn. Oct. 26, 2015) (judicially adopting a summary judgment parallel to the statutory version contained in Tenn. Code Ann. § 20-16-101). When the moving party has made a properly supported motion, the "burden of production then shifts to the nonmoving party to show that a genuine issue of material fact exists." ***Id.*** at 5; *see* ***Robinson v. Omer***, 952 S.W.2d 423, 426 (Tenn. 1997); ***Byrd v. Hall***, 847 S.W.2d 208, 215 (Tenn. 1993). The nonmoving party may not simply rest upon the pleadings but must offer proof by affidavits or other discovery materials to show that there is a genuine issue for trial. Tenn. R. Civ. P. 56.06. If the nonmoving party "does not so respond, summary judgment, if appropriate, shall be entered." Tenn. R. Civ. P. 56.06.

[7] At the trial level, Mr. Davis argued that he was excused from complying with the appeals procedure outlined in the Policy because TRH committed the first material breach when it failed to pay his claim. On appeal, Mr. Davis does not does argue this point in his brief. Accordingly, it is waived. ***Childress v. Union Realty Co., Ltd.***, 97 S.W.3d 573, 578 (Tenn. Ct. App. 2002) (deeming an issue waived where a party failed to address it in the argument section of its brief).

On appeal, this Court reviews a trial court's grant of summary judgment *de novo* with no presumption of correctness. *See* ***City of Tullahoma v. Bedford Cnty.***, 938 S.W.2d 408, 412 (Tenn. 1997). In reviewing the trial court's decision, we must view all of the evidence in the light most favorable to the nonmoving party and resolve all factual inferences in the nonmoving party's favor. ***Luther v. Compton***, 5 S.W.3d 635, 639 (Tenn. 1999); ***Muhlheim v. Knox. Cnty. Bd. of Educ.***, 2 S.W.3d 927, 929 (Tenn. 1999). If the undisputed facts support only one conclusion, then the court's summary judgment will be upheld because the moving party was entitled to judgment as a matter of law. *See* ***White v. Lawrence***, 975 S.W.2d 525, 529 (Tenn. 1998); ***McCall v. Wilder***, 913 S.W.2d 150, 153 (Tenn. 1995).

Analysis

The salient issue in this case concerns the interpretation of the Policy. The trial court, in granting summary judgment to TRH found that Mr. Davis failed to fulfill the Policy's requirement that the insured "exercise[] all of his [] review and appeal rights" before filing his legal action, and, therefore, his resort to legal action was premature. On the contrary, as discussed below, Mr. Davis argues that this portion of the Policy is permissive, not mandatory. Thus, he asserts that he did not prematurely resort to legal action because the language of the Policy did not require him to exhaust the internal appeals process first.

The interpretation of a contract is a question of law and not one of fact. ***Pitt v. Tyree Org., Ltd.***, 90 S.W.3d 244, 252 (Tenn. Ct. App.2002). Each provision must be construed in light of the entire agreement, and the language in each provision must be given its natural and ordinary meaning. ***Buettner v. Buettner***, 183 S.W.3d 354, 359 (Tenn. Ct. App. 2005). When interpreting a contract, the court's aim is to ascertain and give effect to the parties' intent. ***Harrell v. Minn. Mut. Life Ins.***, 937 S.W.2d 809 (Tenn. 1996). If a contract is unambiguous, a court must interpret it as written and not in accordance with a party's unexpressed intent. ***Pitt***, 90 S.W.2d at 252***; Sutton v. First Nat. Bank of Crossville***, 620 S.W.2d 526 (Tenn. Ct. App. 1981). Additionally, where a contract is unambiguous, the court may not look beyond its four corners to ascertain the parties' intention. ***Rogers v. First Tenn. Bank Nat'l Ass'n***, 738 S.W.2d 635, 637 (Tenn. Ct. App. 1987); ***Bokor v. Holder***, 722 S.W.2d 676, 679 (Tenn. Ct. App. 1986). The language used in a contract must be taken and understood in its plain, ordinary, and popular sense. ***Ballard v. N. Am. Life & Cas. Co.***, 667 S.W.2d 79 (Tenn. Ct. App. 1983); ***Bob Pearsall Motors, Inc. v. Regal Chrysler–Plymouth, Inc.***, 521 S.W.2d 578 (Tenn. 1975).

When parties reduce their agreement to writing, the law favors enforcing these agreements as written. ***Bob Pearsall Motors, Inc.***, 521 S.W.2d 578 at 580. Stated another way, the court, when interpreting a contract, "does not attempt to ascertain the parties' state of mind at the time the contract was executed, but rather their intentions as actually embodied

and expressed in the contract as written." ***Union Planters Nat'l Bank v. Amer. Home Assur. Co.***, 865 S.W.2d 907, 912 (Tenn. Ct. App. 1993). The role of a court is to enforce an unambiguous contract as it is written unless it is being challenged on the basis of fraud or mistake. ***Boyd v. Comdata Network, Inc.***, 88 S.W.3d 203, 223 (Tenn. Ct. App. 2002) (citing ***Wills & Wills, L.P. v. Gill***, 54 S.W.3d 283, 286–87 (Tenn. Ct. App. 2001).

However, where a provision is ambiguous—that is, susceptible to more than one reasonable interpretation—the parties' intent cannot be determined by a literal interpretation of the language. *See* ***Planters Gin Co. v. Fed. Compress & Warehouse Co.***, 78 S.W.2d 885, 890 (Tenn. 2002). In this situation, the court must resort to other rules of construction. ***Id.*** For example, especially when construing an insurance contract, ambiguous provisions should be construed against the drafter of the policy. *See* ***Kiser v. Wolfe***, 353 S.W.3d 741, 748, 749–50 (Tenn. 2011). Only if ambiguity remains after using the rules of construction does the legal meaning of the contract become a question of fact. ***Id.*** Then, the court must examine other evidence to surmise the parties' intention, including negotiations leading up to the contracts, formation, the course of conduct between the parties, and any statements of the parties that could guide the court in ascertaining the parties' intentions. ***Pinson & Assocs., Inc. v. Kreal***, 800 S.W.2d 486, 487 (Tenn. Ct. App. 1990); ***Jackson v. Miller***, 776 S.W.2d 115, 118 (Tenn. Ct. App. 1989); ***Patterson v. Anderson Motor Co.***, 319 S.W.2d 492, 297 (Tenn. Ct. App. 1958).

With the foregoing in mind, we turn to the language in the Policy. The Policy issued to Mr. Davis contained over sixty pages and is included in the record on appeal. For purposes of this appeal, only two sections are particularly relevant, namely the section titled "Claims Review/Appeal Procedure" and the section titled "Bringing Legal Action." These sections provide:

> **CLAIMS REVIEW/APPEAL PROCEDURE**
>
> If You [i.e., Mr. Davis] do not agree with the denial or partial denial of Your claim, You may appeal the decision. You must begin the appeal within 60 days after you receive notice of a denial or partial denial.[8]

[8] Regarding TRH's denial of benefits, Mr. Davis testified at his deposition that he did not remember the date upon which he was informed about the denial, and he did not remember to whom he spoke. The record indicates that Mr. Davis learned about the denial of benefits through a telephone call from a TRH representative. Still, the parties agree that TRH denied Mr. Davis's claim for benefits at some point. Regardless, Mr. Davis does not dispute that he did not file an appeal pursuant to the Policy.

> You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.
>
> * * *
>
> This Procedure is the exclusive method of resolving any Dispute. . . .
>
> **BRINGING LEGAL ACTION**
>
> Any legal action taken with respect to Coverage under this Plan must begin within 2 years following the period permitted for timely filing. Legal action may not be taken until:
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> - A properly complete notice of claim has been submitted, and
> - Such claim has either been denied in writing or not followed by a written response within 30 days after it is submitted, and
> - The Member has exercised all of his or her review and appeal rights under this [Policy] as defined under Claims Review/Appeal Procedure.

In his brief, Mr. Davis argues that the Policy "does not mandate that Mr. Davis must appeal his coverage denial. . . . Instead, the [P]olicy clearly states that he may do so." (Emphasis in original.) For this proposition, he points to one provision of the cited portion of the Policy, which reads: "If You do not agree with the denial or partial denial of Your claim, You **may** appeal the decision." (Emphasis added.) He states that this language is unambiguous, but even if this Court finds it ambiguous, it must be construed in his favor. Accordingly, he contends that his election not to pursue an appeal pursuant to the Policy, and instead file a lawsuit, was permitted pursuant to the Policy. Although we agree with Mr. Davis that the Policy is not ambiguous, we respectfully disagree that its language permits Mr. Davis to bypass the appeals procedure outlined in the Policy.

As stated above, a provision in a contract must be interpreted in conjunction with the surrounding provisions. *See* ***Adkins v. Bluegrass Estates, Inc.***, 360 S.W.3d 404, 411 (Tenn. Ct. App. 2011) ("The interpretation of an agreement is not dependent on any single provision, but upon the entire body of the contract and the legal effect of it as a whole."); ***Buettner***, 183 S.W.3d at 359. In championing his interpretation of only one provision, Mr.

Davis's interpretation conflicts with other provisions mandating use of the appeals procedure. When read in conjunction with the other provisions of the Policy, as discussed below, it is clear that the word "may," in the provision cited by Mr. Davis, indicates that the policy holder may appeal a denial of a claim, or he may decide to accept the denial of his claim and pursue no further action. Still, the Policy is clear that if the policy holder disagrees with TRH's denial of a claim, the policy holder must exhaust the Policy's appeals procedure before resorting to legal action.

This Court notes that two more provisions in the Policy regarding the appeals procedure make it unambiguously clear that the policy holder **must** utilize the appeals procedure in the Policy before resorting to legal action. First, although not mentioned by either party, the section of the Policy titled "Claims Review/Appeal Procedure" provides that "This Procedure is the exclusive method of resolving any Dispute." This provision leaves no room for uncertainty that the policy holder is not entitled to bypass the appeals procedure as outlined. Thus, the Policy explicitly provides that the policy holder does not have the option of whether to pursue the denial of a claim through an alternate channel; the appeals procedure is, as clearly and plainly stated, the "exclusive method."

The second relevant provision is found under the portion titled "Bringing Legal Action." It provides that the policy holder may not bring legal action before, *inter alia*, "[he] has exercised all of his or her review and appeal rights under this [Policy] as defined under Claims Review/Appeal Procedure." The parties do not dispute that Mr. Davis did not use this procedure to dispute the denial of his claim. The Policy is clear and unambiguous as to Mr. Davis's obligation to do so before resorting to the courts.[9]

Based on the foregoing, we conclude that Mr. Davis was required to utilize the appeals procedure as stated in the Policy before he filed this action. Although we are cognizant that this Opinion may preclude Mr. Davis's recovery of certain medical expenses, this Court's obligation is to interpret the contract as presented, but not to relieve a party of its obligations because they prove to be onerous or burdensome. ***Boyd***, 88 S.W.3d at 223. Accordingly, we affirm the trial court's grant of summary judgment in favor of TRH.

Conclusion

[9] We also note that one provision exists that may excuse a policy holder from complying with the outlined appeals procedure. As stated above, in the section titled "Claims Review/Appeal Procedure," it provides: "The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute." This provision is not cited by either party, and the record is devoid of any indication that the parties agreed to bypass any step of the appeals procedure.

The judgment of the Davidson County Circuit Court is affirmed, and this case is remanded to the trial court for all further proceedings as are necessary and are consistent with the Opinion. Costs of this appeal are taxed to Appellant Richard G. Davis and his surety.

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J. STEVEN STAFFORD, JUDGE