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S.C. SUPREME COURT

IN THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025)

Appellate Case No. 2023-000654
Trial Court Case No. 2020-CP-12-00207

Alexis Jones,.....Petitioner,

v.

Progressive Northern Insurance Company.....Respondent.

PETITION FOR WRIT OF CERTIORARI

John S. Nichols, Esquire
SC Bar # 4210
Bluestein Thompson Sullivan, LLC
P.O. Box 7965
Columbia, SC 29202
(803) 779-7599
John@bluesteinattorneys.com

J. Logan Cannon, Esquire
SC Bar # 101688
Shaw and Cannon, LLC
PO Box 2993
Rock Hill, SC 29732
(803) 329-4200
cannon@shawcannon.com

Attorneys for Petitioner

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CERTIFICATION OF COUNSEL

Counsel for Petitioner Alexis Jones certifies that Petitioner made a petition for rehearing to the Court of Appeals on March 12, 2025, and the Court of Appeals finally ruled on the Petition on April 16, 2025.

INTRODUCTION

Pursuant to Rule 242, SCACR, Respondent-Appellant Alexis Jones petitions this Court to issue a writ of certiorari directed to the Court of Appeals to review the Court's opinion in *Jones v. Progressive Northern Ins. Co.*, 2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025). Ms. Jones asserts that in affirming Ms. Jones' cross-appeal, the Court of Appeals' rulings are in conflict with prior controlling precedent of this Court. Rule 242(b)(3). Furthermore, there are novel questions of law that the Court of Appeals wrongly decided. Rule 242(b)(1).

QUESTIONS PRESENTED FOR REVIEW

I. Did the Court of Appeals err in affirming the circuit court's order dismissing Ms. Jones' claim for bad faith on the finding that Progressive Northern Insurance Company ("Progressive") did not engage in bad faith as a matter of law?

II. Did the Court of Appeals err in affirming the circuit court's order dismissing Ms. Jones' claim for breach of contract accompanied by a fraudulent act on the Court's finding that there was no evidence of an independent fraudulent act that accompanied Progressive's breach of contract because Progressive's "failure to analyze and apply the relevant or proper cases when considering Jones' claim was part of the breach"?

III. Did the Court of Appeals err in affirming the circuit court's order dismissing Ms. Jones' tort claims pursuant to S.C. Code Ann. § 38-77-144 (2015) on the Court's finding that the statute does not create a private right of action?

IV. Did the Court of Appeals err in affirming the circuit court's order denying Ms. Jones recovery under S.C. Code Ann. § 38-59-40 (Supp. 2022) on the Court's conclusion that without a finding of "bad faith" there can be no recovery under the statute?

CONCISE STATEMENT OF THE CASE

Alexis Jones was injured in an automobile collision on October 8, 2019. (R. p. 22). She incurred medical expenses for which her providers charged in excess of $10,000.00. (R. p. 22). Ms. Jones submitted the claims to Progressive for payment under her Progressive policy covering the vehicle she was driving, which included a limit of $10,000.00 in MedPay coverage. (R. pp. 22-23). However, because Ms. Jones was independently covered by Medicaid, Progressive refused to pay the full amount of the medical bills, instead paying only those reduced amounts Medicaid paid to the medical providers.

On March 30, 2020, Ms. Jones filed an action against Progressive for a declaratory judgment seeking a ruling that Progressive's MedPay policy owed her $10,000 in total benefits, for damages for breach of contract, damages for Progressive's bad faith or unreasonable conduct in adjusting the claim, and statutory attorney fees. (R. pp. 21-31).

On April 29, 2020, Progressive filed an answer, contending its obligation was to pay only those amounts Progressive asserted that Ms. Jones "actually incurred" so that Progressive only owed Ms. Jones $1,323.00, the amount Medicaid paid to Ms. Jones' medical providers. (R. pp. 32-38).

On May 11, 2020, Progressive moved to dismiss Ms. Jones' complaint. (R. p. 38). Ms. Jones filed a Memorandum in Opposition to Progressive's motion. (R. pp. 94-106). On August 10, 2020, the circuit court entered a Form 4 order granting Progressive's motion as to Ms. Jones' claim under the SC Unfair Trade Practices Act but denying the remainder of the motion. (R. pp. 2-4).

On August 17, 2020, Ms. Jones filed an Offer of Judgment pursuant to Rule 68, SCRCP.

Thereafter, Progressive moved pursuant to Rule 59, SCRCP, to Alter or Amend the August 10, 2020 order. The circuit court granted the motion in part and denied it in part. (R. pp. 5-10). The circuit court ruled that because Progressive submitted case law that appeared to support Progressive's position, "South Carolina law would not recognize a cause of action for bad faith, breach of the duty of good faith and fair dealing (which is duplicative), breach of fiduciary duty (which is also duplicative) or breach of contract accompanied by a fraudulent act under these circumstances." (R. p. 7). The circuit court also held that Section 38-77-144 does not create a private cause of action. (*Id.*) The circuit court dismissed Ms. Jones' causes of action except for a claim for breach of the insurance contract. (*Id.*)

On May 28, 2021, the parties entered into a stipulation of facts as follows:

1. Alexis Jones was injured in an automobile accident that occurred on October 8, 2019.

2. She was riding in a vehicle owned by Willie Brown and insured by Defendant Progressive Northern Insurance Company under policy number 930693102. The policy provided medical payments coverage of $10,000.00 per person.

3. The Plaintiff received medical treatment from several providers following an automobile accident that occurred on October 8, 2019. Those providers include the Medical University of South Carolina-Lancaster, and Carolina Radiology Associates, LLC.

4. The Plaintiff was a Medicaid recipient and was entitled to benefits pursuant to WellCare of South Carolina Medicaid.

5. On October 8, 2019, Plaintiff was treated at the MUSC facility in Lancaster, South Carolina. The total charges were $23,742.82.

6. MUSC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $115.52 for all treatment rendered to Plaintiff on October 8, 2019.

7. Plaintiff made no payments to MUSC for the treatment received on October 8, 2019 nor is she legally obligated to make any further payment other than the amount accepted by MUSC from South Carolina Medicaid.

8. On October 8, 2019, Plaintiff was treated by physicians in the Emergency Room Department at the MUSC facility in Lancaster, South Carolina (App of South Carolina ED, PLLC). The total charges were $883.63.

9. App of South Carolina ED PPLC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $89.13 for all treatment rendered to Plaintiff on October 8, 2019 by the MUSC Emergency Room Department physicians.

10. Plaintiff made no payments to App of South Carolina ED PPLC for the treatment she received on October 8, 2019, nor is she legally obligated to may any further payment other than the amount accepted by App of South Carolina ED PPLC from South Carolina Medicaid.

11. On October 9, 2019, Plaintiff was treated at the MUSC facility in Lancaster, South Carolina. The total charges were for MUSC were $1,726.09.

12. MUSC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $165.17 for all treatment rendered to the Plaintiff on October 9, 2019.

13. Plaintiff made no payments to MUSC for the treatment received on October 8, 2019, nor is she legally obligated to make any further payment other than the amount accepted by MUSC from South Carolina Medicaid.

14. On October 9, 2019, Plaintiff underwent diagnostic radiology by Carolina Radiology Associates, LLC. The total charges for Carolina Radiology Associates, LLC were $550.00.

15. Carolina Radiology Associates, LLC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $70.15 for all treatment rendered to Plaintiff on October 9, 2019.

16. Plaintiff made no payments to Carolina Radiology Associates, LLC for the treatment received on October 9, 2019 nor is she legally obligated to make any further payment other than the amount accepted by Carolina Radiology Associates, LLC from South Carolina Medicaid.

17. Plaintiff was a recipient of South Carolina Medicaid which had agreements in place with the medical providers listed above which required the medical providers to accept the total sum of $439.97 for the treatment rendered to the Plaintiff. The Plaintiff has not paid any additional sums to any of the medical providers, nor is she legally obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments listed above.

(R. pp. 138-140).

The circuit court heard the matter by bench trial on March 23, 2023. (R. pp. 14-19). On March 29, 2023, the circuit court entered a Form 4 order ruling in favor of Ms. Jones that Progressive had to pay based upon the full amount of the medical charges, not the amount reduced due to Medicaid payments. (R. pp. 10-13). The court denied Ms. Jones' claim for statutory attorney fees based upon the court's prior order dismissing her claim of bad faith. (R. pp. 11). The court issued a more complete order on April 6, 2023 and ordered judgment for Ms. Jones in the amount of $8,676.40. (R. p. 18).

On April 24, 2023, Progressive served and filed a Notice of Appeal. Ms. Jones filed and served a Notice of Cross-Appeal on May 3, 2023. The Court of Appeals heard arguments on December 3, 2024, and on February 26, 2024, the Court issued its opinion affirming the trial court's order in its entirety. *Jones v. Progressive Northern Ins. Co.*, 2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025). Each party petitioned for rehearing and on April 16, 2025, the Court issued its order denying both petitions but amending the opinion to correct a scrivener's error in the filing date.

ARGUMENTS

I. The Court of Appeals Erroneously Affirmed the Dismissal of Plaintiff's Bad Faith Claim

The Court of Appeals erroneously held the circuit court properly dismissed Ms. Jones' bad faith claim, stating "we believe there is no evidence Progressive acted in bad faith." The Court added "Progressive denied Jones the full policy limits based upon its *misapplication* of [*Gordon v. Fid. & Cas. Co. of N.Y.*, 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961)] and [*Barker v. Washington Nat. Ins. Co.*, No. 9:12-cv-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013)]. Although we disagree with Progressive's *interpretation of those cases*, we do not find Progressive acted in bad faith." (emphasis added). This ruling is tantamount to holding that where an insurer "misapplies" or "misinterprets" a case despite the clarity of the case's holdings that do not control and the lack of ambiguity in the contract, the insurer can defeat a bad faith claim in South Carolina. The Court of Appeals' holding is inconsistent with South Carolina law and presents an unacceptable opportunity for mischief on the part of unscrupulous insurance carriers.

South Carolina law provides: "An insurer is not insulated from liability for bad faith *merely because there is no clear precedent* resolving a coverage issue raised under the particular facts of the case." *Portrait Homes-South Carolina, LLC v. Pennsylvania National Mut. Cas. Ins. Co.*, 442 S.C. 515, 900 S.E.2d 245 (Ct. App. 2023), *reh'g denied* April 24, 2024 (emphasis added), citing *Mixson, Inc. v. Am. Loyalty Ins. Co.*, 349 S.C. 394, 400, 562 S.E.2d 659, 662 (Ct. App. 2002). *See, also, Hood v. United Services Auto Association*, 445 S.C. 1, 910 S.E.2d 767 (2025) (citing favorably to *Mixon*'s holding that expanded "a bad faith claim to include not just

nonpayment of a legitimate claim but how that claim was processed").

If an insurer can be liable in bad faith where there is *no* clear precedent, then an insurer most certainly can be liable in bad faith where the insurer "misapplies," "misinterprets," or even misstates the holding of precedent that does not support or is contrary to its position, or fails to bring controlling precedent to the court's attention. Otherwise, all an insurer who denies coverage due under the policy will need to do to defeat a bad faith claim is to "overlook" controlling precedent, or misstate a case's holding based upon a "misinterpretation," that is, "misapplication" of a case. This cannot and should not be the law. *Cf.* Dominik C. Capossa, *First-Party Bad Faith: The Search for a Uniform Standard of Culpability*, 52 Hastings L.J. 181, 188-191 (2000) (noting the "most compelling argument for First-Party Bad Faith states that, without the tort, insurers have a perverse incentive to 'arbitrarily deny coverage and delay payment of a claim with nor more penalty than interest on the amount owed,'" and citing favorably to *Nichols v. State Farm*; article sets forth other considerations underlying the tort, such as unequal availability of counsel, unequal bargaining positions of the parties, the vulnerable physical and financial positions of insureds, and the expectations of the insurance-consuming public).

In this matter, as the Court of Appeals observed, neither of the two cases Progressive relied upon, *Gordon* and the unpublished federal court order in *Barker*, supported the position Progressive took in denying payment to Ms. Jones of benefits she was due under her policy. The Court of Appeals stated that in order to justify its position, Progressive "misapplied" or "misinterpreted" the holdings of each case. This "misapplication" or "misinterpretation" was not reasonable given the plain language and facts of each case. *Gordon*'s holding was

straightforward, involving a soldier who *never* incurred any costs for his medical treatment at the VA Hospital. *Barker*, relying on the same misapplication of *Gordon* Progressive advocated in this case, as well as a specific clause in the subject policy that was absent in this case,[1] is wrongly decided and, being an unpublished order by a Federal District Court, is not binding on South Carolina courts; it is not good precedent for Progressive's position. Even so, each of these holdings is contrary to more current, settled precedent from this Court. *See, e.g., Covington v. George*, 359 S.C. 100, 597 S.E.2d 142 (2004) (evidence that amount hospital accepted in payment was less than what hospital ordinarily charges for its services was inadmissible under collateral source rule); *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003) (amounts "written off" by healthcare providers are recoverable by a plaintiff in a personal injury suit under the collateral source rule). *Cf. Gipson v. Coffey & McKenzie, PA*, Op. No. 28270 (S.C. Sup. Ct. filed March 19, 2025) (Howard Adv. Sh. No. 12 at 13, *16) (noting "the collateral source rule most often arises when the injured party has received money for the injury from one of the following sources of benefits," and including "Medicaid payments" with a cite to *Haselden*).

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[1] The *Barker* case involved a health insurance policy, not an automobile policy. This is a meaningful distinction. Insurers have more flexibility when including terms like the "Medicare Provision" found in the *Barker* policy as opposed to automobile insurance coverage. In an automobile policy, a term must comply with the governing statutory provisions or the term is void. *See, e.g., Cothran v. State Farm. Mut. Auto. Ins. Co.*, 427 S.C. 545, 831 S.E.2d 919 (2019) (holding invalid a "coordination clause" which permitted insurer to reduce PIP payments for workers' compensation recovery). The "Medicare Provision" in *Barker* would likely suffer the same infirmity if included in an automobile PIP/Medpay policy; the validity of such a clause would be questionable given the PIP/Medpay statute's provision that benefits "the coverage shall not be assigned or subrogated and is not subject to a setoff." S.C. Code Ann. § 38-77-144. *See Cothran*, at 547-548, 831 S.E.2d at 920 (defining "setoff" to include "any reduction in the amount a[n]... insurance company would otherwise be obligated to pay on a claim, when the right to the reduction arises as a result of payment from a third party.").

As a means of protecting insureds who ordinarily possess no bargaining power when entering into an insurance contract, this Court recognized the tort action for an insurer's bad faith refusal to pay first party benefits in *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616 (1983). Just this year the Court described and reaffirmed this holding from *Nichols*.[2] *Hood v. United Services Auto Association*, *supra* (filed Jan. 8, 2025). Permitting Progressive to escape bad faith exposure based upon an unreasonable application of a case that is nearly 65 years old, and as interpreted unreasonably by Progressive, is contrary to this Court's jurisprudence under *Nichols* and its progeny.

Ms. Jones respectfully requests that this Court grant this Petition, issue a writ of certiorari to the Court of Appeals, and reverse the Court of Appeals' decision affirming the circuit court's dismissal of Ms. Jones' bad faith claim.

II. The Court of Appeals Erroneously Affirmed the Dismissal of Plaintiff's Claim for Breach of Contract Accompanied by a Fraudulent Act

The Court affirmed the circuit court's dismissal of Ms. Jones' claim for breach of contract accompanied by a fraudulent act. The Court stated, "There is no evidence of an independent fraudulent act that accompanied Progressive's breach of contract because its failure to analyze and apply the relevant or proper cases when considering Jones' claim was *part of* the breach." (emphasis by the Court). This Court should reverse.

Although the Court cited to this Court's holding in *Connor v. City of Forest Acres*, the

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[2] Westlaw flags *Nichols* as overruled. This is a mistreatment. The case Westlaw references, *Duncan v. Provident Mut. Life Ins. Co.*, 310 S.C. 465, 427 S.E.2d 657 (1993), holds merely that "the tort created by *Nichols* is expressly preempted when the bad faith claim arises under an employee benefit plan" under ERISA and federal law. *Nichols* is otherwise still good law, as this Court recently reaffirmed in *Hood*.

Court failed to properly apply the case. This Court held:

> In order to have a claim for breach of contract accompanied by a fraudulent act, the plaintiff must establish three elements: (1) a breach of contract; (2) fraudulent intent relating to the breaching of the contract and not merely to its making; and (3) a fraudulent act accompanying the breach. *Harper v. Ethridge*, 290 S.C. 112, 348 S.E.2d 374 (Ct. App. 1986). The fraudulent act is any act characterized by dishonesty in fact *or unfair dealing. Id.* "Fraud," in this sense, "assumes so many hues and forms, that courts are compelled to content themselves with comparatively few general rules for its discovery and defeat, and allow the facts and circumstances peculiar to each case to bear heavily upon the conscience and judgment of the court or jury in determining its presence or absence." *Sullivan v. Calhoun*, 117 S.C. 137, 139, 108 S.E. 189, 189 (1921) (citation omitted).

348 S.C. 454, 465-466, 560 S.E.2d 606, 612 (2002) (emphasis added).

The Court of Appeals rejected Ms. Jones' contention that she provided evidence that Progressive engaged in *unfair dealing* in the manner in which Progressive adjusted her claims for MedPay benefits, and this unfair dealing was separate from the contract breach. Progressive advocated its "misapplication" or "misinterpretation" of *Gordon*, a case that is meaningfully distinct and greatly predates settled precedent to the contrary, and *Barker*, a non-binding US District Court case that is also meaningfully distinct and is wrongly decided. *Barker* relied upon *Gordon*, the same older case, and the district court wrongfully predicted the application of South Carolina law. *Barker* also involved health insurance, which is not as heavily regulated as automobile insurance. Neither Progressive nor the District Court analyzed relevant, applicable, and more recent precedent to the contrary. Ms. Jones was therefore required to bring suit to force Progressive to honor its contractual commitments because of Progressive's unreasonable assertion that *Gordon* and *Barker* permitted it to deny complete coverage. Progressive's action in

"misreading" or "misapplying" these cases amounted to unfair dealing with her, which was apart from its breach of Ms. Jones' contract of insurance by its arbitrary reduction in payments due.

The Court should grant this Petition, issue the writ of certiorari, and reverse the circuit court's order denying Ms. Jones claims for breach of contract accompanied by a fraudulent act as described in *Connor*.

III. The Court of Appeals Erroneously Affirmed the Ruling that Plaintiff Has No Private Right of Action Under Section 38-77-144

The Court of Appeals affirmed the circuit court's ruling that S.C. Code Ann. § 38-77-144 (2015) does not provide a private right of action to Ms. Jones. The Court stated:

> We find the Legislature did not intend to provide insureds a private cause of action under section 38-77-144. The statute does not expressly create a civil liability on behalf of the insurer, and we find the Legislature intended only to protect insureds from an insurance company applying a setoff. Accordingly, we hold the Legislature did not enact this statute with the intention of providing an insured with an additional cause of action when an insurance company improperly reduces the amount it is obligated to pay pursuant to the policy. Therefore, we find the court did not err.

Jones, at p. 5 (internal citations omitted). The Court rejected Ms. Jones' specific arguments in making this ruling.

This was a novel issue before the circuit court and the Court of Appeals. Neither this Court nor the Court of Appeals has previously addressed whether Section 38-77-144 provides a private right of action. Both the circuit court and the Court of Appeals wrongly decided the matter.

Section 38-77-144 provides "[i]f an insurer sells no-fault insurance coverage which provides personal injury protection, medical payment coverage, or economic loss coverage, the

coverage shall not be assigned or subrogated and is not subject to a setoff." Ms. Jones pointed out to both the circuit court and the Court of Appeals that the essential purpose of Section 38-77-144 is not to secure the safety or welfare of the public. Instead, the statute was enacted for the purpose of protecting an insured who elects to purchase PIP or MedPay coverages that an insurer voluntarily offers to the insured. The essential purpose of the statute is to create no-fault coverage for payment of medical bills or lost wages, and to prevent any assignment, subrogation *or set-off* of those benefits.

Progressive improperly sought a set-off for reductions done due to a collateral source, Medicaid. The only way Ms. Jones, as the insured, can enforce the express provisions of Section 38-77-144 and force Progressive to comply is by bringing a private lawsuit. *Cf. Nichols v. State Farm Mut. Ins. Co.*, at 340, 306 S.E.2d at 619 ("Absent the threat of a tort action, the insurance company can, with complete impunity, deny any claim they wish, whether valid or not."). Ms. Jones' right to sue to force Progressive to follow the plain language of Section 38-77-144 is implied within the statute's language and purpose.

The Court of Appeals also failed to consider this Court's precedent holding "[i]n order to show that the defendant owes him a duty of care arising from a statute, the plaintiff must show two things: (1) that the essential purpose of the statute is to protect from the kind of harm the plaintiff has suffered; and (2) that he is a member of the class of persons the statute is intended to protect." *Denson v. National Casualty Co.*, 439 S.C. 142, 151-152, 886 S.E.2d 228, 233-234 (2023), citing *Rayfield v. S.C. Dep't of Corr.*, 297 S.C. 95, 103, 374 S.E.2d 910, 914 (Ct. App. 1988). *See, also, Isaac v. Onions*, Op. No. 28274 (S.C. Sup. Ct. filed April 23, 2025) (Howard Adv. Sh. No. 16 at 7, *15) ("the general rule is that a statute which does not purport to establish a

civil liability, but merely makes provision to secure the safety or welfare of the public as an entity is not subject to a construction establishing a civil liability"). The essential purpose of Section 38-77-144 is not to secure the safety or welfare of the public as an entity, but rather to protect insureds who buy optional PIP or Medpay coverage from having the insurer reduce the payments based upon an arbitrary claim of a setoff, as Progressive did in this case. The only way that an insured can enforce that protection is through a lawsuit. *Nichols*. Ms. Jones falls squarely within the class of persons the statute is intended to protect.

By holding the statute only prevents an insurer from applying a setoff without any risk of a private cause of action, the Court construes the statute to provide the insurers a "free shot" at denying payments rightly due under the agreement. If they are wrong, they simply pay what was always due while enjoying the use of the funds during the dispute. Insurers must be held to account for violating a statute designed to protect a discrete class of persons like Ms. Jones, that is, those who purchased voluntary PIP or Medpay.

This Court should issue the writ of certiorari and reverse the Court of Appeals' opinion which affirmed the trial court's ruling, and should remand the matter with instructions to permit Ms. Jones to proceed with her claim under Section 38-77-144.

IV. The Court of Appeals Erroneously Affirmed the Dismissal of Plaintiff's Claim for Attorneys' Fees Pursuant to S.C. Code Ann. § 38-59-40

The Court of Appeals ruled "because we hold the circuit court properly dismissed the bad faith claim, we do not reach the issue of attorneys fees." Because the Court improperly affirmed the dismissal of Ms. Jones' bad faith claim, this Court should issue a writ of certiorari, review the

Court of Appeals' holding dismissing Ms. Jones' claim for attorneys' fees, and reverse.

Furthermore, the Court of Appeals ignored that an award of fees under S.C. Code Ann. § 38-59-40 (Supp. 2022) does *not* require a finding of bad faith for an award. The statute provides:

> In the event of a claim, loss, or damage which is covered by a policy of insurance or a contract of a nonprofit hospital service plan or a medical service corporation and the refusal of the insurer, plan, or corporation to pay the claim within ninety days after a demand has been made by the holder of the policy or contract and a finding on suit of the contract made by the trial judge that the *refusal was without reasonable cause or in bad faith*, the insurer, plan, or corporation *is liable to pay the holder*, in addition to any sum or any amount otherwise recoverable, all reasonable attorneys' fees for the prosecution of the case against the insurer, plan, or corporation. The amount of reasonable attorneys' fees must be determined by the trial judge and the amount added to the judgment. The amount of the attorneys' fees may not exceed one-third of the amount of the judgment.

S.C. Code Ann. § 38-59-40 (emphasis added). Thus, an insurer "is liable" to an insured for reasonable attorneys' fees as determined by the trial judge upon a finding of one of two things: Either (1) refusal to pay the claim without reasonable cause, *or* (2) refusal to pay the claim due to bad faith. By summarily dismissing the claim for attorney fees under the statute under a holding that there is no evidence of bad faith (which is wrong), both the circuit court and the Court of Appeals essentially amended the statute's use of the word "or" into an "and." Amending this statute, however, is for the General Assembly, not the Court. *Cf. Doe v. State*, 421 S.C. 490, 508, 808 S.E.2d 807, 816 (2017) (the Court cannot construe or effectively amend statutes to change the plain language of "and" to "or"), citing *Shelley Constr. Co. v. Sea Garden Homes, Inc.*, 287 S.C. 24, 28, 336 S.E.2d 488, 491 (Ct. App. 1985) ("We are not at liberty, under the guise of construction, to alter the plain language of the statute by adding words which the Legislature saw fit not to include.")

The Court of Appeals rejected Ms. Jones' argument that the trial judge erred as a matter of law by stating that his finding that Progressive did not act in bad faith precluded payment under the statute. The preponderance of the evidence demonstrates that Progressive at least acted without reasonable cause in light of the settled law of South Carolina. Progressive refused to pay Ms. Jones based upon Progressive's "misapplication," "misinterpretation," or misstatement of the holdings in *Gordon* and *Barker* (two cases that are meaningfully distinct) so as to support Progressive's unsupported argument that Ms. Jones' contract of insurance permitted Progressive to limit payment to the medical expenses it claims she "actually incurred." Progressive then arbitrarily deemed the claims to be the reduced amount paid by a collateral source, Medicaid. This was not "reasonable cause" to deny payment to her in light of this Court's precedent.

The Court should grant this Petition, issue the writ of certiorari, and reverse the Court of Appeals' decision affirming the circuit court's order denying Ms. Jones the right to seek attorney fees under Section 38-59-40.

CONCLUSION

For the reasons stated the Court should grant this Petition, issue the writ of certiorari and reverse the Court of Appeals' opinion upholding the trial court's order dismissing Ms. Jones' claims for bad faith, violation of Section 38-77-144, and breach of contract accompanied by a fraudulent act. The Court should remand this matter to the circuit court for further proceedings. The Court should also reverse the circuit court's order denying Ms. Jones' motion for an award of statutory fees and costs, and should remand the matter for entry of judgment or other proceedings in accordance with this Court's mandate.

Respectfully submitted,

John S. Nichols, Esquire
SC Bar # 4210
Bluestein Thompson Sullivan, LLC
P.O. Box 7965
Columbia, SC 29202
(803) 779-7599
John@bluesteinattorneys.com

J. Logan Cannon, Esquire
SC Bar # 101688
Shaw and Cannon, LLC
PO Box 2993
Rock Hill, SC 29732
(803) 329-4200
cannon@shawcannon.com

Attorneys for Respondent-Appellant

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