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

FRANCES KIRBY, AUDREY LOGAN, ASHLEY WALDMAN, JOHN DAVID MARKS, WANDA SILVA, TONYA BEACH, DAVID FROHMAN, individually and on behalf of all others similarly situated,	*	
Plaintiffs,	*	
v.	*	1:19-CV-00597-ELR
ANTHEM, INC., BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC., ANTHEM INSURANCE COMPANIES, INC.,	*	
Defendants.	*	

O R D E R

Presently before the Court is Plaintiffs' Emergency Motion for a Temporary Restraining Order ("TRO"), Preliminary Injunction, and Permanent Injunction. For the reasons set forth below, the Court denies Plaintiffs' Motion.

I. Background

Plaintiffs Frances Kirby, Audrey Logan, Ashley Waldman, John David Marks, Wanda Silva, Tonya Beach, David Frohman, individually and on behalf of a

Class, have filed a First Amended Complaint against Defendants Anthem, Inc., Blue Cross and Blue Shield of Georgia, Inc. ("BCBS of Ga."), and Anthem Insurance Companies, Inc. [Doc. 10]. Plaintiffs then filed an Emergency Motion for a Temporary Restraining Order, Preliminary Injunction, and Permanent Injunction. [Doc. 11]. The Court issued an Order setting expedited briefing of Plaintiffs' Motion and heard oral argument on March 13, 2019.

Plaintiffs allege the following:

> [Defendants] knowingly and intentionally [made] uniform material misrepresentations and omissions that falsely inflated the size of its physician and hospital network available to consumers who purchased [Defendants'] individual and family Pathway health insurance plan(s). [Defendants] lied to Georgia consumers and agents who sold [Defendants'] health insurance plans as well as state and federal regulators. [Defendants] falsely included physicians and health systems in its list of in-network providers knowing that those physicians and health systems such as the largest hospital system in Atlanta – Emory Healthcare ("Emory"), and Georgia's largest health system, WellStar Health System, Inc. ("WellStar") – did not accept [Defendants'] Pathway plans. [Defendants] also listed other physicians and health provider groups in the metro-Atlanta area, which are not exclusively in the WellStar and Emory health systems, as in-network knowing that the physicians and groups did not accept Pathway health plans either.

Pls.' First Am. Compl. [Doc. 10] at ¶ 1. Plaintiffs allege that before enrolling in insurance plans with Defendants, they checked to ensure that their physicians and hospitals were in-network. After they had enrolled, Plaintiffs assert that they learned that the physicians and hospitals they had previously checked and found to be in-network with Defendants were in reality out of network.

Plaintiffs bring the following claims against all Defendants: fraud, fraudulent concealment, negligence per se, negligence, constructive trust, unjust enrichment, and declaratory judgment and injunctive relief. Plaintiffs bring claims for breach of contract and breach of the covenant of good faith and fair dealing against BCBS of Ga. and Anthem Inc. Plaintiffs move for a TRO on their claim for breach of contract against BCBS of Ga. and Anthem Inc., which is now ripe for the Court's review.

II. Discussion

It is well established in this Circuit that a TRO is an "extraordinary and drastic remedy[.]" Zardui-Quintana v. Richard, 768 F.2d 1213, 1216 (11th Cir. 1985). A plaintiff seeking a TRO must demonstrate that: (1) there is a substantial likelihood of success on the merits; (2) he will suffer irreparable injury if relief is not granted; (3) the threatened injury outweighs any harm the requested relief would inflict on the non-moving party; and (4) entry of relief would serve the public interest. E.g., KH Outdoor, LLC v. City of Trussville, 458 F.3d 1261, 1268 (11th Cir. 2006). The decision as to whether a plaintiff has carried this burden "is within the sound discretion of the district court and will not be disturbed absent a clear abuse of discretion." Int'l Cosmetics Exch., Inc. v. Gapardis Health & Beauty, Inc., 303 F.3d 1242, 1246 (11th Cir. 2002) (quoting Palmer v. Braun, 287 F.3d 1325, 1329 (11th Cir. 2002)) (internal quotation marks omitted). Failure to

establish any one of the four elements results in the denial of a TRO. Four Seasons Hotels & Resorts, B.V. v. Consorcio Barr, S.A., 320 F.3d 1205, 1210 (11th Cir. 2003).[1]

A. Likelihood of Success on the Merits

Plaintiffs move for a TRO on their claim for breach of contract, alleging that Defendants[2] breached their contracts with Plaintiffs by requiring Plaintiffs to get a referral from a PCP ("primary care physician") in order to see a specialist. To fully evaluate whether Plaintiffs have shown a substantial likelihood of success on the merits, it is important to understand the process for enrollment with Defendants' insurance plans and the information Defendants provided to Plaintiffs associated with these plans, as follows.

Plaintiffs assert that they enrolled in Pathway health insurance plans from Defendants.

> The Pathway Guided Access plans are individual health benefit plans that comply with various requirements under the Affordable Care Act. [Defendants] sold Pathway Guided Access plans during the 2019 Open Enrollment Period (November 1, 2018 to December 15, 2018) through healthcare.gov, the federal marketplace or exchange, and directly through anthem.com. For the 2019 coverage year, [Defendants] offered various Pathway Guided Access plans to

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[1] The Court will refer to the relief sought by Plaintiffs as a TRO rather than a preliminary injunction, despite Plaintiffs' title of their Motion, as this is the relief that was most discussed at the hearing. Nevertheless, the standards for issuing a TRO or a preliminary injunction are the same. See Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1223, 1225 (11th Cir. 2005).

[2] Plaintiffs assert that all three (3) Defendants breached the contract but Plaintiffs have only asserted a breach of contract claim against Defendants BCBS of Ga. and Anthem Inc. in their First Amended Complaint.

> consumers in certain counties in Georgia. The various Pathway Guided Access plans include the same covered benefits, but differ with regard to the member's costs shares—deductibles, co-payments, coinsurance, and out-of-pocket maximums levels—and the monthly premium for the plan.

Decl. of Jane Ames[3] ("Ames Decl.") at ¶ 5.

The Guided Access plan webpages, both on healthcare.gov and Anthem.com, included links to the "Summary of Benefits and Coverage" ("SBC") and a "Plan Brochure." See Decl. of Patrick Quirk[4] ("Quirk Decl."), Ex. A.; Decl. of Stacey Woodbridge[5] ("Woodbridge Decl."), Exs. A and B. The SBC is a plain-language summary that allows consumers to better understand the coverage of a health plan and to easily compare different coverage options. Quirk Decl. at ¶ 4. The SBC for all Guided Access plans stated the following: "Important Questions": "Do you need a referral to see a specialist? Yes." Id. at ¶ 5; Ex. A. at 2. This information was never revised. Quirk Decl. at ¶ 9.

"The Georgia Plan Brochure concerns the Individual and Family Plans sold in Georgia, including the Pathway Guided Access plans." Woodbridge Decl. at ¶ 4. The Plan Brochure stated the following:

> What should I know about my network?

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[3] Ms. Ames is the Business Development Director for Individual and Small Group business supporting Defendants. Ames Decl. at ¶ 2.
[4] Mr. Quirk is the Director for Individual Product supporting Defendants. Quirk Decl. at ¶ 2.
[5] Ms. Woodbridge is the Marketing Director for Consumer Marketing supporting Defendants. Woodbridge Decl. at ¶ 2.

> With our **Pathway X Guided Access** plans, you have to choose a primary care doctor (PCP) to manage your health care needs—including getting referrals . . . .

Id. at ¶ 10; Exs. A and B at 6. The Plan Brochure also included a footnote on numerous pages stating: "PCP selection and referrals to most specialists are required for our **Pathway X Guided Access** plans." Id. at ¶ 11; Exs. A and B at 9-32. This information was never revised. Id. at ¶12.

In addition, when an individual visited healthcare.gov, the page for each Guided Access plan prominently read, "**Need referral to see a specialist[:]** Yes." Quirk Decl., Ex. C at 5.[6] This information was never revised. Id. at ¶ 11.

> During the 2019 Open Enrollment, Georgia consumers in certain counties could complete an application for a Guided Access plan at healthcare.gov or at anthem.com. The consumer submitted payment of the first premium with the application, or once the application was received by [Defendants], a letter was sent to the consumer advising of the initial premium that was due. The consumer completed his or her enrollment in the Guided Access plan and became a member covered under the plan by paying the first premium.
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> After the first premium payment was received from the member and applied to the member's account, [Defendants] sent the member a Welcome Kit and identification card. . . . The Welcome Kit identifies the name of the Pathway Guided Access plan under which the member is covered and states that the member can "download" the "Contract" for their Guided Access plan by logging into bcbsga.com

[6] That notice was displayed because [Defendants] submitted a "Plans & Benefits" template to the U.S. Department of Health and Human Services with that information for use on healthcare.gov. See Quirk Decl. at ¶ 11 & Ex. B at 1. During open enrollment, the U.S. Center for Medicare and Medicaid Services ("CMS") audited the SBC and Plan Brochure to ensure it matched the information found in the Plans & Benefits template, thereby reflecting the information found on heathcare.gov. Id. at ¶ 13. CMS did not report any problems regarding the referral language as a result of this audit. Id.

> and selecting "Plan Information from the menu." See, e.g., Ex. A at 009. The document available for download through this process is the member benefit booklet, titled Individual Member Contract ("contract booklet") for the Guided Access plan under which the member is covered. . . .

Ames Decl. at ¶¶ 6-7.[7]

On page 17, the Individual Member Contract states as follows:

> **Referrals**
>
> You will receive most of Your health care services from Your Primary Care Physician. If Your Primary Care Physician determines that You need specialized care, he or she will authorize You to receive health care services from another health care Provider. . . .
>
> If Your Primary Care Physician authorizes a Referral to a Provider, make sure You understand:
> · The name of the Provider to whom You are being referred.
> · The period of time, the number of visits and services for which care is authorized.
> · Who is to make the appointment(s) with that Provider - You or Your Primary Care Physician's office staff.
>
> You will need to discuss additional care recommended by the referring Provider with Your Primary Care Physician, if the care exceeds the initial Referral for services. If Your referred Provider recommends You to another Provider, You must contact Your Primary Care Physician prior to any treatment so he or she can determine if that care will be authorized. Only Your Primary Care Physician can authorize care with another Provider. . . .
>
> Note: If Your Primary Care Physician determines You do not need a Referral and You disagree, You have the right to Appeal . . . .

Decl. of Sharon Mos[8] ("Mos Decl."), Exs. A at 6.

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[7] The Welcome Kit notes that the same SBC linked on the healthcare.gov and Anthem websites provides the "highlights" of the Guided Access plan. Id. at Ex. A at 9.

Additionally, the Individual Member Contract provided the following:

> **Referrals to Specialists**
>
> Your Primary Care Physician may refer You to a Specialist. Specialists are Providers who practice in specialty areas such as neurology, surgery, and others. With the prior authorization of Your Primary Care Physician, You can obtain care from Network Specialists.
>
> You do not need a Referral or approval from Your PCP to see an Obstetrician/Gynecologist (OB/GYN), Dermatologist, or eye care professionals including Optometrists and Ophthalmologists.

Id.

In a section called "**Standing Referrals**," the Individual Member Contract provided the following:

> A Member with a special condition requiring ongoing care from a Specialist may receive a standing Referral to a Specialist for treatment of the special condition from the Member's PCP. A special condition is a condition or disease that is life-threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time.

Id. at 6-7. The Court will refer to all of this language as "page 17 language."[9]

Also in the Individual Member Contract, under the heading, "How to Find a Provider in the Network," Defendants stated the following:

> You do not need a Referral to see a Specialty Care Physician. You can visit any Network Specialist including a behavioral health Provider without a referral from a Primary Care Physician.

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[8] Ms. Mos is a Legal Specialist Sr. with Defendants. Mos Decl. at ¶ 1.

[9] This is in order to remain consistent with how the parties have referred to this language and corresponds to the actual page numbers of the Individual Member Contract.

Id. at Ex. A at 5. The Court will refer to this language as "page 16 language."

Defendants assert that this last language on page 16 was a mistake. Ames Decl. at ¶ 11. Defendants state that on January 28, 2019, they contacted the Georgia Department of Insurance ("GOI") and advised them that this language needed to be edited to correct this mistake, and the GOI allowed Defendants to make the correction. Id. at ¶ 12. Defendants then updated the electronic version of the Individual Member Contract by deleting the incorrect text. Id. at ¶ 13. On or about February 21, 2019, Defendants sent a letter to members with the Pathway Guided Access plan regarding the error, noting that the page 16 language had been a mistake, that the member's plan did require a referral to see a specialist, and that the updated contract information was available on Defendants' website.

Plaintiffs argue that Defendants unilaterally amended the contract by taking these actions and requiring a referral to see a specialist when the Individual Member Contract did not require a referral. In this way, Plaintiffs assert that Defendants have breached the contract. Plaintiffs argue that contradictory provisions in a contract must be construed in favor of the insured, and therefore, the page 16 language in the contract not requiring a referral is the operative and binding language and Defendants' unilateral change of this language violated the contract.

In response, Defendants argue that Plaintiffs have not shown a substantial likelihood of success on the merits because during open enrollment, Plaintiffs and Defendants agreed to the essential terms of the contract. Defendants assert that the offer materials available on the websites stated that a referral was required to see a specialist. Defendants contend that individuals could review the terms of Defendants' offer on the website and then decide whether to accept, which Plaintiffs did by submitting an application. Defendants argue that the contrary page 16 language in the Individual Member Contract not requiring the referral was a mistake or scrivener's error, and such error should not be permitted to defeat the clear intention of the parties otherwise shown by the remainder of the contract. Additionally, Defendants argue that the Court must look to the entire contract to ascertain the parties' intent and not merely one part of the contract.

> The construction of contracts involves three steps. At least initially, construction is a matter of law for the court. 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. The existence or nonexistence of an ambiguity is a question of law for the court. If the court determines that an ambiguity exists, however, a jury question does not automatically arise, but rather the court must first attempt to resolve the ambiguity by applying the rules of construction in O.C.G.A. § 13–2–2.

Barrett v. Britt, 319 Ga. App. 118, 122 (2012). Finally, the Court notes that "[i]t is the function of the court to construe the contract as written and not to make a new contract for the parties." Ga. Magnetic Imaging v. Greene Cty. Hosp. Auth., 219 Ga. App. 502, 504 (1995).

"[U]nder Georgia law in attempting to ascertain the intentions of the parties, insurance contracts are governed by the ordinary rules of construction applicable to other contracts." Hooters of Augusta, Inc. v. Am. Glob. Ins. Co., 272 F. Supp. 2d 1365, 1379 (S.D. Ga. 2003), aff'd, 157 F. App'x 201 (11th Cir. 2005). Here, the parties agree that there are conflicting provisions in the Individual Member Contract: the page 16 language not requiring a referral from a PCP to see a specialist and the page 17 language requiring a referral. Therefore, the Court will apply the rules of contract construction. DJ Mortg., LLC v. Synovus Bank, 325 Ga. App. 382, 389 (2013) (applying rules of contract construction where two provisions in a contract conflicted).

As Plaintiffs argue, "[w]hen two provisions of an insurance contract conflict or are repugnant to each other, the provision most favorable to the insured shall apply." W. Pac. Mut. Ins. Co. v. Davies, 267 Ga. App. 675, 678–79 (2004) (quotation omitted); see O.C.G.A. § 13-2-2(5) ("If the construction is doubtful, that which goes most strongly against the party executing the instrument or undertaking the obligation is generally to be preferred."); State Farm Mut. Auto. Ins. Co. v.

Staton, 286 Ga. 23, 25 (2009) ("When an insurance contract is deemed to be ambiguous, it will be construed liberally against the insurer and most favorably for the insured.").

While Plaintiff would end the Court's inquiry there, this one rule of contract construction does not require that the Court turn a blind eye to all other rules of construction. See RLI Ins. v. Highlands on Ponce, LLC, 280 Ga. App. 798 (2006) (reversing the trial court, which found that the insurance contract must be construed in favor of the insurer, and instead applying additional rules of construction to conclude that ambiguity remained for the jury); DJ Mortg., LLC, 325 Ga. App. at 386-93 (recognizing that ambiguities are to be construed against the drafter of the contract but applying additional rules of construction to find that ambiguity remained for jury). Indeed, "[n]o canon of interpretation is absolute. Each may be overcome by the strength of differing principles that point in other directions." DJ Mortg., LLC, 325 Ga. App. at 391 (quotation omitted).

Instead, Georgia courts favor construing and enforcing a contract as a whole over construing a contract against the party drawing and executing it. Bratton v. Am. Nat. Ins. Co., No. C82-1156A, 1983 WL 518, at *2 (N.D. Ga. June 24, 1983), aff'd, 740 F.2d 978 (11th Cir. 1984) (citing Sachs vs. Jones, 83 Ga. App. 441, 444 (1951)). "Although O.C.G.A. § 13-2-2 provides that contracts should be construed against the drafter, it also provides that '[t]he construction which will uphold a

contract in whole and in every part is to be preferred' and that 'the whole contract should be looked to in arriving at the construction of any part.'" Bratton, 1983 WL 518, at *2 (quoting O.C.G.A. § 13-2-2(4)). "While contracts, where the construction is doubtful, must be construed against the party drawing and executing them, nevertheless, a contract should not be torn apart and construed in pieces, but the court should look to the entire instrument and so construe it as to reconcile its different parts and reject a construction which leads to contradiction, in order to ascertain the true intention of the parties, which is the real purpose of the judicial construction of contracts." Perimeter Mall, Inc. v. Retail Sense, Inc., 162 Ga. App. 465, 466 (1982) (quotation omitted); see 16 WILLISTON ON CONTRACTS § 49:16 (4th ed.) ("The rule that an insurance policy will be interpreted liberally in favor of the insured and strictly against the insurer,[] applies only if the language of the policy is ambiguous[] after application of other principles or canons of interpretation,[] such as that requiring the court to view the contract as a whole in light of the circumstances,[] and only if the ambiguity cannot otherwise be resolved.") (citation omitted).

The ambiguity created by the inconsistent provisions may be resolved by looking to the contract as a whole to ascertain the intention of the parties. Viewing the contract as a whole, where there are conflicting provisions, "[t]he clause contributing most essentially to the contract is entitled to the greater consideration

. . . . A subsidiary provision should be so interpreted as not to be in conflict with what clearly appears to be the 'dominant purpose' of the contract." Joseph Camacho Assocs., Inc. v. Millard, 169 Ga. App. 937, 938 (1984) (citations and quotation omitted); see also Amin v. Mercedes-Benz USA, LLC, 301 F. Supp. 3d 1277, 1286 (N.D. Ga. 2018); Amerisave Mortg. Corp. v. Recovco Mortg. Mgmt., LLC, No. 1:17-CV-164-AT, 2017 WL 7519074, at *5 (N.D. Ga. Apr. 7, 2017); Golden Peanut Co. v. Bass, 275 Ga. 145, 149 (2002).

Moreover, "[i]n construing contracts, a specific provision will prevail over a general one." Amin, 301 F. Supp. 3d at 1286 (quoting Holland v. Holland, 287 Ga. 866 (2010)); RLI Ins., 280 Ga. App. at 802 ("when a provision specifically addresses the issue in question, it prevails over any conflicting general language").

When viewing the contract as a whole, and "not merely by examining isolated clauses and provisions," the language on page 16 consists of two sentences under a heading about finding a provider. Alimenta (USA) v. Oil Seed South, 276 Ga. App. 62, 63 (2005). On the other hand, the language on page 17 contains paragraphs and details about specialists and requiring a referral. Additionally, the language on page 17 is specifically listed under a section titled, "Referrals." Thus, the page 17 language is specific language about referrals compared to the general language found in two sentences on page 16 under a heading that is unrelated to referrals. Moreover, the detailed and specific language about the referral process

on page 17 contributes more essentially to the contract than the two general sentences on page 16. The page 17 language sets out not only that the member will need a referral from their PCP but also the essential terms of the contract that the member needs to "understand" including the period of time to visit the specialist and the services that are authorized. Additionally, the page 17 specific language sets forth how to appeal if the member believes a referral from a PCP to see a specialist is not required. Thus, the Court finds that in applying the rules of contract construction stated above, when viewing the contract as a whole, the detailed language about referrals on page 17 prevails over the general language on page 16 and the specific language on page 17 is entitled to greater consideration and serves the dominant purpose of the contract rather than the subsidiary provision found on page 16.

Under Plaintiffs' construction – that is to adhere to the two sentences on page 16 not requiring a referral – all of the detailed language on page 17, including the requirement to get a referral and the appeal process – would be rendered meaningless. On the other hand, adopting Defendants' construction of the specific language on page 17 would render meaningless the two general sentences on page 16, while leaving intact all of the details about seeing a specialist and the appeals process. While either option will render language meaningless, the Court finds that applying the rules of contract construction to give the greatest possible effect

to all provisions favors Defendants' construction. See Immel v. Immel, 298 Ga. App. 424, 426–27 (2009) ("a contract must be interpreted to give the greatest effect possible to all provisions rather than to leave any part of the contract unreasonable or having no effect. And, one of the most fundamental principles of construction is that a court should, if possible, construe a contract so as not to render any of its provisions meaningless.")

Accordingly, as a result of applying the rules of contract construction to the Individual Member Contract, the Court finds that the parties' intent was to agree that a referral for a specialist was required based on looking at the contract as a whole and determining that the language on page 17 contributed most essentially to the contract and was the specific provision compared to the general provision of page 16.

Nevertheless, to the extent any ambiguity remains between the conflicting contract provisions and there was any question about the parties' intent, even after the Court has applied the rules of contract construction above, it would be permissible for the Court to look to parol evidence. See Henninger v. Standard Ins. Co., 332 F. App'x 557, 559 (11th Cir. 2009) (noting that under Georgia law courts are required to apply the rules of construction, including parol evidence, to resolve ambiguities). The "cardinal rule" of contract construction "is to ascertain the intention of the parties," O.C.G.A. § 13–2–3, and parol evidence may be

considered to ascertain intent in construing an ambiguous contract. DJ Mortg., LLC, 325 Ga. App. at 391; see Nguyen v. Talisman Roswell, LLC, 262 Ga. App. 480, 482 (2003) (courts may look to parol evidence to resolve ambiguity despite an "entire agreement" clause in the contract).

The Court turns to the pre-enrollment materials in the Plan Brochure and the SBC. Both of those materials stated that a referral from a PCP to see a specialist was necessary. These are the terms that Defendants offered to Plaintiffs, and Plaintiffs accepted these terms when they submitted an application and paid their premium to Defendants for the plans. Thus, to the extent that any ambiguity remains between the conflicting provisions, the Court finds that when it views the parol evidence of pre-enrollment materials, the parties' intent and the terms on which the offer was made and accepted was that a referral from a PCP to see a specialist was required.

After the hearing on the TRO Motion, Defendants submitted a notice to correct the record, stating that the contract language, including the page 16 language about a referral not being required, was included in the pre-enrollment materials. Defendants explain that on the individual plan websites on anthem.com and healthcare.gov, there was a hyperlink to the SBC. Inside the SBC, there was a hyperlink to the Individual Member Contract containing the page 16 language about a referral not being required, which Defendants maintain was in error.

However, at this time, there is no evidence that any of the Plaintiffs moving for the TRO ever viewed the terms of the Individual Member Contract during pre-enrollment. Indeed, Ms. Logan stated merely that she reviewed information provided on healthcare.gov and Anthem's website and then enrolled in the plan. Pls.' First Am. Compl. at ¶ 89. In her affidavit submitted in support of the TRO, Ms. Logan states that she made sure her specialists were listed by Defendants as being in-network when she signed up for her plan. Decl. of Audrey Logan at ¶ 6. Ms. Kirby stated that prior to enrolling in any plan she also visited Anthem's website and used the provider tool to search whether her specialists were in-network. Pls.' First Am. Compl. at ¶ 107; Decl. of Frances Kirby Aff. at ¶ 4. Similarly, Mr. Johnson states that his doctors were listed on healthcare.gov as being in network. Decl. of Wendell Johnson at ¶ 4.[10] None of these individuals state that they followed the hyperlinks to the contract language and were aware that there was conflicting language or any language about a referral not being required, upon which they relied when accepting Defendants' terms for insurance.

While further discovery may show that Plaintiffs' intent at the time they accepted the terms of insurance from Defendants was that a referral was not needed, at this stage and based on the limited record before the Court, the Court concludes that Plaintiffs have failed to establish a substantial likelihood of success

[10] Mr. Johnson is a putative class member.

on the merits for their breach of contract claim. Instead, viewing the contract in its entirety, giving more weight to the clauses that contribute most essentially to the contract and adhering to the rule that a specific provision prevails over a general one, the Court finds that the parties intended that a referral from a PCP to see a specialist was required. Having found that Plaintiffs have failed to establish a likelihood of success on the merits, the Court need not address the other factors for a TRO. See Ingram v. Ault, 50 F.3d 898, 901 (11th Cir. 1995).

III. Conclusion

For the foregoing reasons, the Court **DENIES** Plaintiffs' Emergency Motion for Temporary Restraining Order, Preliminary Injunction, and Permanent Injunction [Doc. 11].

SO ORDERED, this 21st day of March, 2019.

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