

IN THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

Appellate Case No. 2023-000654

RECEIVED
MAY 16 2025
S.C. SUPREME COURT

Alexis Jones Respondent,

v.

Progressive Northern Insurance Company.....Petitioner.

APPENDIX

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INDEX

Record on Appeal	1
Appellant Brief of Appellant-Respondent	192
Respondent Brief of Respondent -Appellant	210
Reply Brief of Appellant-Respondent	220
Appellant Brief of Respondent-Appellant	241
Respondent Brief of Appellant-Respondent	266
Court of Appeals Opinion filed February 26, 2025	295
Appellant-Respondent Petition for Rehearing	300
Respondent-Appellant Petition for Rehearing	310
Order Denying Petitions for Rehearing filed April 16, 2025	326
Court of Appeals Opinion filed April 16, 2025	328

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

RECEIVED

Nov 08 2023

SC Court of Appeals

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company Appellant – Respondent

RECORD ON APPEAL

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INDEX

	Page
<u>ORDERS</u>	
Form 4 Order of August 10, 2020.....	002
Order of February 10, 2021	005
Form 4 Order of March 29, 2023.....	010
Order of April 6, 2023	014
<u>PLEADINGS</u>	
Complaint.....	020
Answer to Complaint.....	032
<u>MOTIONS</u>	
Defendant's Motion to Dismiss filed May 11, 2020.....	038
Defendant's Memorandum of Law in Support of Motion to Dismiss filed May 11, 2020.....	039
Ex. A Progressive Policy	053
Plaintiff's Motion in Opposition to Defendant's Motion for Summary Judgment filed June 18, 2020.....	094
Defendant's Motion to Reconsider filed August 20, 2020	107
<u>TRANSCRIPTS</u>	
Bench Trial Transcript dated March 27, 2023	109
<u>OTHER MATERIALS</u>	
Stipulation of Fact filed May 28, 2021	138
Ex. A Progressive Policy	141
Ex. B Medical Bill	184
Ex. C Medical Bill	185
Ex. D Medical Bill	186
Ex. E Medical Bill.....	187
Ex. F Medical Bill.....	188
Certificate of Counsel	189

STATE OF SOUTH CAROLINA
COUNTY OF Chester
IN THE COURT OF COMMON PLEAS

FORM 4

JUDGMENT IN A CIVIL CASE

CASE NO. 2020CP1200207

Willie Brown et al
PLAINTIFF(S)

Progressive Northern Insurance Company
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

- ☐ JURY VERDICT. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ DECISION BY THE COURT. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ ACTION DISMISSED (CHECK REASON): ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled); ☐ Other
- ☐ ACTION STRICKEN (CHECK REASON): ☐ Rule 40(j), SCRPC; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other
- ☐ STAYED DUE TO BANKRUPTCY
- ☐ DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

After further review and deliberation Judge Gibbons has granted the Motion to Dismiss in part and denied in part. Granted as to the SCUTPA claim and denied as to the remaining claims.

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

☐ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 08/10/2020 .

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Fileers or who are appearing pro se. See Rule 77(d), SCRCF.

ELECTRONICALLY FILED - 2020 Aug 10 10:52 AM - CHESTER - COMMON PLEAS - CASE#2020CP1200207



Chester Common Pleas

Case Caption: Willie Brown , plaintiff, et al VS Progressive Northern Insurance Company
Case Number: 2020CP1200207
Type: Order/Electronic Form 4

So Ordered

s/Brian M. Gibbons #2168 Circuit Judge

Electronically signed on 2020-08-10 10:49:03 page 3 of 3

STATE OF SOUTH CAROLINA
COUNTY OF CHESTER

IN THE COURT OF COMMON PLEAS
CIVIL ACTION NO: 2020-CP-12-00207

Alexis Jones,

Plaintiff,

v.

Progressive Northern Insurance Company,

Defendant.

ORDER

This matter comes before the Court on Defendant's Motion to Alter or Amend the prior Order of this Court, dated August 10, 2020, which granted in part and denied in part the Defendant's Motion to Dismiss. For the reasons set forth below, the Motion to Alter or Amend the prior Order is granted in part and denied in part.

This lawsuit arises out of Progressive Northern Insurance Company's ("Progressive Northern") payment of Plaintiff's Medical Payments claim under a Progressive Northern auto policy, Policy No. 930693102, issued to Willie Brown. The Complaint alleges that Plaintiff Alexis Jones incurred medical expenses as a result of an October 8, 2019 automobile accident and timely submitted a Medical Payments claim to Progressive Northern. Plaintiff is a Medicaid recipient. In South Carolina, Medicaid has agreements in place with medical service providers wherein the providers have agreed to accept reduced rates as payment-in-full when treating Medicaid recipients. The Complaint alleges that Progressive Northern paid Jones' Medical Payments claim based on the Medicaid-adjusted rates charged by her medical providers rather than total charges listed on the medical providers' initial bills.

This action concerns whether Medical Payment benefits under the policy are to be paid: (1) based on the Medicaid-adjusted rates accepted by the medical providers as payment-in-full for the services rendered; or (2) based on the stated amounts listed on the initial bills. The Complaint

alleges the following causes of action: (1) breach of contract; (2) bad faith/breach of the duty of good faith and fair dealing/breach of fiduciary duty; (3) violation of the South Carolina Unfair Trade Practices Act; (4) violation of South Carolina Code § 38-77-144; and (5) and breach of contract accompanied by a fraudulent act. In the prior Order, the Court dismissed the South Carolina Unfair Trade Practices Act claim and also dismissed Willie Brown as a Plaintiff. That portion of the prior Order is unchanged, and those rulings remain in effect. However, the Court now alters its prior Order and dismisses the remaining causes of action except for the breach of contract cause of action. The Court denies Defendant's Motion to Dismiss with respect to the breach of contract cause of action. This case will proceed only on the breach of contract cause of action.

Under South Carolina law, an insurer who has a meritorious coverage defense is free to litigate the issue without fear of a bad faith or extra contractual claim. *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359, 415 S.E.2d 393, 396 (1992). Moreover, an insurer is not required to concede a novel issue of law in order to avoid a bad faith lawsuit. *Id.*; *Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 357 S.C. 631, 645, 594 S.E.2d 455, 462 (2004).

In this case, Progressive Northern submitted legal authority that the term or the phrase "expenses incurred" meant the amount of money which an insured is legally obligated to pay for medical treatment. *Gordon v. Fidelity & Cas. Co. of N. Y.*, 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961); *Barker v. Washington Nat. Ins. Co.*, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013). Progressive Northern also submitted out of jurisdiction cases supporting this principle of law. In opposition, the Plaintiff contends that the reduction of the medical invoices pursuant to an agreement between South Carolina Medicaid and the medical provider constitutes a setoff under South Carolina Code Section 38-77-144. As such, she contends that the reduction is improper, and

she should be entitled to the full policy limits of medical payments coverage. *See* S.C. Code § 38-77-144; *Cothran v. State Farm Mut. Auto. Ins. Co.*, 427 S.C. 545, 831 S.E.2d 919 (2019). Based on this, the Court declines to alter its earlier ruling and dismiss the cause of action for breach of contract. However, the Court finds that based on the allegations of the Complaint, and the legal positions of the parties, that 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. Therefore, those causes of action in the Plaintiff's Complaint, are hereby dismissed. Plaintiff's violation of South Carolina Code § 38-77-144 claim is also dismissed. The statute creates no private cause of action. *See Dorman v. Aiken Commc'ns, Inc.*, 303 S.C. 63, 67, 398 S.E.2d 687, 689 (1990) ("[T]he 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."). "However, statutes relating to an insurance contract are generally part of the contract as a matter of law." *Lincoln Gen. Ins. Co. v. Progressive N. Ins. Co.*, 406 S.C. 534, 539, 753 S.E.2d 437, 439 (Ct. App. 2013). Therefore, a violation of this statute may constitute a breach of the insurance contract.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED:

The prior ruling dismissing the Plaintiff Willie Brown and the South Carolina Unfair Trade Practices Act claim is reaffirmed. The causes of action for bad faith, breach of the duty of good faith and fair dealing, breach of fiduciary duty, and breach of contract accompanied by a fraudulent act are also dismissed.

The only remaining cause of action in this case will be the Plaintiff's cause of action for breach of contract. Nothing in this Order should be construed as a ruling on whether the

reimbursement of the reduced amounts of the bills of the medical providers, pursuant to an agreement with South Carolina Medicaid by the providers, constitutes a setoff under South Carolina law. That issue is subject to further argument after discovery is completed.

IT IS SO ORDERED.

The Honorable Brian M. Gibbons

Chester, South Carolina

Dated: _____



Chester Common Pleas

Case Caption: Alexis Jones , plaintiff, et al VS Progressive Northern Insurance Company
Case Number: 2020CP1200207
Type: Order/Amend

So Ordered

s/Brian M. Gibbons #2168 Circuit Judge

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APPENDIX - 00010

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHESTER	)	FOR THE SIXTH JUDICIAL CIRCUIT
	)	
Alexis Jones,	)	CIVIL ACTION NUMBER: 2020-CP12-00207
Plaintiff,	)	
v.	)	
	)	FORM 4 ORDER
Progressive Northern Insurance Co.,	)	
Defendant.	)	

This matter came before the court for a bench trial on a breach of contract claim disputing the definition of 'incurred' within the policy. The parties stipulated to the following: Plaintiff was injured in an automobile accident while riding as a passenger in a vehicle insured by the defendant; The policy includes a \$10,000 medical payments coverage limit for "reasonable expenses incurred" as a result of an accident; Plaintiff was treated for her injuries with the total medical expenses being in excess of the policy limits; Subsequently, medical providers agreed to accept less than the original amount charged from Medicaid as required by law and/or its agreement; Defendant made payments to Plaintiff for the amount Medicaid paid to satisfy the medical bills.

The issue before the court is whether the Plaintiff "incurred" the full amount charged by her medical providers or the amount her providers got paid by Medicaid. The Defendant and Medicaid do not have contractual relationship. Plaintiff argues she "incurred" the full expense of the bill irrespective of how the expenses were paid by Medicaid and thus the Defendant's failure to reimburse her the expenses "incurred" is a breach of contract. Plaintiff seeks judgment in the amount of \$8,676.40, policy limits minus the amount already paid to Medicaid, as well as attorney's fees in the amount of \$14,000.

Defendant argues Plaintiff "incurred" only the expenses at the reduced rate and therefore cannot establish a breach of contract claim. Defendant asserts that under *Gordon v. Fidelity Cas. Co. of N.Y.* plaintiff "incurs" no expense above the reduced rates negotiated with the providers, and the insurer has no duty to pay the amounts the insured did not actually pay. 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961). Additionally, the Defendant points to *Barker v. Washington Nat. Ins. Co.*, a factually similar case, where the Court held that under South Carolina law, the insured was never obligated to pay more than the amount that the hospital has agreed to accept as full payment under Medicare. No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013).

Following the presentation of evidence, the court took this matter under advisement. After further review and deliberation, the court respectfully finds the Plaintiff "incurred" the full amount charged at the time services were rendered and thus became entitled to the full amount of reimbursement coverage under the policy. An insurer's obligation under an insurance policy is defined by the terms of the policy and cannot be enlarged by judicial construction. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137 (Ct. App. 1990). The terms of the insurance policy must be construed most liberally in favor of the insured and where the words of a policy are ambiguous, or where they are capable of two reasonable interpretations, that construction will be adopted which is most favorable to the insured. *Pitts v. Glens Falls Indemnity Company*, 222 S.C. 133 72 S.E.2d 174 (1952). Here, the term "incurred" is not defined within the policy and both parties have offered reasonable interpretations, therefore the term "incurred" is ambiguous.

The dictionary definition of "incurred" means "[t]o become liable or subject to." *Black's Law Dictionary* 768 (6th Ed. 1990). The Court finds that a patient is responsible for any charges incurred regardless of whether insurance or some other party ultimately pays it or negotiated for a reduced rate. Therefore, Plaintiff incurred the full cost of her medical treatment at the time services were rendered as she became obligated for that amount irrespective of Medicaid. The court finds *Gordon* to be distinguishable from the case at bar. In *Gordon*, the Court found that since the parties to the action stipulated the veteran plaintiff incurred no expenses, made no cash outlay, and there being no obligation on the insured to pay for the hospitalization he received at the Fort Jackson government hospital as the treatment was provided at no cost or expense to him, he "incurred" no expenses within the meaning of the policy. 238 S.C. at 446. Unlike *Gordon*, the Plaintiff in this case was in fact charged for the services rendered at the time they were rendered thereby incurring those expenses notwithstanding Medicaid. For the same reason, this Court respectfully disagrees with the *Barker* Court and declines to follow.

As to attorney's fees, the court finds the plaintiff is not entitled to such. As a general rule, attorney's fees are not recoverable unless authorized by contract or statute. *Keeney's Metal Roofing, Inc. v. Palmieri*, 345 S.C. 550, 553, 548 S.E.2d 900, 902 (Ct. App. 2001). Under S.C. Code Ann. §38-59-40, the insurer is liable to pay all reasonable attorney's fees for the prosecution of the case where the trial judge makes a finding "that the refusal was without reasonable cause or in bad faith." The court previously dismissed the bad faith cause of action in this matter finding the insurer denial of the full amount was not in bad faith, and made no finding at trial or in its review of the record that would suggest the refusal was made in bad faith or without reasonable cause. Additionally, a review of the policy shows no inclusion of such a provision entitling the plaintiff to attorney's fee. Therefore, the court respectfully denies the plaintiff's request for attorney's fees.

Plaintiff is entitled to judgement in the amount of \$8676.40.

Plaintiff's attorney Mr. Logan Cannon to prepare a more formal order in its proper format.

IT IS SO ORDERED



Chester Common Pleas

Case Caption: Alexis Jones , plaintiff, et al VS Progressive Northern Insurance Company
Case Number: 2020CP1200207
Type: Order/Form 4

So Ordered

s/Brian M. Gibbons #2168 Circuit Judge

Electronically signed on 2023-03-29 15:00:16 page 4 of 4

STATE OF SOUTH CAROLINA	}	IN THE COURT OF COMMON PLEAS
	}	FOR THE SIXTH JUDICIAL CIRCUIT
COUNTY OF CHESTER	}	
Alexis Jones and Willie Brown,	}	
	}	Civil Case #: 2020-CP-12-00207
Plaintiffs,	}	
-vs-	}	
	}	ORDER
Progressive Northern Insurance Company,	}	
	}	
Defendant.	}	

This matter was heard by the Court as a bench trial on March 27, 2023. After hearing testimony, reviewing the evidence and hearing the arguments of the parties, the Court submitted a verdict on March 29, 2023 that found for the Plaintiff Alexis Jones on her breach of contract claim. This Order accompanies that verdict pursuant to Rules 52 and 58, SCRPC.

FACTS / BACKGROUND

This action arose out of Progressive's failure to pay Plaintiff Alexis Jones the full \$10,000 in medical payments coverage owed to her under Willie Brown's auto policy as a result of an auto accident on October 8, 2019. The policy includes a \$10,000.00 medical payments coverage limit for "reasonable expenses incurred for necessary medical services" sustained by an insured as a result of an auto accident. Plaintiff Jones is a listed driver on the policy. As a result of the accident, Plaintiff Jones sought medical care and treatment with total billing that amounted to \$27,786.17. Plaintiff Jones submitted a demand to Progressive for full payment of the \$10,000.00 medical payment coverage in light of the total medical bill amount.

Progressive was made aware that Plaintiff Jones is a Medicaid recipient. After receiving Plaintiff's demand, Progressive disagreed and only made payment to Plaintiff Jones for the amount Medicaid paid to satisfy the medical bills (\$1,323.60) rather than the medical payment coverage limit.

This suit for breach of contract followed the dispute. At trial, Plaintiff sought full payment of the medical payments coverage that was owed under the insurance policy with Defendant Progressive. Defendant Progressive argued that Plaintiff Jones was only entitled to reimbursement for the amount paid by Medicaid. This Court was presented with the issue of determining the amount of reasonable expenses "incurred" by the Plaintiff.

The parties stipulated to facts before trial and no further objections were raised at trial. Plaintiff presented testimony from herself and Willie Jones.

LAW /ANALYSIS

This matter came before the court for a bench trial on a breach of contract claim disputing the definition of "incurred" within the policy. The parties stipulated to the following: Plaintiff was injured in an automobile accident while riding as a passenger in a vehicle insured by the defendant; The policy includes a \$10,000 medical payments coverage limit for "reasonable expense incurred" as a result of an accident; Plaintiff was treated for her injuries with the total medical expenses being in excess of the policy limits; Subsequently, medical providers agreed to accept less than the original amount charged from Medicaid as required by law and/or its agreement; Defendant made payments to Plaintiff for the amount Medicaid paid to satisfy the medical bills.

The issue before the court is whether the Plaintiff "incurred" the full amount charged by her medical providers or the amount her providers got paid by Medicaid. The Defendant and Medicaid do not have a contractual relationship. Plaintiff argues she "Incurred" the full expense of the bill irrespective of how the expenses were paid by Medicaid and thus the Defendant's failure to reimburse her the expenses "incurred" is a breach of contract. Plaintiff seeks judgment in the amount of \$8,676.40, policy limits minus the amount already paid to Medicaid, as well as attorney's fees in the amount of \$14,000.00

Defendant argues Plaintiff "incurred" only the expenses at the reduced rate and therefore cannot establish a breach of contract claim. Defendant asserts that under *Gordon v. Fidelity Cas. Co. of N.Y.* plaintiff "incurs no expense above the reduced rates negotiated with the providers, and the insurer has no duty to pay the amounts the insured did not actually pay. 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961). Additionally, the Defendant points to *Barker v. Washington Nat. Ins. Co.*, a factually similar case, where the Court held that under South Carolina law, the insured was never obligated to pay more than the amount that the hospital has agreed to accept as full payment under Medicare. No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013).

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services was rendered as she became obligated for that amount irrespective of Medicaid. The court finds *Gordon* to be distinguishable from the case at bar. In *Gordon*, the Court found that since the parties to the action stipulated the veteran plaintiff incurred no expenses, made no cash outlay, and there being no obligation on the insured to pay for the hospitalization he received at the Fort Jackson government hospital as the treatment was provided at no cost or expense to him, he 'incurred' no expenses within the meaning of the policy. 238 S.C. at 446. Unlike *Gordon*, the Plaintiff in this case was in fact charged for the services rendered at the time they were rendered thereby incurring those expenses notwithstanding Medicaid. For the same reason, this Court respectfully disagrees with the *Barker* Court and declines to follow.

As to attorney's fees, the court finds the plaintiff is not entitled to such. As a general rule, attorney's fees are not recoverable unless authorized by contract or statute. *Keeney's Metal Roofing, Inc. v. Palmieri*, 345 S.C. 550, 553, 548 S.E.2d 900, 902 (Ct. App. 2001). Under S.C. Code Ann. §38-59-40, the insurer is liable to pay all reasonable attorney's fees for the prosecution of the case where the trial judge makes a finding "that the refusal was without reasonable cause or in bad faith." The court previously dismissed the bad faith cause of action in this matter finding the insurer denial of the full amount was not in bad faith, and made no finding at trial or in its review of the record that would suggest the refusal was made in bad faith or without reasonable cause. Additionally, a review of the policy shows no inclusion of such a provision entitling the plaintiff to attorney's fee. Therefore, the court respectfully denies the plaintiff's request for attorney's fees. Plaintiff is entitled to judgement in the amount of \$8,676.40.

CONCLUSION

Based on the foregoing analysis, this Court finds that the Defendant Progressive Northern Insurance Company owed a contractual obligation to Plaintiff Jones, that Progressive Northern

Insurance Company breached that contract, and that Plaintiff experienced damages as a proximate cause of said breach.

THEREFORE, this Court hereby finds for the Plaintiff as stated on the verdict that has been filed and orders that a judgment be entered in the amount of \$8,676.40 against the Defendant.

IT IS SO ORDERED.

April __, 2023
Chester, South Carolina

Judge Brian M. Gibbons
Sixth Judicial Circuit



Chester Common Pleas

Case Caption: Alexis Jones , plaintiff, et al VS Progressive Northern Insurance Company
Case Number: 2020CP1200207
Type: Order/Other

So Ordered

s/Brian M. Gibbons #2168 Circuit Judge

Electronically signed on 2023-04-06 11:54:05 page 6 of 6

STATE OF SOUTH CAROLINA	}	IN THE COURT OF COMMON PLEAS
	}	FOR THE SIXTH JUDICIAL CIRCUIT
COUNTY OF CHESTER	}	
Alexis Jones and Willie Brown,	}	
	}	Civil Case #: 2020-CP-12-
Plaintiff,	}	
-vs-	}	
	}	SUMMONS
Progressive Northern Insurance Company,	}	
	}	
Defendant.	}	

TO THE ABOVE NAMED DEFENDANT:

YOU ARE HEREBY SUMMONED and required to appear and defend the within action and to answer the Complaint in this action of which a copy is herewith served upon you, and to serve a copy of your Answer to the Said Complaint on the subscribers at their office located at 1169 Ebenezer Road, Rock Hill, South Carolina 29732 OR Post Office Drawer 36250, Rock Hill, South Carolina 29732, within thirty (30) days after the service thereof, exclusive of the day of such service; and if you fail to appear and defend the within action within the time aforementioned, then judgment by default will be rendered against you for the relief demanded in the Complaint.

Dated this 30 day of March 2020.

Respectfully submitted,

s/J. Logan Cannon
J. Logan Cannon, SC Bar #101688
Shaw Law Firm
Post Office Drawer 36250
Rock Hill, South Carolina 29732
(803) 329-4200
Attorney for the Plaintiff

STATE OF SOUTH CAROLINA
COUNTY OF CHESTER

IN THE COURT OF COMMON PLEAS
FOR THE SIXTH JUDICIAL CIRCUIT

Alexis Jones and Willie Brown,

Plaintiff,

-vs-

Progressive Northern Insurance Company,

Defendant.

Civil Case #: 2020-CP-12-

**BAD FAITH COMPLAINT AND
DECLARATORY JUDGMENT**

Now come the Plaintiffs complaining of the Defendant herein, and would respectfully allege and show the following:

PARTIES AND JURISDICTION

1. Plaintiffs are citizens and residents of Chester County, South Carolina.
2. Defendant is a corporation organized and existing under the laws of one of the states of the United States and maintains agents and servants in the county and state aforesaid for the purpose of carrying on its business.
3. At all relevant times herein, Defendant Progressive, regularly and repeatedly conducted business within Chester County, South Carolina. As such, Defendant, its agents, servants, adjusters, counsel and employees are charged with the knowledge of those laws and regulations as they relate to the evaluation, processing and handling of insurance claims, including but not limited to medical payments, and/or personal injury protection coverage and claims.
4. Defendant and Plaintiff Brown entered into an insurance contract in Chester County, South Carolina.

5. This Court has jurisdiction over the subject matter and the parties, and venue is appropriate in the Chester County Court of Common Pleas.

FACTS AND COMPLAINT FOR DAMAGES

6. Plaintiffs repeat and reiterate their foregoing paragraphs as if fully set forth herein verbatim.

7. At all relevant times herein, Defendant acted by and through its agents, servants, adjusters, counsel and/or employees, all of whom acted within the course and scope of their agency and/or employment.

8. At all relevant times herein, Plaintiff Brown's insurance policy (policy no. 930693102) included a provision for Medical Payments and/or Personal Injury Protection (hereinafter "MedPay") in the amount of ten thousand (\$10,000.00) dollars.

9. At all relevant times herein, Plaintiff paid in full all premiums requested by Defendant with respect to the policy, and the policy was in full force and effect on or before October 8, 2019.

10. On or about October 8, 2019, Plaintiff Jones was driving Plaintiff Brown's vehicle which was insured by Defendant.

11. On or about the same date, Plaintiff Jones was struck in the rear by a motor vehicle owned and operated by Corissia Lakathern on Great Falls Highway in Lancaster County, South Carolina.

12. That, as a direct proximate result of the collision, Plaintiff Jones suffered bodily injuries and Plaintiff's medical providers submitted billing statements in excess of the MedPay coverage limits of \$10,000.00.

13. Thereafter, Plaintiff Jones provided the medical provider billing statements to Defendant and made a claim for MedPay pursuant to Plaintiff Brown's insurance policy.

14. The Defendant, pursuant to its established institutional practices and procedures, unreasonably and unjustifiably denied payment in full of the MedPay claim by:

- a. Deliberately and/or recklessly ignoring the medical reports, records, and medical information already in Defendant's possession and information which had been fully review by Defendant's claim personnel;
- b. Repeatedly failing to review for completeness Defendant's own files that referred or related to the Plaintiff's MedPay claim, to the accident and the injuries suffered;
- c. Failing to issue payment without justification or basis; and
- d. Such other particulars as the evidence at trial may show.

15. At all relevant times, Defendant reaped a financial benefit from its denial in resolving the MedPay claim.

16. As a result of Defendant's wrongful actions, Plaintiff Jones has not received the benefits to which she is entitled to recover under Defendant's policy and has suffered monetary damages.

17. Defendant's conduct was in bad faith in the *inter alia*:

- a. Defendant misrepresented the benefits, advantages, conditions or terms of its insurance policy;
- b. Defendant misrepresented pertinent facts or contract provisions relating to coverages at issue;

- c. Defendant failed to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies;
- d. Defendant failed to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- e. Defendant refused to pay claims without conducting a reasonable investigation based upon all available information;
- f. Defendant did not attempt in good faith to effectuate prompt, fair, and equitable settlement of claims in which the company's liability to pay under the MedPay policy has become reasonably clear;
- g. Defendant acted to compel Plaintiff to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amount due;
- h. Defendant invoked and/or threatened to invoke policy defenses not in good faith and with a reasonable expectation of prevailing with respect to the policy defense, but for the primary purpose of discouraging or reducing a claim;
- i. Defendant engaged in the improper claims practices as set forth in S.C. Code Ann. Section 38-59-20 (1976 as amended).

18. The actions taken by Defendant were committed in wanton, malicious, and/or reckless disregard to the rights of the Plaintiffs and without a reasonable basis, the lack of which reasonable basis Defendant knew or recklessly disregarded, thereby justifying an award of punitive damages and attorney's fees.

19. Defendant conduct was in breach of contract in the *inter alia*:

- a. Defendant entered into a contractual relationship with Plaintiff Brown whereby it agreed in consideration for premiums paid, to pay for reasonable and necessary healthcare and MedPay incurred by 'an insured person's' injuries in auto collisions;
- b. To the extent there are any, Plaintiffs have performed all conditions precedent to Defendant's obligations to pay the full amount of all reasonable and necessary health care and other MedPay benefits;
- c. As a direct and proximate result of these breaches of contract, Defendant has damaged the Plaintiffs in the amount to be determined by a jury at trial.

20. Defendant's conduct as averred hereinabove was in breach of fiduciary duty in the *inter alia*:

- a. At all relevant times, Defendant acting through its agents and employees, owed to the Plaintiffs fiduciary duties in the adjustment of MedPay claims;
- b. Additionally, at all relevant times, Defendant acting through its agents and employees, owed to the Plaintiffs fiduciary duties to fairly, accurately and fully represent the terms and conditions of insurance policies sold to the Plaintiffs, including without limitation, any restrictions, omissions, or limitations, thereto;
- c. Defendant breached its fiduciary duties by its actions and conduct alleged herein;

- d. As a direct and proximate result of the breaches of these duties the Plaintiffs suffered damages in an amount to be determined by a jury;

21. Defendant's conduct was in breach of the Covenant of Good Faith and Fair Dealing in the, *inter alia*;

- a. Defendant is subject to the duty of good faith and fair dealing, and owes its insured the fiduciary duty both to disclose relevant matters arising from their relation, and to inform the insured about any limitation on benefits in clear and explicit language in its policies.
- b. That Defendant's actions are in violation of its duty of good faith and fair dealing that all its actions be actuated by good faith, to abstain from deception, and practice honesty and equity in all matters related to the business of insurance.
- c. At the time Defendant sold Plaintiff Brown the policy of insurance, the Defendant knew of and intended to implement its secretly disclosed policy and practice in the events its insured were injured in auto collisions.
- d. The special relationship between the parties made the injury from the malicious breach of the implied covenant of good faith and fair dealing relating to MedPay coverage foreseeable, and thereby tortious. Defendant and the Plaintiffs are parties to a contract of policy of insurance, such that:
 - i. Defendant owed the Plaintiffs a duty to exercise reasonable care to avoid misrepresenting facts;

- ii. Defendant is subject to a standard of care independent of the contract, pursuant to the special relationship between the Plaintiffs and their insurer;
- iii. Defendant's conduct, including its failure to perform in accordance with the reasonable expectation of its insured, and its other acts as herein alleged, destroyed the Plaintiffs' right to receive the benefits of the contract, and resulted in other damages in an amount to be determined at or prior to trial.

22. Defendant's conduct was in breach of contract accompanied by a fraudulent act in the, *inter alia*:

- a. Defendant entered into a contractual relationship with Plaintiff Brown whereby it agreed in consideration for premiums paid, to pay for reasonable and necessary health care and other MedPay benefits incurred by its insured's injuries in auto collisions;
- b. To extent there are any, Plaintiffs have performed all conditions precedent to Defendant's obligation to pay the full amount of all reasonable and necessary health care and other PIP benefits;
- c. Defendant had fraudulent intent relating to breach of contract;
- d. Defendant committed a fraudulent act accompanying its breach of contract.

23. Defendant's actions were motivated by its own financial interests and done with indifference to the rights and interests of the Plaintiffs, or conducted with reckless, willful or wanton disregard under the laws of this state where the Defendant's decisions, policies or acts

were decided entitling the Plaintiffs to punitive damages in an amount to be determined by a jury.

24. Defendant's conduct was in violation of the South Carolina Unfair Trade Practice Act in that, *inter alia*:

- a. Section 39-5-20 of the South Carolina Code of Laws ("South Carolina Unfair Trade Practice Act) states that "[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful.";
- b. Defendant willfully and knowingly violated Section 39-5-20 by engaging in both unfair and deceptive acts;
- c. That such act is capable of repetition and against public policy;
- d. As of October 8, 2019, Plaintiffs have suffered damages in the amount of ten thousand and 00/100 dollars (\$10,000.00) from Defendant's bad faith, fraud, and breach of fiduciary duty;
- e. Plaintiffs would have not been damaged but for the unfair and deceptive act of the Defendant;
- f. That S.C. Code 39-5-140 provides that the Court shall award any person who suffers an ascertainable loss by another person for an unfair or deceptive method three times the actual damages sustained, reasonable attorney's fees and costs and other relief as the Court deems necessary.
- g. By reason of the Defendant's violation of the South Carolina Unfair Trade Practice Act, Plaintiffs are informed and believes he is entitled to

judgment against Defendant in an amount of \$30,000.00 and reasonable attorney's fees and costs.

25. Defendant's conduct was in violation of the South Carolina Code of Laws Section 38-77-144, *inter alia*:

- a. Section 38-77-144 of the South Carolina Code of Laws states that "If 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.";
- b. Defendant willfully and knowingly violated Section 38-77-144 by refusing to pay Plaintiff any amount above what Medicaid paid to Plaintiff Jones's health care providers;
- c. That such act is a setoff and in direct violation of the statute;
- d. Defendant owes Plaintiff Jones \$8,676.40 in outstanding Medpay coverage;

26. That the Plaintiffs are informed and believe they are entitled to judgment against the Defendant for actual damages in an amount to be determined by a jury; an appropriate amount of punitive damages; and reasonable attorney's fees.

27. That the total amount in controversy, including fees and costs, does not exceed seventy-five thousand (\$75,000.00) Dollars.

28. That Plaintiffs are not now seeking, nor will she ever seek, in excess of seventy-five Thousand (\$75,000.00) as a result of the allegations alleged in the Complaint, inclusive of actual and punitive damages.

29. That the Plaintiffs hereby agree to and stipulates that the amount in controversy for the aggregate total of Plaintiffs, under no circumstances will exceed seventy-five thousand (\$75,000.00) inclusive of both actual and punitive damages, fees and costs, and that Plaintiffs will not attempt to plead, prove, or recover damages in excess of \$75,000.00.

WHEREFORE, Plaintiffs pray for the following:

- A. Judgment against the Defendant for actual damages in an amount to be determined by a jury, an appropriate amount of punitive damages; reasonable attorney's fees, for the costs of this action, for pre-judgment interest on all special damages, for post-judgment interest, and for such other and further relief as this court may deem just and proper not to exceed Seventy-five thousand dollars (\$75,000.00).
- B. A declaratory judgment finding and declaring that:
 - i. Defendant's policy was valid and in effect on or about October 8, 2019.
 - ii. That Defendant's policy contained MedPay coverage in the amount of \$10,000.00.
 - iii. That Plaintiff Jones had medical bills as of October 8, 2019 exceeding the \$10,000.00 Medpay limit.
 - iv. That Defendant issue a medical payments check in the amount of \$8,676.40, the amount owed and due to Plaintiff Jones.

Respectfully submitted,

s/J. Logan Cannon
J. Logan Cannon, SC Bar #101688
Shaw Law Firm
Post Office Drawer 36250
Rock Hill, South Carolina 29732
(803) 329-4200
Attorney for the Plaintiff

March 30, 2020

STATE OF SOUTH CAROLINA
COUNTY OF CHESTER

IN THE COURT OF COMMON PLEAS
CIVIL ACTION NO: 2020-CP-12-00207

Alexis Jones and Willie Brown,

Plaintiffs,

v.

Progressive Northern Insurance Company,

Defendant.

ANSWER ON BEHALF OF DEFENDANT

TO: J. LOGAN CANNON, ESQUIRE, ATTORNEY FOR PLAINTIFFS AND TO
PLAINTIFFS ABOVE-NAMED:

The Defendant, Progressive Northern Insurance Company (hereinafter "Progressive"),
answering the Plaintiffs' Complaint herein, would respectfully show unto the Court that:

FOR A FIRST DEFENSE

1. The Defendant denies each and every allegation of the Plaintiffs' Complaint not hereinafter specifically admitted.
2. Paragraphs one (1) of Plaintiffs' Complaint is admitted upon information and belief.
3. As to paragraphs two (2) and three (3) of Plaintiffs' Complaint, Progressive would show that it is a corporation organized and existing under the laws of the State of Wisconsin with its principal place of business in the State of Ohio but that it is authorized to transact business and sell insurance policies in South Carolina; otherwise, paragraphs two (2) and three (3) are denied.
4. As to paragraph four (4) of Plaintiffs' Complaint, Progressive admits that it issued a personal auto policy, Policy No. 930693102, to Willie Brown, and Progressive craves reference to the policy for all terms, conditions and provisions therein; otherwise, paragraph (4) is denied.
5. Paragraph five (5) of Plaintiffs' Complaint is admitted.

6. In response to paragraph six (6) of Plaintiffs' Complaint, Progressive repeats its responses to paragraphs one (1) through five (5) above as if fully set forth verbatim herein.

7. As to paragraphs seven (7), eight (8) and nine (9) of Plaintiffs' Complaint, Progressive issued a personal auto policy, Policy No. 930693102, to Willie Brown and Progressive craves reference to the policy for all terms, conditions and provisions therein; Progressive admits such policy includes a Medical Payments coverage limit of \$10,000 each person and all premiums were paid and the policy was in effect at the time of the events described in the Complaint; otherwise, paragraphs seven (7), eight (8) and nine (9) are denied.

8. As to paragraphs ten (10) and eleven (11) of Plaintiffs' Complaint, Progressive is without sufficient knowledge and information to either admit or deny the allegations of paragraphs ten (10) and eleven (11), and therefore, paragraphs ten (10) and eleven (11) are denied.

9. As to paragraphs twelve (12), thirteen (13), fourteen (14), fifteen (15) and sixteen (16) of Plaintiffs' Complaint, Progressive would show that the policy issued to Willie Brown, Policy No. 930693102, provides Medical Payments coverage for certain "reasonable expenses incurred" by an "insured person" for necessary medical services; prior to Plaintiff Jones submitting a claim to Progressive for Medical Payments coverage, Medicaid paid a portion of Jones' medical bills and negotiated with the providers for a large reduction in the amount Jones owed for such bills; Progressive paid Jones \$1,323.60 in Medical Payments coverage, which represents the full amount required to reimburse Medicaid for the payments made on behalf of Jones and the amount required to pay the outstanding amounts owed on Jones' submitted medical bills (after the medical provider's reductions and Medicaid's payment) – i.e. all medical expense amounts actually incurred by Jones; Plaintiff Jones has submitted no additional medical

bills showing outstanding balances owed by her; consequently, Progressive has paid Jones all amounts due and owing under the Progressive policy's Medical Payments coverage as a result of the October 8, 2019 accident; otherwise, paragraphs twelve (12), thirteen (13), fourteen (14), fifteen (15) and sixteen (16) are denied.

10. Paragraphs seventeen (17) and eighteen (18) of Plaintiffs' Complaint are denied.

11. As to paragraph nineteen (19) of Plaintiffs' Complaint, Progressive would show that Policy No. 930693102 only provides Medical Payments coverage for certain medical expenses actually incurred by insureds and, according to the medical bills Plaintiff Jones has submitted, she has only actually incurred medical expenses of \$1,323.60, which Progressive has paid; any other amounts initially billed by Jones' medical providers were reduced by such medical providers to total \$1,323.60 and, consequently, Progressive has paid all amounts due and owing under its Medical Payments coverage as a result of the October 8, 2019 accident; otherwise paragraph nineteen (19) is denied.

12. Paragraphs twenty (20), twenty-one (21), twenty-two (22), and twenty-three (23) of Plaintiffs' Complaint are denied.

13. As to Paragraph twenty-four (24) of Plaintiffs' Complaint, the South Carolina Unfair Trade Practices Act, South Carolina Code §§ 39-5-10, et seq., is inapplicable to the business of insurance, and paragraph twenty-four (24) based on the same is denied.

14. Paragraphs twenty-five (25) and twenty-six (26) of Plaintiffs' Complaint are denied.

15. It does not appear that any response is required to paragraphs twenty-seven (27), twenty-eight (28), and twenty-nine (29) of Plaintiffs' Complaint, but to the extent a response is required, those paragraphs are denied.

16. The "Wherefore" paragraph in Plaintiffs' Complaint is denied.

FOR A SECOND DEFENSE

17. Progressive would show, upon information and belief, that the Complaint fails to state facts sufficient to constitute a cause of action pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure and, therefore, the Plaintiff's Complaint should be dismissed with costs.

FOR A THIRD DEFENSE

18. Progressive would show that Plaintiff Willie Brown is not a real party in interest in that he has not asserted any claim for coverage under the policy related to the October 8, 2019 accident and therefore, Plaintiff Willie Brown lacks standing to maintain this action and should be dismissed as a plaintiff with costs.

FOR A FOURTH DEFENSE

19. Any award of punitive damages should not exceed the greater of three (3) times the amount of compensatory damages as provided for in S.C. Code Ann. §15-32-530.

FOR A FIFTH DEFENSE

20. Pursuant to S.C. Code Ann. §15-32-520, any proceeding to determine punitive damages should be bifurcated from any trial to determine liability and compensatory damages.

FOR A SIXTH DEFENSE

21. This Defendant would show, upon information and belief, that the Plaintiffs' claims for punitive damages violate the Fifth, Sixth, Seventh, Eighth and Fourteenth Amendments to the Constitution of the United States of America in that it violates the double jeopardy clause in that this Defendant could be subjected to multiple awards of punitive damages for the same set of facts; the self-incrimination clause is being violated because this Defendant

can be compelled to give testimony against itself in a penalty situation such as punitive damages; the assessment of punitive damages by a burden of proof less than beyond a reasonable doubt is violative of the Sixth and Fourteenth Amendments in that punitive damages are a fine or penalty and are, therefore, quasi-criminal in nature; Plaintiffs' claims for punitive damages violate this Defendant's right to access the courts as guaranteed by the Seventh and Fourteenth Amendments because the threat of an award of punitive damages chills this Defendant's exercise of that right; the Plaintiff's claim for punitive damages violates the Eighth Amendment's guarantee that excessive fines shall not be imposed, the Plaintiffs' claim for punitive damages violates both the due process and equal protection clauses of the Fourteenth Amendment in that the standard for awarding either punitive damages is unduly vague and, therefore, violates both procedural and substantive due process safeguards; therefore, the Plaintiffs' claims for punitive damages should be dismissed.

FOR A SEVENTH DEFENSE

22. The South Carolina Unfair Trade Practices Act, South Carolina Code §§ 39-5-10, et seq., is inapplicable to the business of insurance, and Plaintiffs' claim based on such Act should be dismissed with costs.

FOR AN EIGHTH DEFENSE

23. South Carolina Code § 38-59-20 does not create a private cause of action, and Plaintiffs' claim based on such statute should be dismissed with costs.

WHEREFORE, Defendant Progressive prays that the Court inquire into this matter and issue a declaratory judgment that the Plaintiffs are not entitled to any additional Medical Payments coverage under the policy issued to Willie Brown as a result of the October 8, 2019

accident, together with the costs of this action and such other and further relief as the Court may deem just and proper.

MURPHY & GRANTLAND, P.A.

s/J.R. Murphy, Esquire
J.R. Murphy, Esquire (SC Bar #7941)
P.O. Box 6648
Columbia, SC 29260
(803) 782-4100
Attorneys for Defendant Progressive
Northern Insurance Company

Columbia, South Carolina
April 28, 2020

STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF CHESTER

CIVIL ACTION NO: 2020-CP-12-00207

Alexis Jones and Willie Brown,

Plaintiffs,

v.

Progressive Northern Insurance Company,

Defendant.

MOTION TO DISMISS

TO: J. LOGAN CANNON, ESQUIRE, ATTORNEY FOR PLAINTIFFS AND TO PLAINTIFFS ABOVE-NAMED:

YOU WILL PLEASE TAKE NOTICE that the Defendant, Progressive Northern Insurance Company, by its undersigned attorney will move before the Presiding Judge of the County Court of Common Pleas at the Chester County Courthouse at 10:00 a.m. on the tenth (10th) day after service hereof, or as soon thereafter as counsel may be heard for an Order dismissing the Plaintiff's Complaint pursuant to South Carolina Rules of Civil Procedure 12(b)(6) on the grounds that the Plaintiff's Complaint fails to state facts sufficient to constitute a cause of action against this Defendant. The basis for this motion is more clearly set out in the attached memorandum of law.

MURPHY & GRANTLAND, P.A.

s/J.R. Murphy

J.R. Murphy, Esquire (SC Bar #7941)

P.O. Box 6648

Columbia, SC 29260

(803) 782-4100

Attorneys for Defendant Progressive

Northern Insurance Company

Columbia, South Carolina
May 11, 2020

STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF CHESTER

CIVIL ACTION NO: 2020-CP-12-00207

Alexis Jones and Willie Brown,

Plaintiffs,

v.

**DEFENDANT'S MEMORANDUM IN
SUPPORT OF ITS MOTION TO DISMISS**

Progressive Northern Insurance Company,

Defendant.

Defendants Progressive Northern Insurance Company ("Progressive"), by and through its undersigned counsel, hereby submits its Memorandum of Law in Support of its Motion to Dismiss Plaintiffs' claims and, in the alternative, to dismiss Plaintiff Willie Brown as a Plaintiff.

SUMMARY

This action arises out of Progressive's payment of Plaintiff Alexis Jones' Medical Payments claim for an alleged October 8, 2019 auto accident. Jones' submitted her Medical Payments claim under a personal auto policy issued to Willie Brown under which Jones is listed as a driver and resident relative. The policy includes a \$10,000 Medical Payments coverage limit for certain medical "expenses incurred" by an insured as a result of an accident. Jones is a Medicaid recipient, and Medicaid negotiated reduced rates with her service providers before Jones submitted her Medical Payments coverage claim. Progressive based payment of Jones' Medical Payments claim on the Medicaid-adjusted rates charged by the medical providers rather than total charges listed on the medical providers' initial bills. In their Complaint, Plaintiffs base their various causes of action on Progressive's payment of the Medicaid-adjusted provider rates rather than the providers' "sticker price." Because the policy only provides Medical Payments coverage for certain medical "expenses incurred" by Jones and Jones did not incur expenses beyond the Medicaid-adjusted rates, Plaintiffs' claims fail as a matter of law.

In addition to this being premised on this improper basis, Plaintiffs' statutory claims are improper because those statutes do not apply to the conduct alleged in the Complaint. Therefore, Plaintiffs' common law and statutory claims should be dismissed. In the alternative, Plaintiff Brown is not a proper plaintiff to this action and should be dismissed.

FACTS

A. The Progressive Policy

Progressive issued a personal auto policy, Policy No. 930693102, to Willie Brown with effective dates of June 21, 2019 to December 21, 2019 (the "Policy"). (Compl. ¶ 8); (Ex. A, Policy).¹ The Policy includes a Medical Payments coverage limit of \$10,000 each person. (Compl. ¶ 8); (Ex. A, Policy). The Policy only provides Medical Payments coverage for certain medical expenses actually incurred by an insured person. The Policy provides in pertinent part:

PART II – MEDICAL PAYMENTS COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury:

1. Sustained by an insured person; and
2. Caused by that motor vehicle accident.

(Ex. A, Policy, p. 14). Thus, the Policy only provides Medical Payments coverage for certain "expenses incurred for necessary medical services."

¹ Without converting a motion to dismiss into a motion for summary judgment, the Court may "consider documents that are incorporated by reference in the complaint but not actually attached thereto." *Brazell v. Windsor*, 384 S.C. 512, 516, 682 S.E.2d 824, 826 (2009). This "prevents a plaintiff from benefitting from his own oversight or from surviving a motion to dismiss by intentionally omitting documents upon which their claims are based." *Id.* The Progressive Policy is incorporated by reference in Plaintiffs' Complaint, particularly since Plaintiffs allege Progressive breached the insurance contract and seek additional coverage under the policy. *See, e.g.*, (Compl. ¶¶ 4, 8, 12-14, 16-17, 19). Therefore, Defendant has relied upon and attached the policy herein.

B. The October 8, 2019 Accident and Jones' Resulting Medical Payments Claim

Plaintiffs' allege that Plaintiff Jones was involved in an auto accident on October 8, 2019. (Compl. ¶ 11). Plaintiff Jones made a claim for Medical Payments coverage under the Progressive Policy. (Compl. ¶ 13). With her claim, Jones submitted medical provider billing statements in excess of \$10,000. (Compl. ¶¶ 12-13). However, Jones is a Medicaid beneficiary, and the Complaint does not allege what amount of medical expenses Jones has paid or become liable to pay to her medical providers. *See* (Compl. ¶ 25.b.). Specifically, the Complaint does not allege that Jones has paid or has become legally obligated to pay the charges on the submitted bills rather than her providers' Medicaid-adjusted rates. *See* (Compl.).

The Complaint alleges Jones is owed the full \$10,000 Medical Payments coverage limit and that Progressive still "owes Plaintiff Jones \$8,676.40 in outstanding Medpay coverage." (Compl. ¶¶ 14, 16, 25, Wherefore B.) Thus, Progressive has paid Jones Medical Payments coverage of \$1,323.60 ($\$10,000 - \$8,676.40 = \$1,323.60$). *See* (Compl. ¶¶ 17, 25, Wherefore B). At a minimum, such amount is equal to the amount Medicaid paid to Jones' healthcare providers. *See* (Compl. ¶ 25.d. (alleging Progressive refused "to pay Plaintiff *any amount above* what Medicaid paid to Plaintiff Jones's health care providers" (emphasis added))). The Complaint asserts the following causes of action related to Jones' Medical Payments coverage claim: (1) bad faith; (2) breach of contract; (3) breach of fiduciary duty; (4) breach of the covenant of good faith and fair dealing; (5) breach of contract accompanied by a fraudulent act; (6) violation of the South Carolina Unfair Trade Practice Act; and (7) violation of South Carolina Code § 38-77-144. (Compl.).

ARGUMENT

Plaintiffs assert two statutory claims: (1) violation of the South Carolina Unfair Trade Practice Act (the "SCUTPA"); and (2) violation of South Carolina Code § 38-77-144. Both statutory causes of action must be dismissed because such statutes are inapplicable to the conduct alleged. Plaintiff

also asserts numerous common-law causes of action, all of which are premised on Progressive's payment of Jones' medical payments claim at the Medicaid-reduced provider rates. Because the Progressive Policy only provides Medical Payments coverage for "expenses incurred," such claims must be dismissed. Under both federal and state Medicaid provisions, Jones never incurred expenses beyond her medical providers' Medicaid-adjusted rates. Alternatively, Plaintiff Brown is not a proper plaintiff to this action and he should be dismissed.

I. Plaintiffs' "violation of the South Carolina Unfair Trade Practice Act" claim must be dismissed because the Act is not applicable to the business of insurance.

In the Complaint, Plaintiffs allege as a cause of action "violation of the South Carolina Unfair Trade Practices Act." (Compl. ¶ 24). Such claim must be dismissed because the South Carolina Unfair Trade Practices Act, South Carolina Code §§ 39-5-10, et seq. ("SCUTPA"), does not regulate and is inapplicable to the business of insurance. *See, e.g., Trustees of Grace Reformed Episcopal Church v. Charleston Ins. Co.*, 868 F. Supp. 128, 131 (D.S.C. 1994) (stating S.C. Code "§ 39-5-40(c) exempts from the coverage of SCUTPA all unfair trade practices in the business of insurance"); *Lewis v. Omni Indemnity Co.*, 970 F. Supp. 2d 437, 451 (D.S.C. 2013); *Hicklin v. State Farm Fire & Cas. Co.*, No. 5:17-CV-03463-SAL, 2020 WL 1244631, at *10 (D.S.C. Mar. 13, 2020) (granting insurer judgment as a matter of law on SCUTPA claim against it).²

As the Court in *Thomas v. Tramaine-Frost* thoroughly explained:

[I]nsurance providers are separately regulated under South Carolina law and are not subject to the SCUTPA. SCUTPA does not create a private right of action against insurers and/or agents of insurers. Section 39-5-40(c) of the SCUTPA provides that "[t]his article does not supersede or apply to unfair trade practices covered and regulated under Title 38, Chapter 57, §§ 38-57-10 through 38-55-320." S.C. Code Ann. § 39-5-40(c). Chapter 57 "clearly is intended to define and regulate all unfair

² *See also Whitehead v. Travelers Indem. Co. of Am.*, No. 3:15-CV-04200-JMC, 2016 WL 5920857, at *2 (D.S.C. Oct. 11, 2016); *Tapp v. Minnesota Life Ins. Co.*, No. CV 3:15-4799-MBS, 2017 WL 2839636, at *4 (D.S.C. June 29, 2017); *Colter v. Omni Ins. Co.*, No. 3:15-CV-04171-JMC, 2016 WL 3690123, at *3 n.1 (D.S.C. July 12, 2016) (dismissing plaintiff's SCUTPA claim against insurer); *Meadows v. Nationwide Mut. Ins. Co.*, No. 1:14-CV-04531-JMC, 2015 WL 3490062, at *4 (D.S.C. June 3, 2015).

trade practices in the business of insurance" and "SCUTPA, through § 39-5-40(c), provides a clear exemption for the practices covered by Chapter 57." *Trustees of Grace Reformed Episcopal Church v. Charleston Ins. Co.*, 868 F. Supp. 128, 130 (D.S.C. 1994). Accordingly, "all unfair trade practices regarding the insurance business are regulated by the Insurance Trade Practices Act, §§ 38-57-10 et seq., and are exempt from the coverage of SCUTPA." *Id.* at 130-31; see also *Advanced Pain Therapies, LLC v. Hartford Fin. Servs. Grp., Inc.*, No. 3:14-cv-00050-MGL, 2014 WL 4402800, at *4 (D.S.C. Sept. 3, 2014) (finding that a plaintiff's SCUTPA claim failed as a matter of law because the claim pertained to the business of insurance and such a claim is "not regulated under SCUTPA"); *K & M Merch., LLC v. Am. W. Home Ins. Co.*, No. 4:09-cv-1943-TLW, 2010 WL 597217, at *2 (D.S.C. Feb. 16, 2010) (granting a defendant's motion to dismiss a claim under the SCUTPA where the claim related to a dispute over insurance coverage and thus was "not supported by the terms of the [SCUTPA] itself nor by the relevant case law interpreting the [SCUTPA]"); *Ray v. Gen. Ins. Co. of Am.*, No. 3:11-CV-449-JFA, 2011 WL 1254106, at *2 (D.S.C. Apr. 4, 2011) (dismissing a plaintiff's claim under the SCUTPA with prejudice where the claim involved "conduct concerning the business of insurance"). Furthermore, the Insurance Trade Practices Act (ITPA), S.C. Code Ann. § 38-57-10, et seq., "clearly manifests legislative intent to create an administrative remedy and not a private right of action." *Masterclean, Inc. v. Star Ins. Co.*, 347 S.C. 405, 556 S.E.2d 371 (2001). Thus, any claim under the ITPA is not properly before the court. For these reasons, Plaintiff has failed to state a claim against the GEICO Defendants upon which relief may be granted and dismissal is appropriate.

No. 4:16-CV-1266-TLW-TER, 2017 WL 9287004, at *5 (D.S.C. Jan. 12, 2017), *report and recommendation adopted*, No. 4:16-CV-1266-TLW, 2017 WL 781071 (D.S.C. Feb. 28, 2017).

Accordingly, Plaintiffs' SCUTPA claim against Progressive must be dismissed because the Act exempts the business of insurance from its coverage and is inapplicable to the same.

II. Plaintiffs' "violation of South Carolina Code of Laws Section 38-77-144" claim must be dismissed because the "violation" alleged by Plaintiffs is not the conduct prohibited by the statute.

South Carolina Code § 38-77-144 provides that "medical payments coverage...is not subject to a setoff." S.C. Code § 38-77-144. Plaintiffs' allege that Progressive's payment of medical payments coverage at the Medicaid-adjusted provider rates constitutes a setoff under § 38-77-144, but it does not. See (Compl. ¶ 25). The South Carolina Supreme Court recently described what constitutes a "setoff" under South Carolina Code § 38-77-144. In *Cothran v. State Farm Mut. Auto. Ins. Co.*, a provision in the insurance policy purported to reduce the insurer's obligation to pay PIP coverage to

the insured by the amount the workers compensation carrier paid for the insured's medical expenses. 427 S.C. 545, 550, 831 S.E.2d 919, 922 (2019). The Court held that this was a "setoff" in violation of § 38-77-144. *Id.* As the Court explained: "The term 'setoff' is used universally to describe the reduction of PIP benefits by the amount of a third-party payment." *Id.* at 550 n.3, 831 S.E.2d at 922 n.3.

Thus, a "setoff," as that term has been defined by the South Carolina Supreme Court, would occur if Progressive attempted to reduce its medical payments coverage by the amounts paid by Medicaid. That is not what Plaintiffs have alleged. Plaintiffs' Complaint does not allege that Progressive has reduced its Medical Payments benefits by the amount of the Medicaid payment. *See* (Compl. ¶ 25). Rather, Plaintiffs allege Progressive has "violated Section 38-77-144 by refusing to pay Plaintiff *any amount above* what Medicaid paid to Plaintiff Jones's health care providers." (Compl. ¶ 25) (emphasis added). Paying medical payments coverage at a Medicaid-adjusted provider rate does not constitute a "reduction of PIP benefits by the amount of a third-party payment." *Id.* at 550 n.3, 831 S.E.2d at 922 n.3. Because this does not constitute a "setoff" under South Carolina Code § 38-77-144, Plaintiffs' "violation of South Carolina Code of Laws Section 38-77-144" claim must be dismissed.

Moreover, nothing in South Carolina Code § 38-77-144 requires Medical Payments coverage for amounts greater than those actually incurred by the insured – i.e. amounts greater than the reduced rates negotiated between Medicaid and medical providers. Such a requirement would be contrary to prior South Carolina Supreme Court precedent.

In a similar case, *Gordon v. Fidelity & Cas. Co. of N. Y.*, the insured had an insurance policy that included medical expense coverage under which the insurer "agreed 'to pay all reasonable expense incurred' for necessary medical and surgical service." 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961). The Court held the insurer was not required to provide any medical expense coverage to

the insured because the insured did not incur any expenses for medical treatment. *Id.* at 446, 120 S.E.2d at 513. The insured was a soldier and received free medical treatment at an army hospital for injuries he sustained in a motor vehicle accident. *Id.* at 441, 120 S.E.2d at 510. Thus, the insured incurred no expense for his treatment. As the Court explained:

[T]he [insured] incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the [insurer] was not liable to the [insured] for the reasonable cost of his hospitalization, because the [insurer] had limited its liability to pay only 'all reasonable expenses incurred' by the [insured]. There being no obligation on the part of the [insured] to pay for the hospitalization he received at Fort Jackson hospital, he 'incurred' no expense within the meaning of the provision of the policy of insurance issued by the [insurer].

Id. at 446, 120 S.E.2d at 513. Likewise, when Medicaid negotiates with medical providers for reduced rates for medical services, the insured incurs no expense above the reduced rates negotiated with the providers, and the insurer has no duty to pay amounts the insured did not actually incur.

III. Plaintiffs' breach of contract, breach of contract accompanied by a fraudulent act, bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims should be dismissed because Progressive's alleged actions at issue were in accordance with the terms of the insurance contract and South Carolina law.

Like the foregoing claims, each of these claims are also premised on Progressive paying the reduced rates Medicaid negotiated with Plaintiff Jones' medical providers rather than "sticker prices" on the providers' bills. *See* (Compl. ¶¶ 12-13, 20.c, 21.d.iii., 25.d., Wherefore B.). These actions were taken in accordance with the policy terms and allowed under South Carolina law.³ Therefore, all of the remaining causes of action should also be dismissed.

An insurer's obligation under an insurance policy is defined by the terms of the policy and cannot be enlarged by judicial construction. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137, 390 S.E.2d 471, 474 (Ct. App. 1990). "[I]f the intention of the parties is clear, courts have no

³ Under South Carolina law, there is no statutorily mandated medical payments/personal injury protection coverage. S.C. Code § 38-77-144; *State Farm Mut. Auto. Ins. Co. v. Richardson*, 313 S.C. 58, 60, 437 S.E.2d 43, 45 (1993).

authority to torture the meaning of policy language to extend or defeat coverage that was never intended by the parties.” *Kay v. State Farm Mut. Auto. Ins. Co.*, 349 S.C. 446, 450, 562 S.E.2d 676, 679 (Ct. App. 2002). The Policy provides Medical Payments coverage for certain “reasonable expenses incurred for necessary medical services.” (Ex. A, Policy, p. 14). For medical payments coverage purposes, South Carolina law defines the phrase “expense incurred” as meaning there is an obligation on the part of the insured to pay for the medical treatment or service he received. *Gordon*, 238 S.C. at 446, 120 S.E.2d at 513. “[A] thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an ‘expense incurred’.” *Id.* at 445, 120 S.E.2d at 512.

In Plaintiffs’ Complaint, the “breach of contract” and “breach of contract accompanied by a fraudulent act” sections do not set forth any alleged breach of the insurance contract, a required element of each claim. *See* (Compl. ¶ 19); *Branche Builders, Inc. v. Coggins*, 386 S.C. 43, 48, 686 S.E.2d 200, 202 (Ct. App. 2009) (“The elements for breach of contract are the existence of the contract, its breach, and the damages caused by such breach.”); *see also* (Compl. ¶ 22); *Conner v. City of Forest Acres*, 348 S.C. 454, 465, 560 S.E.2d 606, 612 (2002) (“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....”).

From the remainder of the Complaint, it appears the only potential breach Plaintiffs are alleging is failure to pay Medical Payments coverage based on the total charges on the medical bills rather than the Medicaid-adjusted amounts for services rendered. *See* (Compl. ¶¶ 12-13, 25, Wherefore B.). This conduct also appears to be the basis for Plaintiffs’ other claims.⁴ As stated above,

⁴ In the Complaint, Plaintiffs’ “breach of fiduciary duty” and “breach of the covenant of good faith and fair dealing” claim sections do not set forth any specific “breach” but merely state that that Progressive breached its duties by its actions and conduct alleged elsewhere in the Complaint.

the Policy provides Medical Payments coverage for certain "reasonable expenses incurred for necessary medical services." (Ex. A, Policy, p. 14) (emphasis added).⁵ Consequently, the act of paying Medical Payments coverage based on medical providers' adjusted rates for a Medicaid patient rather than amounts listed on a bill is not a breach of the Progressive insurance contract. Therefore, Plaintiffs' breach of contract, breach of contract accompanied by a fraudulent act, bad faith, breach of the duty of good faith and fair dealing, and breach of fiduciary duty claims based on such act must be dismissed. *See Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359, 415 S.E.2d 393, 396 (1992) ("The elements of a cause of action for bad faith refusal to pay first party benefits under a contract of insurance are... (2) refusal by the insurer to pay benefits due under the contract....").⁶

In a factually similar case, *Barker v. Washington Nat. Ins. Co.*, the insured had a policy that provided coverage for "the expenses incurred" for certain medical services and materials. No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013). The insured was a Medicare

(Compl. ¶¶ 20-21). Plaintiffs' bad faith section alleges Progressive acted in bad faith by "offering substantially less than the amount due" under the policy. (Compl. ¶ 17.g.).

⁵ Nowhere in the Complaint do Plaintiffs allege the amount of Plaintiff Jones' medical "expenses incurred" – as that term has been defined by the South Carolina Supreme Court. *See* (Compl.); *Gordon*, 238 S.C. at 446, 120 S.E.2d at 513. The Complaint fails to plausibly allege that Jones has paid or has become legally obligated to pay the initial charges listed on the submitted bills rather than her providers' Medicaid-adjusted rates.

⁶ Plaintiffs' bad faith, breach of the duty of good faith and fair dealing and breach of fiduciary duty claims amount to a single bad faith claim. First, bad faith and breach of an implied duty of good faith and fair dealing are not separate causes of action. *Ocean Winds Council of Co-Owners, Inc. v. Auto-Owners Ins. Co.*, 241 F. Supp. 2d 572, 577 (D.S.C. 2002) ("[B]ad faith refusal to pay benefits and breach of implied warranty of good faith and fair dealing are not separate causes of action."); *Sentry Select Ins. Co. v. Guess Farm Equip., Inc.*, No. CIV.A. 5:12-03504-JM, 2013 WL 5797742, at *10 (D.S.C. Oct. 25, 2013) (dismissing counterclaim for bad faith "because it is duplicative" of claim for breach of duty of good faith and fair dealing). Moreover, when a party's breach of fiduciary duty claim is based on the same duty and arising out of the same factual allegations upon which another claim is based, it is duplicative and should be dismissed. *See RFT Mgmt. Co. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 336, 732 S.E.2d 166, 173 (2012) (dismissing breach of fiduciary duty claim because duplicative of legal malpractice claim based on same attorney-client relationship and factual allegations).

beneficiary, and the insurer adjusted his claim "by paying benefits based only on the debt [the insured] owed to the medical provider." *Id.* at *2. The insured brought a breach of contract claim and bad faith claim against the insurer arguing that the insurer was obligated to pay him the "total charges" on the medical bills "prior to any reductions resulting from any prior agreement between Medicare and the hospital." *Id.* at *4. The insured argued that the insurer's "use of Medicare adjustments was improper." *Id.* at *2. The Court rejected the insured's arguments and explained:

As a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill, i.e., \$55,241. Under 42 U.S.C. § 1395cc(a)(1)(A), a provider of services can participate in Medicare only if the provider files an agreement with the Secretary of Health and Human Services. Pursuant to this agreement, the participant accepts "assignment" of the Medicare payment, meaning that the provider must accept the Medicare approved charge as the full charge for the covered service and "shall not collect from the beneficiary ... more than the applicable deductible and coinsurance." Medicare Participating Physician or Supplier Agreement, Form CMS-460 (04/10), available at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS-007566.html>; see Costs & Assignment, Medicare.gov, <http://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html> (last visited Apr. 24, 2013) (explaining that, under Medicare Part A, "Assignment means that your ... provider ... agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services" and can "charge you only the Medicare deductible and coinsurance amount"). The Southern District of New York recently addressed the issue of whether a Medicare recipient can "incur" the full fee a medical provider lists on its bill prior to applying the agreed-upon Medicare reductions, concluding that "[w]here Medicare contracts with a medical provider to set fees for a given service, the Medicare beneficiary is never liable for the amount forgone by a doctor under that agreement." *Metz v. U.S. Life Ins. Co.*, No. 09 Civ. 10250(BSJ), 2010 WL 3703810, at *3 (S.D.N.Y. Sept. 21, 2010). The court further explained:

A doctor who accepts Medicare assignment has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. [He] agree[s] to ... charge [the beneficiary only] the Medicare deductible and coinsurance amount and wait for Medicare to pay its share. Given this agreement, it is essentially impossible that Plaintiff would ever face liability for a provider's hypothetical full fee.

Id. (internal quotations and citations omitted). The Second Circuit Court of Appeals affirmed, concluding that under New York law, the Medicare recipient "did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her." *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir. 2011). Similarly, this Court concludes that under South Carolina law, Barker was never obligated to

pay more than the amount that the hospital had agreed to accept as full payment under Medicare, which amount appears to be about \$15,929.29.

Id. at *5-6 (emphasis added). As a result, the Court granted the insurer summary judgment on the insured's bad faith and breach of contract claims. *Id.* at *9.

Medicaid works the same way as Medicare. A Medicaid provider is also required to accept the Medicaid payment as "payment in full." 42 C.F.R. § 447.15 (requiring state Medicaid agency to "limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayments required by the plan to be paid by the individual"). Pursuant to the South Carolina Medicaid provider agreement, the provider agrees "that Medicaid reimbursement is payment in full...for care or services to a recipient/patient" and "that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient...." Medicaid Participation and Payment Agreement, Form (07/17), available at <https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf>.

Therefore, like in the *Barker* case, Plaintiff Jones never "incurred" expenses for medical services beyond the Medicaid-adjusted rates. *See State Farm Mut. Auto. Ins. Co. v. Bowers*, 255 Va. 581, 585-586, 500 S.E.2d 212, 214 (1998) (holding insured did not "incur" expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers).⁷ Consequently, Plaintiffs' remaining claims also based on this conduct must be

⁷ *See also Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015) (stating "[a] number of courts in other jurisdictions have found 'expenses incurred' to mean the amount actually paid, as opposed to the amount charged by the care provider" and holding "expenses incurred" meant amount insured actually paid to satisfy medical providers after "other insurance coverage...negotiated a lower rate of payment"); *Metz v. U.S. Life Ins. Co. in City of New York*, 662 F.3d 600, 602 (2d Cir. 2011) (holding "incurred" for insurance coverage meant reduced rates negotiated by Medicare because insured "did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her"); *Woodrich v. Farmers Ins. Co.*, 405 F.Supp.2d 1276, 1279 (N.D.Okla.2004).

dismissed. See *Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019) (dismissing breach of contract, breach of implied covenant of good faith and fair dealing, unfair trade practices, bad faith, and tortious breach of contract claims based on the same theory alleged in Plaintiffs' Complaint).

IV. In the alternative, Plaintiff Willie Brown is not a proper plaintiff to this action and should be dismissed.

Because Plaintiff Willie Brown is not a real party in interest to this suit and lacks standing to bring the claims asserted in the Complaint, he should be dismissed from being a plaintiff in this action. Under Rule 17(a) of the South Carolina Rules of Civil Procedure, "Every action shall be prosecuted in the name of the real party in interest." Rule 17(a), SCRPC. "[T]he real party in interest is the party who, by the substantive law, has the right sought to be enforced. It is ownership of the right sought to be enforced which qualifies one as a real party in interest." *Fisher on behalf of estate of Shaw-Baker v. Huckabee*, 422 S.C. 234, 238, 811 S.E.2d 739, 741 (2018), *reh'g denied* (Apr. 17, 2018) (citation omitted). "A real party in interest is one who has a real, material, or substantial interest in the subject matter of the action, as opposed to one who has only a nominal or technical interest in the action." *Sea Pines Ass'n for Prot. of Wildlife, Inc. v. S.C. Dep't of Nat. Res.*, 345 S.C. 594, 600, 550 S.E.2d 287, 291 (2001); *Hill v. South Carolina Dep't of Health & Env'tl. Control*, 389 S.C. 1, 22, 698 S.E.2d 612, 623 (2010) ("A real party in interest is a party with a real, material, or substantial interest in the outcome of the litigation."). "The purpose of a real party in interest provision is to assure that a defendant is required only to defend an action brought by a proper party...." *Bardoon Properties, NV v. Eidolon Corp.*, 326 S.C. 166, 169, 485 S.E.2d 371, 373 (1997).

Moreover, "to have standing, a litigant must have a personal stake in the subject matter of the litigation." *Powell ex rel. Kelley v. Bank of Am.*, 379 S.C. 437, 445, 665 S.E.2d 237, 241 (Ct. App. 2008). Standing "is concerned with whether a particular person may raise legal arguments or claims." *Id.* at 444, 665 S.E.2d at 241. "The party seeking to establish standing carries the burden of

demonstrating each of the three elements” – (1) “the plaintiff must have suffered an ‘injury in fact’”; (2) “there must be a causal connection between the injury and conduct complained of”; and (3) it must be likely that the injury will be redressed by a favorable decision. *Id.* Plaintiff Brown cannot meet this burden.

The Complaint concerns the payment of Alexis Jones’ Medical Payments claim arising out of an alleged October 8, 2019 auto accident. (Compl. “Facts” section, ¶¶ 6-16). Although the Progressive policy at issue was issued to Plaintiff Willie Brown, this fact does not give him standing to be joined as a Plaintiff to this action. According to the Complaint, only Plaintiff Alexis Jones was involved in the October 8, 2019 accident and only Plaintiff Alexis Jones submitted a Medical Payments claim under the Progressive policy. (Compl. ¶¶ 11-13). Therefore, Jones is the only proper plaintiff to this action, and Brown should be dismissed.

Under Rule 21 of the South Carolina Rules of Civil Procedure, “[p]arties may be dropped...by order of the court on motion of any party or of its own initiative at any stage of the action and on such terms as are just.” Rule 21, SCRPC. Plaintiff Brown is not a real party in interest to this action as required by Rule 17(a) of the South Carolina Rules of Civil Procedure because he lacks any substantial interest in the subject matter of the action – Jones’ Medical Payments claim. He also lacks standing because he has no personal stake in the subject matter of the litigation. Therefore, Progressive respectfully requests that he be dismissed from being a plaintiff to this action.

CONCLUSION

For the foregoing reasons, Plaintiffs’ claims against Progressive should be dismissed. The Progressive Policy provides medical payments coverage for certain medical *expenses incurred* by insured persons. As a result of the October 8, 2019 auto accident, Plaintiff Jones only incurred medical expenses at the reduced rates negotiated between Medicaid and her medical providers – not the amounts initially billed. Therefore, Plaintiffs have no cause of action based on Progressive paying

medical payments coverage based on such reduced rates. Additionally, Plaintiffs' "violation of the South Carolina Unfair Trade Practice Act" claim must be dismissed because the Act is not applicable to the business of insurance, and Plaintiffs' "violation of South Carolina Code of Laws Section 38-77-144" claim must be dismissed because the Complaint does not allege conduct prohibited by the statute. In the alternative, Plaintiff Brown is not a proper plaintiff to this action and should be dismissed. Progressive respectfully requests that this Court grant its Motion to Dismiss.

MURPHY & GRANTLAND, P.A.

s/J.R. Murphy

J.R. Murphy, Esquire (Fed. I.D. No. 3119)

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Attorneys for Defendant Progressive Northern
Insurance Company

Columbia, South Carolina
May 11, 2020

AUTO PLUS INS GRP
PO BOX 10
LANCASTER, SC 29721

WILLIE BROWN
2663 GEORGETOWN ROAD
GREAT FALLS, SC 29055

PROGRESSIVE
AUTO

Policy Number: 930693102
Underwritten by:
Progressive Northern Insurance Co
October 2, 2019
Policy Period: Jun 21, 2019 - Dec 21, 2019
Page 1 of 2

1-803-289-1169
AUTO PLUS INS GRP
Contact your agent for personalized service.

progressiveagent.com
Online Service
Make payments, check billing activity, update
policy information or check status of a claim.

1-800-274-4499
To report a claim.

Auto Insurance Coverage Summary

This is your Declarations Page

Your policy information has changed

Your coverage began on June 21, 2019 at the later of 12:01 a.m. or the effective time shown on your application. This policy period ends on December 21, 2019 at 12:01 a.m.

This coverage summary replaces your prior one. Your insurance policy and any policy endorsements contain a full explanation of your coverage. The policy contract is form 9611A SC (10/14). The contract is modified by form A048 SC (07/11).

Policy changes effective October 1, 2019

Changes requested on:	Oct 1, 2019 12:34 p.m.
Requested by:	WILLIE BROWN
Premium change:	-\$429.71
Changes:	The 2001 GMC SIERRA C1500/K1500 has been removed. The Multi-Car discount has been removed from your policy.

The changes take effect as of the date and time requested shown above.

Underwriting Company

Progressive Northern Insurance Co
P.O. Box 6807
Cleveland, OH 44101
1-800-876-5581

Drivers and resident relatives

	Additional information
WILLIE BROWN	Named Insured
ALEXIS JONES	

Form 6489 SC (02/18)



APPENDIX - 00054

 Continued

ELECTRONICALLY FILED - 2020 May 11 3:45 PM - CHESTER - COMMON PLEAS - CASE#2020CP1200207

Policy Number: 930693102

WILLIE BROWN

Page 2 of 2

Outline of coverage**2005 CHEVROLET TAHOE C1500/K1500 4 DOOR WAGON**

VIN: 1GNEK13TXSR101102

Garaging ZIP Code: 29055

Primary use of the vehicle: Commute

Length of vehicle ownership when policy started or vehicle added: At least 3 years but less than 5 years

	Limits	Deductible	Premium
Liability To Others			\$1,030
Bodily Injury Liability	\$25,000 each person/\$50,000 each accident		
Property Damage Liability	\$25,000 each accident		
Uninsured Motorist			44
Bodily Injury	\$25,000 each person/\$50,000 each accident		
Property Damage	\$25,000 each accident	\$200	
Underinsured Motorist Bodily Injury	Rejected		-
Medical Payments	\$10,000 each person		480
Subtotal policy premium			\$1,554.00
South Carolina Uninsured Motorist Fund charge			1.00
Total 6 month policy premium and fees			\$1,555.00

Premium discount

Policy

930693102

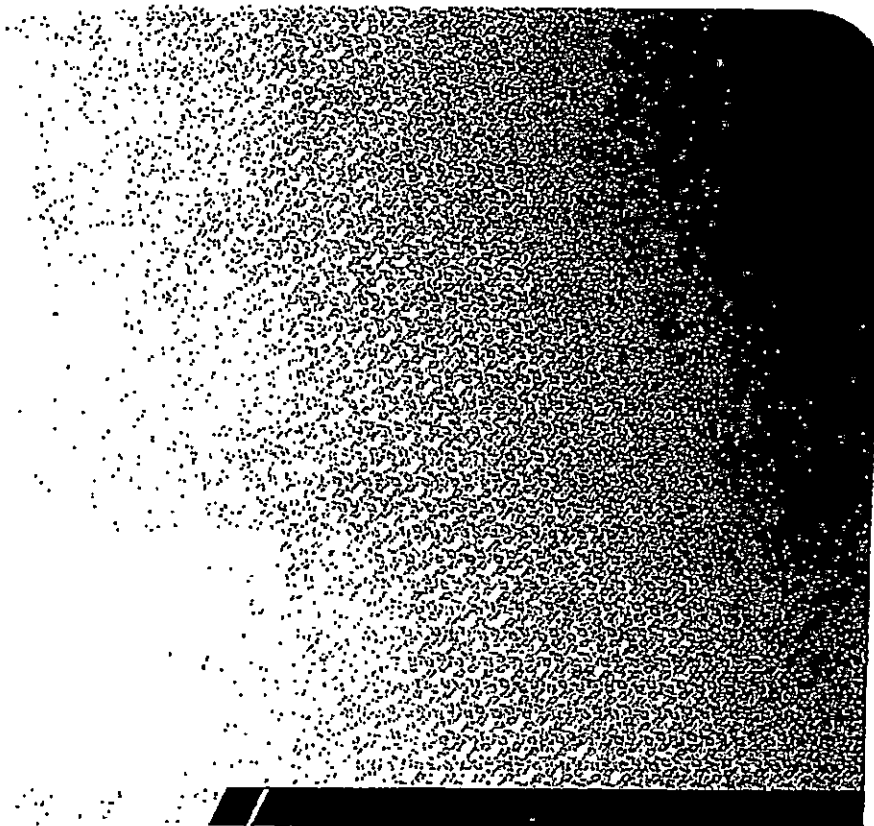
Continuous Insurance: Gold

9511A SC 1014



SOUTH CAROLINA

AUTO POLICY



Form 9511A SC (10/14)
version 2.0

PROGRESSIVE
AUTO

055

APPENDIX - 00056

ELECTRONICALLY FILED - 2020 May 11 3:45 PM - CHESTER - COMMON PLEAS - CASE#2020CP1200207

IMPORTANT NOTICE

IN ADDITION TO THE INSURANCE COVERAGE REQUIRED BY LAW TO PROTECT YOU AGAINST A LOSS CAUSED BY AN UNINSURED MOTORIST, IF YOU HAVE PURCHASED LIABILITY INSURANCE COVERAGE THAT IS HIGHER THAN THAT REQUIRED BY LAW TO PROTECT YOU AGAINST LIABILITY ARISING OUT OF THE OWNERSHIP, MAINTENANCE, OR USE OF THE MOTOR VEHICLES COVERED BY THIS POLICY, AND YOU HAVE NOT ALREADY PURCHASED UNINSURED MOTORIST INSURANCE COVERAGE EQUAL TO YOUR LIABILITY INSURANCE COVERAGE:

1. YOUR UNINSURED AND UNDERINSURED MOTORIST INSURANCE COVERAGE HAS INCREASED TO THE LIMITS OF YOUR LIABILITY COVERAGE AND THIS INCREASE WILL COST YOU AN EXTRA PREMIUM CHARGE; AND
2. YOUR TOTAL PREMIUM CHARGE FOR YOUR MOTOR VEHICLE INSURANCE COVERAGE WILL INCREASE IF YOU DO NOT NOTIFY YOUR AGENT OR INSURER OF YOUR DESIRE TO REDUCE COVERAGE WITHIN TWENTY DAYS OF THE MAILING OF THE POLICY OR THE PREMIUM NOTICE, AS THE CASE MAY BE;
3. IF THIS IS A NEW POLICY AND YOU HAVE ALREADY SIGNED A WRITTEN REJECTION OF SUCH HIGHER LIMITS IN CONNECTION WITH IT, PARAGRAPHS (1) AND (2) OF THIS NOTICE DO NOT APPLY.

CONTENTS

INSURING AGREEMENT	1
GENERAL DEFINITIONS	1
PART I—LIABILITY TO OTHERS	
Insuring Agreement.....	3
Additional Definition	3
Additional Payments	3
Exclusions.....	4
Limits of Liability.....	5
Financial Responsibility Laws	6
Other Insurance	6
Out-of-State Coverage.....	6
Arbitration of Property Damage Liability Claims.....	7
PART II—MEDICAL PAYMENTS COVERAGE	
Insuring Agreement.....	7
Additional Definitions	7
Exclusions.....	8
Limits of Liability.....	9
Unreasonable or Unnecessary Medical Expenses	9
Other Insurance	10
PART III—UNINSURED/UNDERINSURED MOTORIST COVERAGE	
Insuring Agreement—Uninsured Motorist Coverage	10
Insuring Agreement—Underinsured Motorist Coverage	10
Notice Requirement	11
Additional Definitions	11
Exclusions.....	12
Limits of Liability.....	13
Other Insurance	15
Arbitration for Bodily Injury Claims.....	15
Arbitration for Property Damage Claims	16
PART IV—DAMAGE TO A VEHICLE	
Insuring Agreement—Collision Coverage	16
Insuring Agreement—Comprehensive Coverage	16
Insuring Agreement—Additional Custom Parts or Equipment Coverage	17
Insuring Agreement—Rental Reimbursement Coverage.....	17
Insuring Agreement—Loan/Lease Payoff Coverage	18
Insuring Agreement—Pet Injury Coverage	19
Additional Definitions	19
Exclusions.....	19

Limits of Liability.....	21
Payment of Loss	22
No Benefit to Bailee	23
Loss Payable Clause	23
Other Sources of Recovery.....	23
Appraisal	23
PART V—ROADSIDE ASSISTANCE COVERAGE	
Insuring Agreement.....	24
Additional Definitions	24
Exclusions.....	24
Unauthorized Service Provider	25
Other Insurance	25
PART VI—DUTIES IN CASE OF AN ACCIDENT OR LOSS	25
PART VII—GENERAL PROVISIONS	
Policy Period and Territory.....	26
Changes.....	26
Duty to Report Changes	27
Settlement of Claims.....	27
Terms of Policy Conformed to Statutes	27
Transfer of Interest.....	28
Fraud or Misrepresentation.....	28
Payment of Premium and Fees	29
Cancellation	29
Cancellation Refund.....	30
Nonrenewal.....	30
Legal Action Against Us.....	30
Our Rights to Recover Payment	31
Joint and Individual Interests	31
Bankruptcy	32

SOUTH CAROLINA AUTO POLICY

INSURING AGREEMENT

In return for your payment of the premium, we agree to insure you subject to all the terms, conditions and limitations of this policy. We will insure you for the coverages and the limits of liability shown on this policy's **declarations page**. Your policy consists of the policy contract, your insurance application, the **declarations page**, and all endorsements to this policy.

GENERAL DEFINITIONS

The following definitions apply throughout the policy. Defined terms are printed in bold-face type and have the same meaning whether in the singular, plural, or any other form.

1. **"Additional auto"** means an auto you become the owner of during the policy period that does not permanently replace an auto shown on the **declarations page** if:
 - a. we insure all other autos you own;
 - b. the additional auto is not covered by any other insurance policy;
 - c. you notify us within 30 days of becoming the owner of the additional auto; and
 - d. you pay any additional premium due.

An additional auto will have the broadest coverage we provide for any auto shown on the **declarations page**. If you ask us to insure an additional auto more than 30 days after you become the owner, any coverage we provide will begin at the time you request coverage.

2. **"Auto"** means a land motor vehicle:
 - a. of the private passenger, pickup body, or cargo van type;
 - b. designed for operation principally upon public roads;
 - c. with at least four wheels; and
 - d. with a gross vehicle weight rating of 12,000 pounds or less, according to the manufacturer's specifications.

However, "auto" does not include step-vans, parcel delivery vans, or cargo cut-away vans or other vans with cabs separate from the cargo area.

3. **"Auto business"** means the business of selling, leasing, repairing, parking, storing, servicing, delivering or testing vehicles.
4. **"Bodily injury"** means bodily harm, sickness, or disease, including death that results from bodily harm, sickness, or disease.
5. **"Covered auto"** means:
 - a. any auto or trailer shown on the **declarations page** for the coverages applicable to that auto or trailer;
 - b. any additional auto;
 - c. any replacement auto; or
 - d. a trailer owned by you.
6. **"Declarations page"** means the document showing your coverages, limits of liability, covered autos, premium, and other policy-related information. The **declarations page** may also be referred to as the Auto Insurance Coverage Summary.

7. **"Occupying"** means in, on, entering or exiting.
8. **"Personal vehicle sharing program"** means a system or process, operated by a business, organization, network, group, or individual, that facilitates the sharing of private passenger motor vehicles for use by individuals, businesses, or other entities.
9. **"Property damage"** means physical damage to, destruction of, or loss of use of, tangible property.
10. **"Rated resident"** means a person residing in the same household as you at the time of the loss who is not a relative, but only if that person is both:
 - a. listed in the "Drivers and household residents" section on the declarations page; and
 - b. not designated as either an "Excluded" or a "List Only" driver.
11. **"Relative"** means a person residing in the same household as you, and related to you by blood, marriage or adoption, and includes a ward, stepchild, or foster child. Your unmarried dependent children temporarily away from home will qualify as a relative if they intend to continue to reside in your household.
12. **"Replacement auto"** means an auto that permanently replaces an auto shown on the declarations page. A replacement auto will have the same coverage as the auto it replaces if the replacement auto is not covered by any other insurance policy. However, if the auto being replaced had coverage under Part IV—Damage To A Vehicle, such coverage will apply to the replacement auto only during the first 30 days after you become the owner unless you notify us within that 30-day period that you want us to extend coverage beyond the initial 30 days. If the auto being replaced did not have coverage under Part IV—Damage To A Vehicle, such coverage may be added, but the replacement auto will have no coverage under Part IV until you notify us of the replacement auto and ask us to add the coverage.
13. **"Ride-sharing activity"** means the use of any vehicle to provide transportation of persons or property in connection with a transportation network company from the time a user logs on to, or signs in to, any online-enabled application, software, website or system until the time the user logs out of, or signs off of, any such online-enabled application, software, website or system, whether or not the user has accepted any passenger(s) or delivery assignment, including the time the user is on the way to pick up any passenger(s) or property, or is transporting any passenger(s) or property.
14. **"Trailer"** means a non-motorized trailer, including a farm wagon or farm implement, designed to be towed on public roads by an auto and not being used:
 - a. for commercial purposes;
 - b. as an office, store, or for display purposes; or
 - c. as a passenger conveyance.
15. **"Transportation network company"** means a corporation, partnership, sole proprietorship, or other entity that uses any online-enabled application, software, website or system to connect drivers with clients or passengers to facilitate and/or provide transportation or delivery services for compensation or a fee.
16. **"We," "us" and "our"** mean the underwriting company providing the insurance, as shown on the declarations page.

17. "You" and "your" mean:
- a person shown as a named insured on the **declarations page**; and
 - the spouse of a named insured if residing in the same household at the time of the loss.

PART I—LIABILITY TO OTHERS

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay damages for **bodily injury** and **property damage** for which an **Insured person** becomes legally responsible because of an accident.

Damages include prejudgment interest awarded against an insured person.

We will settle or defend, at our option, any claim for damages covered by this Part I.

ADDITIONAL DEFINITION

When used in this Part I:

"**Insured person**" means:

- you, a relative, or a **rated resident** with respect to an accident arising out of the ownership, maintenance or use of an auto or a trailer;
- any person with respect to an accident arising out of that person's use of a covered auto with the permission of you, a relative, or a **rated resident**;
- any person or organization with respect only to vicarious liability for the acts or omissions of a person described in a. or b. above; and
- any "Additional Interest" shown on the **declarations page** with respect only to its liability for the acts or omissions of a person described in a. or b. above.

ADDITIONAL PAYMENTS

In addition to our limit of liability, we will pay for an **Insured person**:

- all expenses we incur in the settlement of any claim or defense of any lawsuit;
- Interest accruing after entry of judgment, until we have paid, offered to pay, or deposited in court, that portion of the judgment which does not exceed our limit of liability. This does not apply if we have not been given notice of suit or the opportunity to defend an **Insured person**;
- the premium on any appeal bond or attachment bond required in any lawsuit we defend. We have no duty to purchase a bond in an amount exceeding our limit of liability, and we have no duty to apply for or furnish these bonds;
- up to \$250 for a bail bond required because of an accident resulting in **bodily injury** or **property damage** covered under this Part I. We have no duty to apply for or furnish this bond; and
- reasonable expenses, including loss of earnings up to \$200 per day, incurred at our request.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART I.

Coverage under this Part I, including our duty to defend, will not apply to any insured person for:

1. **bodily injury or property damage** arising out of the ownership, maintenance or use of any vehicle or trailer while being used:
 - a. to carry persons or property for compensation or a fee; or
 - b. for retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food.

For damages arising out of the ownership, maintenance, or use of a covered auto, this exclusion applies only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina. This exclusion does not apply to shared-expense car pools;
2. any liability assumed under any contract or agreement by you, a relative, or a rated resident;
3. **bodily injury** to an employee of that insured person arising out of or within the course of employment. This exclusion does not apply to domestic employees if benefits are neither paid nor required to be provided under workers' compensation, disability benefits, or similar laws;
4. **bodily injury or property damage** arising out of an accident involving any vehicle while being maintained or used by a person while employed or engaged in any auto business. For damages arising out of the ownership, maintenance, or use of a covered auto, this exclusion applies only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina. This exclusion does not apply to you, a relative, a rated resident, or an agent or employee of you, a relative, or a rated resident, when using a covered auto;
5. **bodily injury or property damage** resulting from, or sustained during practice or preparation for:
 - a. any pre-arranged or organized racing, stunting, speed or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
6. **bodily injury or property damage** due to a nuclear reaction or radiation;
7. **bodily injury or property damage** for which insurance:
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
8. any obligation for which the United States Government is liable under the Federal Tort Claims Act;
9. **bodily injury or property damage** caused by an intentional act of that insured person, or at the direction of that insured person, even if the actual injury or damage is different than that which was intended or expected. For damages arising out of the ownership, maintenance, or use of a covered auto, this exclu-

- sion applies only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina;
10. **property damage** to any property owned by, rented to, being transported by, or in the charge of that **Insured person**. This exclusion does not apply to a rented residence or a rented garage;
 11. **bodily injury or property damage** arising out of the ownership, maintenance or use of any vehicle owned by you or furnished or available for your regular use, other than a **covered auto** for which this coverage has been purchased;
 12. **bodily injury or property damage** arising out of the ownership, maintenance or use of any vehicle owned by a **relative** or a **rated resident** or furnished or available for the regular use of a **relative** or a **rated resident**, other than a **covered auto** for which this coverage has been purchased. This exclusion does not apply to your maintenance or use of such vehicle;
 13. **bodily injury or property damage** arising out of your, a **relative's**, or a **rated resident's** use of a vehicle, other than a **covered auto**, without the permission of the owner of the vehicle or the person in lawful possession of the vehicle;
 14. **bodily injury or property damage** arising out of the use of a **covered auto** while leased or rented to others or given in exchange for any compensation, including while being used in connection with a **personal vehicle sharing program**. This exclusion does not apply to the operation of a **covered auto** by you, a **relative**, or a **rated resident**;
 15. **bodily injury or property damage** caused by, or reasonably expected to result from, a criminal act or omission of that **Insured person**. This exclusion applies regardless of whether that **Insured person** is actually charged with, or convicted of, a crime. However, this exclusion will apply only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina. For purposes of this exclusion, criminal acts or omissions do not include traffic violations; or
 16. **bodily injury or property damage** arising out of the ownership, maintenance or use of any vehicle or trailer while being used for **ride-sharing activity**. This exclusion does not apply to shared-expense car pools.

LIMITS OF LIABILITY

The limit of liability shown on the declarations page for liability coverage is the most we will pay regardless of the number of:

1. claims made;
2. **covered autos**;
3. **Insured persons**;
4. lawsuits brought;
5. vehicles involved in the accident; or
6. premiums paid.

If your declarations page shows a split limit:

1. the amount shown for "each person" is the most we will pay for all damages due to **bodily injury** to one person resulting from any one accident;

2. subject to the "each person" limit, the amount shown for "each accident" is the most we will pay for all damages due to **bodily injury** sustained by two or more persons in any one accident; and
3. the amount shown for "property damage" is the most we will pay for the total of all **property damage** resulting from any one accident.

The "each person" limit of liability applies to the total of all claims made for **bodily injury** to a person and all claims of others derived from such **bodily injury**, including, but not limited to, loss of society, loss of companionship, loss of services, loss of consortium, and wrongful death.

If the **declarations** page shows that "combined single limit" or "CSL" applies, the amount shown is the most we will pay for the total of all damages resulting from any one accident. However, without changing this limit of liability, we will comply with any law that requires us to provide any separate limits.

The limits of liability under this Part I shall not be reduced by payments made under Part II—Medical Payments Coverage. However, no one is entitled to duplicate payments for the same elements of damages.

We will not pay under this Part I any expenses paid or payable under Part II—Medical Payments Coverage.

If multiple auto policies issued by us are in effect for you, we will pay no more than the highest limit of liability for this coverage available under any one policy.

An auto and attached trailer are considered one auto. Therefore, the limits of liability will not be increased for an accident involving an auto that has an attached trailer.

FINANCIAL RESPONSIBILITY LAWS

When we certify this policy as proof of financial responsibility, this policy will comply with the law to the extent required. The insured person must reimburse us if we make a payment that we would not have made if this policy was not certified as proof of financial responsibility.

OTHER INSURANCE

If there is any other applicable liability insurance or bond, we will pay only our share of the damages. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide for a vehicle or trailer, other than a covered auto, will be excess over any other collectible insurance, self-insurance, or bond.

OUT-OF-STATE COVERAGE

If an accident to which this Part I applies occurs in any state, territory or possession of the United States of America or any province or territory of Canada, other than the

one in which a covered auto is principally garaged, and the state, province, territory or possession has;

1. a financial responsibility or similar law requiring limits of liability for bodily injury or property damage higher than the limits shown on the declarations page, this policy will provide the higher limits; or
2. a compulsory insurance or similar law requiring a non-resident to maintain insurance whenever the non-resident uses an auto in that state, province, territory or possession, this policy will provide the greater of:
 - a. the required minimum amounts and types of coverage; or
 - b. the limits of liability under this policy.

ARBITRATION OF PROPERTY DAMAGE LIABILITY CLAIMS

Any party to a disputed property damage liability claim may submit the claim to arbitration in accordance with South Carolina law.

PART II—MEDICAL PAYMENTS COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury:

1. sustained by an insured person; and
2. caused by that motor vehicle accident.

We, or someone on our behalf, will determine:

1. whether the expenses for medical services are reasonable; and
2. whether the medical services are necessary.

ADDITIONAL DEFINITIONS

When used in this Part II:

1. "Insured person" means:
 - a. you, a relative, or a rated resident:
 - (i) while occupying an auto; or
 - (ii) when struck by a motor vehicle or a trailer while not occupying a self-propelled motorized vehicle; and
 - b. any other person while occupying a covered auto with the permission of you, a relative, or a rated resident.
2. "Medical services" means medical, surgical, dental, x-ray, ambulance, hospital, professional nursing, and funeral services, and includes the cost of eyeglasses, hearing aids, pharmaceuticals, orthopedics, and prosthetic devices.
3. "Motor vehicle" means a land motor vehicle designed for use principally on public roads.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART II.

Coverage under this Part II will not apply to bodily injury:

1. sustained by any person while occupying a covered auto while it is being used:
 - a. to carry persons or property for compensation or a fee;
 - b. for retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food; or
 - c. for ride-sharing activity.

This exclusion does not apply to shared-expense car pools;
2. arising out of an accident involving a vehicle while being maintained or used by a person while employed or engaged in any auto business. This exclusion does not apply to you, a relative, a rated resident, or an agent or employee of you, a relative, or a rated resident, when using a covered auto;
3. to any person resulting from, or sustained during practice or preparation for:
 - a. any pre-arranged or organized racing, stunting, speed or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
4. due to a nuclear reaction or radiation;
5. for which insurance:
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
6. for which the United States Government is liable under the Federal Tort Claims Act;
7. sustained by any person while occupying any vehicle or trailer while located for use as a residence or premises;
8. if workers' compensation benefits are available for the bodily injury;
9. sustained by any person while occupying or when struck by any vehicle owned by you or furnished or available for your regular use, other than a covered auto for which this coverage has been purchased;
10. sustained by any person while occupying or when struck by any vehicle owned by a relative or a rated resident or furnished or available for the regular use of a relative or a rated resident, other than a covered auto for which this coverage has been purchased. This exclusion does not apply to you;
11. to you, a relative, or a rated resident, while occupying any vehicle, other than a covered auto, without the permission of the owner of the vehicle or the person in lawful possession of the vehicle;
12. to any person while occupying a covered auto while leased or rented to others or given in exchange for any compensation, including while being used in connection with a personal vehicle sharing program. This exclusion does not apply to the operation of a covered auto by you, a relative, or a rated resident;
13. caused directly or indirectly by:
 - a. war (declared or undeclared) or civil war;

- b. warlike action by any military force of any government, sovereign or other authority using military personnel or agents. This includes any action taken to hinder or defend against an actual or expected attack; or
 - c. Insurrection, rebellion, revolution, usurped power, or any action taken by a governmental authority to hinder or defend against any of these acts;
14. caused directly or indirectly by:
- a. any accidental or intentional discharge, dispersal or release of radioactive, nuclear, pathogenic or poisonous biological material; or
 - b. any intentional discharge, dispersal or release of chemical or hazardous material for any purpose other than its safe and useful purpose; or
15. caused by, or reasonably expected to result from, a criminal act or omission of an insured person. This exclusion applies regardless of whether the insured person is actually charged with, or convicted of, a crime. For purposes of this exclusion, criminal acts or omissions do not include traffic violations.

LIMITS OF LIABILITY

The limit of liability shown on the declarations page for Medical Payments Coverage is the most we will pay for each insured person injured in any one accident, regardless of the number of:

- 1. claims made;
- 2. covered autos;
- 3. insured persons;
- 4. lawsuits brought;
- 5. vehicles involved in the accident; or
- 6. premiums paid.

No one will be entitled to duplicate payments under this policy for the same elements of damages.

Any amount payable to an insured person under this Part II will be reduced by any amount paid or payable for the same expense under Part I—Liability To Others or Part III—Uninsured/Underinsured Motorist Coverage.

If multiple auto policies issued by us are in effect for you, we will pay no more than the highest limit of liability for this coverage available under any one policy.

UNREASONABLE OR UNNECESSARY MEDICAL EXPENSES

If an insured person incurs expenses for medical services that we deem to be unreasonable or unnecessary, we may refuse to pay for those expenses and contest them.

If the medical service provider sues the insured person because we refuse to pay expenses for medical services that we deem to be unreasonable or unnecessary, we will pay any resulting defense costs, and any resulting judgment against the

Insured person, subject to the limit of liability for this coverage. We will choose the counsel. We will also pay reasonable expenses, including loss of earnings up to \$200 per day, incurred at our request.

The **insured person** may not sue us for expenses for **medical services** we deem to be unreasonable or unnecessary unless the **insured person** paid the entire disputed amount to the medical service provider or the medical service provider has initiated collection activity against the **insured person** for the unreasonable or unnecessary expenses.

OTHER INSURANCE

If there is other applicable auto medical payments insurance, we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide for an **insured person occupying** a vehicle or trailer, other than a **covered auto**, will be excess over any other auto insurance providing payments for **medical services**.

PART III—UNINSURED/UNDERINSURED MOTORIST COVERAGE

INSURING AGREEMENT—UNINSURED MOTORIST COVERAGE

If you pay the premium for this coverage, we will pay for damages that an **insured person** is legally entitled to recover from the owner or operator of:

1. an **uninsured motor vehicle** because of **bodily injury**:
 - a. sustained by an **insured person**;
 - b. caused by an accident; and
 - c. arising out of the ownership, maintenance or use of an **uninsured motor vehicle**; or
2. an **uninsured motor vehicle** because of **property damage**:
 - a. caused by an accident; and
 - b. arising out of the ownership, maintenance, or use of an **uninsured motor vehicle**.

INSURING AGREEMENT—UNDERINSURED MOTORIST COVERAGE

If you pay the premium for this coverage, we will pay for damages that an **insured person** is legally entitled to recover from the owner or operator of:

1. an **underinsured motor vehicle** because of **bodily injury**:
 - a. sustained by an **insured person**;
 - b. caused by an accident; and
 - c. arising out of the ownership, maintenance, or use of an **underinsured motor vehicle**; or
2. an **underinsured motor vehicle** because of **property damage**:
 - a. caused by an accident; and
 - b. arising out of the ownership, maintenance, or use of an **underinsured motor vehicle**.

We will pay under this Part III only after the limits of liability under all applicable liability bonds and policies have been exhausted by payment of judgments or settlements.

NOTICE REQUIREMENT

Any judgment or settlement for damages against an owner or operator of an **uninsured motor vehicle** or an **underinsured motor vehicle** that arises out of a lawsuit brought for which we have not received notice in accordance with South Carolina law is not binding on us.

ADDITIONAL DEFINITIONS

When used in this Part III:

1. **"Insured person"** means:
 - a. **you, a relative, or a rated resident;**
 - b. **any person while operating a covered auto with the permission of you, a relative, or a rated resident;**
 - c. **any person occupying, but not operating, a covered auto; and**
 - d. **any person who is entitled to recover damages covered by this Part III because of bodily injury sustained by a person described in a., b. or c. above.**
2. **"Underinsured motor vehicle"** means a land motor vehicle or trailer of any type to which liability insurance or a bond applies at the time of the accident with limits of liability that equal or exceed the minimum amounts required by the South Carolina motor vehicle financial responsibility law, but which are less than the amount of the damages sustained by the **insured person** in the accident.
An **"underinsured motor vehicle"** does not include any vehicle or equipment:
 - a. **operated on rails or crawler treads;**
 - b. **designed mainly for use off public roads, while not on public roads;**
 - c. **while located for use as a residence or premises; or**
 - d. **that is an uninsured motor vehicle.**
3. **"Uninsured motor vehicle"** means a land motor vehicle or trailer of any type:
 - a. **to which no liability bond, cash deposit, security, or liability policy in at least the amounts of coverage required by South Carolina law applies at the time of the accident;**
 - b. **to which a liability bond or policy applies at the time of the accident, but the bonding or insuring company:**
 - (i) **denies coverage;**
 - (ii) **is or becomes insolvent;**
 - (iii) **is in delinquency proceedings, suspension, or receivership; or**
 - (iv) **is financially unable to fully satisfy a judgment rendered in favor of an insured person;**
 - c. **to which a liability bond or policy applies at the time of the accident, but its limit of liability is less than the minimum limit of liability specified by the financial responsibility law of the state in which the covered auto is principally garaged; or**

- d. that is a hit-and-run vehicle whose owner or operator cannot be identified and which causes an accident resulting in **bodily injury** to an **insured person**, or **property damage** to the property of an **insured person**, provided:
 - (i) the **insured person**, or someone on his or her behalf, reports the accident to the police or civil authority within 24 hours or as soon as practicable after the accident; and
 - (ii) if the **bodily injury** or **property damage** was not caused by physical contact between the vehicle operated by the unidentified operator and the **insured person**, or a vehicle occupied by the **insured person**, there must be independent corroborative evidence by a witness to the accident who executes a signed affidavit attesting to the truth of the accident to prove that the **bodily injury** or **property damage** was proximately caused by the negligent or intentional actions of the unidentified operator of the motor vehicle. The testimony of the owner or operator of the **covered auto** shall not constitute independent corroborative evidence. No recovery will be provided under this Part III if the **insured person** was negligent in failing to determine the identity of the other motor vehicle and its driver at the time of the accident.

An "uninsured motor vehicle" does not include any vehicle or equipment:

- a. owned or operated by a self-insurer under any applicable motor vehicle law, except a self-insurer that:
 - (i) is or becomes insolvent; or
 - (ii) fails to qualify as a self-insurer under South Carolina law;
- b. owned by any governmental unit or agency, except when:
 - (i) operated by a person without property authorization; or
 - (ii) a cause of action against that governmental unit or agency arising out of a motor vehicle accident is barred by the Tort Claims Act of South Carolina;
- c. operated on rails or crawler treads;
- d. designed mainly for use off public roads, while not on public roads;
- e. while located for use as a residence or premises;
- f. that is an **underinsured motor vehicle**; or
- g. that is a **covered auto**.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART III.

Coverage under this Part III will not apply:

- 1. to **bodily injury** sustained by any person while using or occupying a **covered auto** while being used:
 - a. to carry persons or property for compensation or a fee;
 - b. or retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food; or
 - c. for **ride-sharing activity**.

This exclusion does not apply to shared-expense car pools;

2. to **bodily injury** sustained by the owner of a motor vehicle if:
 - a. the **bodily injury** is sustained while using or **occupying** that owned motor vehicle; and
 - b. if uninsured motorist coverage or underinsured motorist coverage, as the case may be, has not been purchased for that motor vehicle;
3. to **bodily injury** sustained by you, a relative, or a rated resident while using any vehicle, other than a **covered auto**, without the permission of the owner of the vehicle or the person in lawful possession of the vehicle;
4. to **bodily injury** arising out of the use of a **covered auto** while being used in connection with a **personal vehicle sharing program**. This exclusion does not apply to the operation of a **covered auto** by you, a relative, or a rated resident; or
5. directly or indirectly to benefit any insurer or self-insurer under any of the following or similar laws:
 - a. workers' compensation law; or
 - b. disability benefits law.

Coverage under this Part III will not apply to **property damage**:

1. sustained while a **covered auto** is being used:
 - a. to carry persons or property for compensation or a fee;
 - b. for retail or wholesale delivery, including but not limited to, the pickup, transport, or delivery of magazines, newspapers, mail, or food; or
 - c. for ride-sharing activity.

This exclusion does not apply to shared-expense car pools;
2. resulting from, or sustained during practice or preparation for:
 - a. any pre-arranged or organized racing, stunting, speed, or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
3. to a **covered auto** for which insurance:
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
4. to a trailer;
5. to any motor vehicle owned by you, a relative, or a rated resident if uninsured motorist coverage or underinsured motorist coverage, as the case may be, has not been purchased for that motor vehicle; or
6. sustained while a **covered auto** is being used in connection with a **personal vehicle sharing program**. This exclusion does not apply to the operation of a **covered auto** by you, a relative, or a rated resident.

LIMITS OF LIABILITY

The limit of liability shown on the **declarations page** for Uninsured Motorist Coverage or Underinsured Motorist Coverage, as the case may be, is the most we will pay regardless of the number of:

1. claims made;

2. covered autos, but only with respect to **insured persons** other than you, a relative, or a **rated resident**;
3. **insured persons**;
4. lawsuits brought;
5. vehicles involved in the accident; or
6. premiums paid, but only with respect to **insured persons** other than you, a relative, or a **rated resident**.

When you, a relative, or a **rated resident** are not occupying an auto and sustain **bodily injury** caused by the owner or operator of an **uninsured motor vehicle** or **underinsured motor vehicle**, our limit of liability shall not exceed the limit of liability shown on the **declarations page** for any one **covered auto**.

If your **declarations page** shows a split limit:

1. the amount shown for "each person" for "**bodily injury**" is the most we will pay for all damages due to **bodily injury** to one person;
2. subject to the "each person" limit, the amount shown for "each accident" is the most we will pay for all damages due to **bodily injury** sustained by two or more persons in any one accident; and
3. the amount shown for "property damage" is the most we will pay for the aggregate of all **property damage** caused by any one accident.

The "each person" limit of liability includes the total of all claims made for **bodily injury** to an **insured person** and all claims of others derived from such **bodily injury**, including, but not limited to, loss of society, loss of companionship, loss of services, loss of consortium, and wrongful death.

If the **declarations page** shows that "combined single limit" or "CSL" applies, the amount shown is the most we will pay for the total of all **bodily injury** damages resulting from any one accident. However, without changing this total limit of liability, we will comply with any law that requires us to provide any separate limits.

The amount of damages payable for **bodily injury** under this Part III will be reduced by all sums:

1. paid because of **bodily injury** by or on behalf of any persons or organizations that may be legally responsible;
2. paid under Part I—Liability To Others; and
3. paid or payable because of **bodily injury** under any disability benefits law or similar law.

We will not pay under this Part III any expenses paid or payable under Part II—Medical Payments Coverage.

The limit of liability for property damage to a **covered auto** is the lowest of:

1. the actual cash value of the **covered auto** at the time of the accident;
2. the amount necessary to replace the **covered auto**;

3. the amount necessary to repair the covered auto to its pre-loss condition; or
4. the limit of liability shown on the declarations page for Uninsured Motorist Property Damage or Underinsured Motorist Property Damage, whichever applies.

The amount of damages payable for property damage under this Part III will be reduced by all sums paid because of property damage by or on behalf of any persons or organizations that may be legally responsible, including, but not limited to, all sums paid under Part I—Liability To Others.

We shall not pay for property damage to the extent that such damages are paid or payable under any other property damage or physical damage insurance, including all sums paid or payable under Part IV—Damage To A Vehicle.

Payments for property damage under this Part III are subject to the following provisions:

1. any amount payable under this Part III for property damage shall be subject to the applicable deductible shown on the declarations page; and
2. no more than one deductible shall be applied to any one accident.

No one will be entitled to duplicate payments for the same elements of damages.

OTHER INSURANCE

If there is other applicable uninsured or underinsured motorist coverage, we will pay only our share of the damages. Our share is the proportion that our limit of liability bears to the total of all available coverage limits. However, when you, a relative, or a rated resident are occupying a motor vehicle other than a covered auto and sustain bodily injury covered under this Part III, our coverage shall be excess to the coverage applicable to the motor vehicle that you, the relative, or the rated resident are occupying, and our total limit of liability under this policy shall not exceed our limit of liability for one auto.

However, when you, a relative, or a rated resident are operating, or occupying, a motor vehicle that is owned by you, a relative, or a rated resident but is not a covered auto, in that case, our total limit of liability will be the lesser of the limit of liability listed on the declarations page or the amount of Uninsured Motorist Coverage or Underinsured Motorist Coverage, as the case may be, on the vehicle involved in the accident.

ARBITRATION FOR BODILY INJURY CLAIMS

If we and an insured person cannot agree on:

1. the legal liability of the operator or owner of an uninsured motor vehicle or underinsured motor vehicle; or
 2. the amount of the damages sustained by the insured person;
- this will be determined by arbitration if we and the insured person mutually agree to arbitration prior to the expiration of the bodily injury statute of limitations in the state in which the accident occurred.

If we and the Insured person mutually agree to arbitration, each party will select an arbitrator. The two arbitrators will select a third. If the two arbitrators cannot agree on a third arbitrator within 30 days, then on joint application by the insured person and us, the third arbitrator will be appointed by a court having jurisdiction.

Each party will pay the costs and fees of its arbitrator and any other expenses it incurs. The costs and fees of the third arbitrator will be shared equally.

Unless both parties agree otherwise, arbitration will take place in the county in which the insured person resides. Local rules of procedure and evidence will apply.

A decision agreed to by two of the arbitrators will be binding with respect to a determination of:

1. the legal liability of the operator or owner of an uninsured motor vehicle or underinsured motor vehicle; and
2. the amount of the damages sustained by the insured person.

The arbitrators will have no authority to award an amount in excess of the limit of liability.

We and an insured person may agree to an alternate form of arbitration.

ARBITRATION FOR PROPERTY DAMAGE CLAIMS

An insured person may submit a disputed property damage claim to arbitration in accordance with South Carolina law.

PART IV—DAMAGE TO A VEHICLE

INSURING AGREEMENT—COLLISION COVERAGE

If you pay the premium for this coverage, we will pay for sudden, direct and accidental loss to a:

1. covered auto, including an attached trailer; or
 2. non-owned auto;
- and its custom parts or equipment, resulting from collision.

In addition, we will pay the reasonable cost to replace any child safety seat damaged in an accident to which this coverage applies.

INSURING AGREEMENT—COMPREHENSIVE COVERAGE

If you pay the premium for this coverage, we will pay for sudden, direct and accidental loss to a:

1. covered auto, including an attached trailer; or
 2. non-owned auto;
- and its custom parts or equipment, that is not caused by collision.

A loss not caused by **collision** includes:

1. contact with an animal (including a bird);
2. explosion or earthquake;
3. fire;
4. malicious mischief or vandalism;
5. missiles or falling objects;
6. riot or civil commotion;
7. theft or larceny;
8. windstorm, hail, water or flood; or
9. breakage of glass not caused by **collision**.

In addition, we will pay for:

1. reasonable transportation expenses incurred by you if a **covered auto** is stolen; and
2. loss of use damages that you are legally liable to pay if a **non-owned auto** is stolen.

A combined maximum of \$900, not exceeding \$30 per day, will apply to these additional benefits. The additional benefit for transportation expenses will not apply if you purchased Rental Reimbursement Coverage for the stolen **covered auto**.

Coverage for transportation expenses and loss of use damages begins 48 hours after you report the theft to us and ends the earliest of:

1. when the **auto** has been recovered and returned to you or its owner;
2. when the **auto** has been recovered and repaired;
3. when the **auto** has been replaced; or
4. 72 hours after we make an offer to settle the loss if the **auto** is deemed by us to be a total loss.

We must receive written proof of transportation expenses and loss of use damages.

INSURING AGREEMENT—ADDITIONAL CUSTOM PARTS OR EQUIPMENT COVERAGE

We will pay for sudden, direct and accidental loss to custom parts or equipment on a **covered auto** for which this coverage has been purchased. This coverage applies only if you have purchased both Comprehensive Coverage and Collision Coverage for that **covered auto** and the loss is covered under one of those coverages. This coverage applies in addition to any coverage automatically provided for custom parts or equipment under Comprehensive Coverage or Collision Coverage.

INSURING AGREEMENT—RENTAL REIMBURSEMENT COVERAGE

We will reimburse rental charges incurred when you rent an **auto** from a rental agency or auto repair shop due to a loss to a **covered auto** for which Rental Reimbursement Coverage has been purchased. This coverage applies only if you have

purchased both Comprehensive Coverage and Collision Coverage for that covered auto and the loss is covered under one of those coverages.

Additional fees or charges for insurance, damage waivers, optional equipment, fuel, or accessories are not covered.

This coverage is limited to the each day limit shown on the declarations page for a maximum of 30 days.

If Rental Reimbursement Coverage applies, no other coverage under this policy for rental expenses will apply.

Rental charges will be reimbursed beginning:

1. when the covered auto cannot be driven due to a loss; or
2. if the covered auto can be driven, when you deliver the covered auto to an auto repair shop or one of our Service Centers for repairs due to the loss; and ending the earliest of:
 1. when the covered auto has been returned to you;
 2. when the covered auto has been repaired;
 3. when the covered auto has been replaced;
 4. 72 hours after we make an offer to settle the loss if the covered auto is deemed by us to be a total loss; or
 5. when you incur 30 days worth of rental charges.

You must provide us written proof of your rental charges to be reimbursed.

INSURING AGREEMENT—LOAN/LEASE PAYOFF COVERAGE

If you pay the premium for this coverage, and the covered auto for which this coverage was purchased is deemed by us to be a total loss, we will pay, in addition to any amounts otherwise payable under this Part IV, the difference between:

1. the actual cash value of the covered auto at the time of the total loss; and
2. any greater amount the owner of the covered auto is legally obligated to pay under a written loan or lease agreement to which the covered auto is subject at the time of the total loss, reduced by:
 - a. unpaid finance charges or refunds due to the owner for such charges;
 - b. excess mileage charges or charges for wear and tear;
 - c. charges for extended warranties or refunds due to the owner for extended warranties;
 - d. charges for credit insurance or refunds due to the owner for credit insurance;
 - e. past due payments and charges for past due payments; and
 - f. collection or repossession expenses.

However, our payment under this coverage shall not exceed the limit of liability shown on the declarations page. The limit of liability is a percentage of the actual cash value of the covered auto at the time of the loss.

This coverage applies only if you have purchased both Comprehensive Coverage and Collision Coverage for that covered auto and the loss is covered under one of those coverages.

INSURING AGREEMENT—PET INJURY COVERAGE

If you have purchased Collision coverage for at least one covered auto under your policy, and if your pet sustains injury or death while inside a covered auto or non-owned auto at the time of a loss covered under Collision or Comprehensive coverage, we will provide:

1. up to \$1,000 for reasonable and customary veterinary fees incurred by you, a relative, or a rated resident if your pet is injured in, or as a direct result of, the covered loss; or
 2. a \$1,000 death benefit if your pet dies in, or as a direct result of, the covered loss, less any payment we made toward veterinary expenses for your pet.
- In the event of a covered loss due to the theft of a covered auto or non-owned auto, we will provide the death benefit provided your pet is inside that auto at the time of the theft and your pet is not recovered.

ADDITIONAL DEFINITIONS

When used in this Part IV:

1. "Collision" means the upset of a vehicle or its impact with another vehicle or object.
2. "Custom parts or equipment" means equipment, devices, accessories, enhancements and changes, other than those that are offered by the manufacturer specifically for that auto model, or that are installed by the auto dealership as part of the original sale of a new auto, that:
 - a. are permanently installed or attached; and
 - b. alter the appearance or performance of the auto.
3. "Mechanical parts" means operational parts on a vehicle that wear out over time or have a finite useful life or duration typically shorter than the life of the vehicle as a whole. Mechanical parts do not include external crash parts, wheels, paint, or windshields and other glass.
4. "Non-owned auto" means an auto that is not owned by or furnished or available for the regular use of you, a relative, or a rated resident while in the custody of or being operated by you, a relative, or a rated resident with the permission of the owner of the auto or the person in lawful possession of the auto.
5. "Your pet" means any dog or cat owned by you, a relative, or a rated resident.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART IV.

Coverage under this Part IV will not apply for loss:

1. to any vehicle while being used:
 - a. to carry persons or property for compensation or a fee;

- b. for retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food; or
 - c. for ride-sharing activity.
- This exclusion does not apply to shared-expense car pools;
- 2. to a **non-owned auto** while being maintained or used by a person while employed or engaged in any **auto business**;
 - 3. to any vehicle resulting from, or sustained during practice or preparation for:
 - a. any pre-arranged or organized racing, stunting, speed or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
 - 4. to any vehicle for which insurance:
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
 - 5. to any vehicle caused by an intentional act committed by or at the direction of you, a **relative**, a **rated resident**, or the owner of a **non-owned auto**, even if the actual damage is different than that which was intended or expected;
 - 6. to a **covered auto** while it is leased or rented to others or given in exchange for compensation, including while being used in connection with a **personal vehicle sharing program**. This exclusion does not apply to the operation of a **covered auto** by you, a **relative**, or a **rated resident**;
 - 7. due to destruction or confiscation by governmental or civil authorities of any vehicle because you, any **relative**, or any **rated resident** engaged in illegal activities;
 - 8. to any vehicle that is due and confined to:
 - a. wear and tear;
 - b. freezing;
 - c. mechanical, electrical or electronic breakdown or failure; or
 - d. road damage to tires.

This exclusion does not apply if the damage results from the theft of a vehicle;
 - 9. to portable equipment, devices, accessories, and any other personal effects that are not permanently installed. This includes, but is not limited to:
 - a. tapes, compact discs, cassettes, DVDs, and other recording or recorded media;
 - b. any case or other container designed for use in storing or carrying tapes, compact discs, cassettes, DVDs, or other recording or recorded media;
 - c. any device used for the detection or location of radar, laser, or other speed measuring equipment or its transmissions; and
 - d. CB radios, telephones, two-way mobile radios, DVD players, personal computers, personal digital assistants, or televisions;
 - 10. to any vehicle for diminution of value;
 - 11. to any vehicle caused directly or indirectly by:
 - a. war (declared or undeclared) or civil war;
 - b. warlike action by any military force of any government, sovereign, or other authority using military personnel or agents. This includes any action taken to hinder or defend against an actual or expected attack; or

- c. insurrection, rebellion, revolution, usurped power, or any action taken by a governmental authority to hinder or defend against any of these acts;
- 12. to any vehicle caused directly or indirectly by:
 - a. any accidental or intentional discharge, dispersal or release of radioactive, nuclear, pathogenic or poisonous biological material; or
 - b. any intentional discharge, dispersal or release of chemical or hazardous material for any purpose other than its safe and useful purpose; or
- 13. to any vehicle caused by, or reasonably expected to result from, a criminal act or omission of you, a relative, a rated resident, or the owner of a non-owned auto. This exclusion applies regardless of whether you, the relative, the rated resident, or the owner of the non-owned auto is actually charged with, or convicted of, a crime. For purposes of this exclusion, criminal acts or omissions do not include traffic violations.

LIMITS OF LIABILITY

- 1. The limit of liability for loss to a covered auto, non-owned auto, or custom parts or equipment is the lowest of:
 - a. the actual cash value of the stolen or damaged property at the time of the loss reduced by the applicable deductible;
 - b. the amount necessary to replace the stolen or damaged property reduced by the applicable deductible;
 - c. the amount necessary to repair the damaged property to its pre-loss condition reduced by the applicable deductible; or
 - d. the Stated Amount shown on the declarations page for that covered auto.
 However, the most we will pay for loss to:
 - a. custom parts or equipment is \$1,000 unless you purchased Additional Custom Parts or Equipment Coverage ("ACPE"). If you purchased ACPE, the most we will pay is \$1,000 plus the amount of ACPE you purchased.
 - b. a trailer is the limit of liability shown on the declarations page for that trailer. If the trailer is not shown on the declarations page, the limit of liability is \$500.
- 2. Payments for loss to a covered auto, non-owned auto, or custom parts or equipment are subject to the following provisions:
 - a. If coverage applies to a non-owned auto, we will provide the broadest coverage applicable to any covered auto shown on the declarations page.
 - b. If you have elected a Stated Amount for a covered auto, the Stated Amount is the most we will pay for all loss to that covered auto, including its custom parts or equipment.
 - c. Coverage for custom parts or equipment will not cause our limit of liability for loss to an auto under this Part IV to be increased to an amount in excess of the actual cash value of the auto, including its custom parts or equipment.
 - d. In determining the amount necessary to repair damaged property to its pre-loss condition, the amount to be paid by us:
 - (i) will not exceed the prevailing competitive labor rates charged in the area where the property is to be repaired and the cost of repair or replacement parts and equipment, as reasonably determined by us; and

- (ii) will be based on the cost of repair or replacement parts and equipment which may be new, reconditioned, remanufactured or used, including, but not limited to:
 - (a) original manufacturer parts or equipment; and
 - (b) nonoriginal manufacturer parts or equipment.
- e. To determine the amount necessary to repair or replace the damaged property as referred to in subsection 1., the total cost of necessary repair or replacement may be reduced by unrepaired prior damage. Unrepaired prior damage includes broken, cracked or missing parts; rust; dents; scrapes; gouges; and peeling paint. The reduction for unrepaired prior damage is the cost of labor, parts and materials necessary to repair or replace damage, deterioration, defects, or wear and tear on exterior body parts, windshields and other glass, wheels, and paint, that existed prior to the accident and that is eliminated as a result of the repair or replacement of property damaged in the loss.
- f. To determine the amount necessary to repair or replace the damaged property as referred to in subsection 1., an adjustment may be made for betterment or depreciation and physical condition on:
 - (i) batteries;
 - (ii) tires;
 - (iii) engines and transmissions, if the engine has greater than 80,000 miles; and
 - (iv) any other mechanical parts that are nonfunctioning or inoperative.We will not make an adjustment for the labor costs associated with the replacement or repair of these parts.
- g. The actual cash value is determined by the market value, age, and condition of the vehicle at the time the loss occurs.
- 3. No deductible will apply with respect to damage to automobile safety glass.
- 4. Duplicate recovery for the same elements of damages is not permitted.
- 5. Any amount paid or payable to a person under this Part IV for property damage to an auto shall be reduced by any amount paid for that property damage to the auto under Part III—Uninsured/Underinsured Motorist Coverage.
- 6. The following additional limits of liability apply to Pet Injury coverage:
 - a. The most we will pay for all damages in any one loss is a total of \$1,000 regardless of the number of dogs or cats involved.
 - b. If your pet dies in, or as a direct result of, a covered loss, we will provide a death benefit of \$1,000, less any payment we made toward veterinary expenses for your pet.
 - c. No deductible shall apply to this coverage.

PAYMENT OF LOSS

We may, at our option:

- 1. pay for the loss in money; or
- 2. repair or replace the damaged or stolen property.

At our expense, we may return any recovered stolen property to you or to the address shown on the declarations page, with payment for any damage resulting from the theft. We may keep all or part of the property at the agreed or appraised value.

We may settle any loss with you or the owner or lienholder of the property.

NO BENEFIT TO BAILEE

Coverage under this Part IV will not directly or indirectly benefit any carrier or other bailee for hire.

LOSS PAYABLE CLAUSE

Payment under this Part IV for a loss to a covered auto will be made according to your interest and the interest of any lienholder shown on the declarations page or designated by you. At our option, payment may be made to both jointly, or to either separately. However, if the covered auto is not a total loss, we may make payment to you and the repairer of the auto.

The lienholder's interest will not be protected:

1. where fraud, misrepresentation, material omission, or intentional damage resulting in a denial of coverage by us has been committed by or at the direction of you or any person seeking coverage; or
 2. where the loss is otherwise not covered under the terms of this policy.
- If this policy is cancelled, nonrenewed or voided, the interest of any lienholder under this agreement will also terminate.

OTHER SOURCES OF RECOVERY

If other sources of recovery also cover the loss, we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide for a non-owned auto, or trailer not shown on the declarations page, will be excess over any other collectible source of recovery including, but not limited to:

1. any coverage provided by the owner of the non-owned auto or trailer;
2. any other applicable physical damage insurance; and
3. any other source of recovery applicable to the loss.

APPRAISAL

If we cannot agree with you on the amount of a loss, then we or you may demand an appraisal of the loss. Within 30 days of any demand for an appraisal, each party shall appoint a competent appraiser and shall notify the other party of that appraiser's identity. The appraisers will determine the amount of loss. If they fail to agree, the disagreement will be submitted to a qualified umpire chosen by the appraisers.

If the two appraisers are unable to agree upon an umpire within 15 days, we or you may request that a judge of a court of record, in the county where you reside, select an umpire. The appraisers and umpire will determine the amount of loss. The amount of loss agreed to by both appraisers, or by one appraiser and the umpire, will be binding. You will pay your appraiser's fees and expenses. We will pay our appraiser's fees and expenses. All other expenses of the appraisal, including payment of the umpire if one is selected, will be shared equally between us and you. Neither we nor you waive any rights under this policy by agreeing to an appraisal.

PART V—ROADSIDE ASSISTANCE COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay for our authorized service representative to provide the following services when necessary due to a covered emergency:

1. towing of a covered disabled auto to the nearest qualified repair facility; and
2. labor on a covered disabled auto at the place of disablement.

If a covered disabled auto is towed to any place other than the nearest qualified repair facility, you will be responsible for any additional charges incurred.

ADDITIONAL DEFINITIONS

When used in this Part V:

1. "Covered disabled auto" means a covered auto for which this coverage has been purchased that sustains a covered emergency.
2. "Covered emergency" means a disablement that is a result of:
 - a. mechanical or electrical breakdown;
 - b. battery failure;
 - c. insufficient supply of fuel, oil, water, or other fluid;
 - d. flat tire;
 - e. lock-out; or
 - f. entrapment in snow, mud, water or sand within 100 feet of a road or highway.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART V.

Coverage under this Part V will not apply to:

1. more than three covered emergencies for any single covered auto in a six-month period;
2. the cost of purchasing parts, fluid, lubricants, fuel, or replacement keys, or the labor to make replacement keys;
3. installation of products or material not related to the disablement;

4. labor not related to the disablement;
5. labor on a **covered disabled auto** for any time period in excess of 60 minutes per disablement;
6. towing or storage related to impoundment, abandonment, illegal parking, or other violations of law;
7. assistance with jacks, levelers, airbags or awnings;
8. labor or repair work performed at a service station, garage, or repair shop;
9. auto storage charges;
10. disablement that occurs on roads not regularly maintained, sand beaches, open fields, or areas designated as not passable due to construction, weather, or earth movement;
11. mounting or removing of snow tires or chains;
12. tire repair;
13. disablement that results from an intentional or willful act or action by you, a relative, or the operator of a **covered disabled auto**;
14. any **covered auto** while being used in connection with **ride-sharing activity**;
15. any **covered auto** while being used in connection with a **personal vehicle sharing program**; or
16. a trailer.

UNAUTHORIZED SERVICE PROVIDER

When service is rendered by a provider in the business of providing roadside assistance and towing services, other than one of our authorized service representatives, we will pay only reasonable charges, as determined by us, for:

1. towing of a **covered disabled auto** to the nearest qualified repair facility; and
 2. labor on a **covered disabled auto** at the place of disablement;
- which is necessary due to a **covered emergency**.

OTHER INSURANCE

Any coverage provided under this Part V for service rendered by an unauthorized service provider will be excess over any other collectible insurance or towing protection coverage.

PART VI—DUTIES IN CASE OF AN ACCIDENT OR LOSS

For coverage to apply under this policy, you or the person seeking coverage must promptly report each accident or loss even if you or the person seeking coverage is not at fault. You or the person seeking coverage must provide us with all accident or loss information, including time, place, and how the accident or loss happened. You or the person seeking coverage must also obtain and provide us the names and addresses of all persons involved in the accident or loss, the names and addresses of any witnesses, and the license plate numbers of the vehicles involved.

If you or the person seeking coverage cannot identify the owner or operator of a vehicle involved in the accident, or if theft or vandalism has occurred, you or the

person seeking coverage must notify the police within 24 hours or as soon as practicable.

A person seeking coverage must

1. cooperate with us in any matter concerning a claim or lawsuit;
2. provide any written proof of loss we may reasonably require;
3. allow us to take signed and recorded statements, including sworn statements and examinations under oath, which we may conduct outside the presence of you or any other person seeking coverage, and answer all reasonable questions we may ask as often as we may reasonably require;
4. promptly call to notify us about any claim or lawsuit and send us any and all legal papers relating to the claim or suit;
5. attend hearings and trials as we require;
6. take reasonable steps after a loss to protect the covered auto, or any other vehicle for which coverage is sought, from further loss. We will pay reasonable expenses incurred in providing that protection. If failure to provide such protection results in further loss, any additional damages will not be covered under this policy;
7. allow us to have the damaged covered auto, or any other damaged vehicle for which coverage is sought, inspected and appraised before its repair or disposal;
8. submit to medical examinations at our expense by doctors we select as often as we may reasonably require; and
9. authorize us to obtain medical and other records.

PART VII—GENERAL PROVISIONS

POLICY PERIOD AND TERRITORY

This policy applies only to accidents and losses occurring during the policy period shown on the declarations page and that occur within a state, territory or possession of the United States of America, or a province or territory of Canada, or while a covered auto is being transported between their ports.

CHANGES

This policy contract, your insurance application (which is made a part of this policy as if attached hereto), the declarations page, and all endorsements to this policy issued by us, contain all the agreements between you and us. Subject to the following, the terms of this policy may not be changed or waived except by an endorsement issued by us.

The premium for this policy is based on information we received from you and other sources. You agree to cooperate with us in determining if this information is correct and complete, and to promptly notify us if it changes during the policy period. If this information is determined by us to be incorrect, incomplete, or if it changes during the policy period, you agree that we may adjust your policy information and premi-

um accordingly. Changes that may result in a premium adjustment are contained in our rates and rules. These include, but are not limited to, you, a relative, or a rated resident obtaining a driver's license or operator's permit, or changes in:

1. the number, type or use classification of covered autos;
2. the persons who regularly operate a covered auto;
3. the persons of legal driving age residing in your household;
4. the residents in your household;
5. an operator's marital status;
6. your mailing address and your residence address;
7. the principal garaging address of any covered auto;
8. coverage, deductibles, or limits of liability; or
9. rating territory or discount eligibility.

The coverage provided in your policy may be changed only by the issuance of a new policy or an endorsement by us. However, if during the policy period we broaden any coverage afforded under the current edition of your policy without additional premium charge, that change will automatically apply to your policy as of the date the coverage change is implemented in your state.

If you ask us to delete a vehicle from this policy, no coverage will apply to that vehicle as of the date and time you ask us to delete it.

DUTY TO REPORT CHANGES

You must promptly report to us all changes, including additions and deletions, in policy information. This includes, but is not limited to, changes in:

1. your mailing address or your residence address;
2. the principal garaging address of any covered auto;
3. the residents in your household;
4. the persons of legal driving age residing in your household;
5. the persons who regularly operate a covered auto;
6. an operator's marital status; or
7. the driver's license or operator's permit status of you, a relative, or a rated resident.

SETTLEMENT OF CLAIMS

We may use estimating, appraisal, or injury evaluation systems to assist us in adjusting claims under this policy and to assist us in determining the amount of damages, expenses, or loss payable under this policy. Such systems may be developed by us or a third party and may include computer software, databases, and specialized technology.

TERMS OF POLICY CONFORMED TO STATUTES

If any provision of this policy fails to conform to the statutes of the state listed on your application as your residence, the provision shall be deemed amended to conform

to such statutes. All other provisions shall be given full force and effect. Any disputes as to the coverages provided or the provisions of this policy shall be governed by the law of the state listed on your application as your residence.

TRANSFER OF INTEREST

The rights and duties under this policy may not be transferred to another person without our written consent. However, if a named insured shown on the declarations page dies, this policy will provide coverage until the end of the policy period for the legal representative of the named insured, while acting as such, and for persons covered under this policy on the date of the named insured's death.

FRAUD OR MISREPRESENTATION

This policy was issued in reliance upon the information provided on your insurance application. We may void this policy at any time, including after the occurrence of an accident or loss, if you:

1. made incorrect statements or representations to us with regard to any material fact or circumstance;
2. concealed or misrepresented any material fact or circumstance; or
3. engaged in fraudulent conduct;

at the time of application. This means that we will not be liable for any claims or damages that would otherwise be covered unless we have certified this policy as proof of financial responsibility. If we have certified this policy as proof of financial responsibility, nothing in this provision shall affect coverage under Part I—Liability To Others up to the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina for an accident that occurs before we notify you that the policy is void. If we void this policy, you must reimburse us if we make a payment.

Any changes we make at your request to this policy after inception will be made in reliance upon information you provide. If you:

1. make incorrect statements or representations to us with regard to any material fact or circumstance;
2. conceal or misrepresent any material fact or circumstance; or
3. engage in fraudulent conduct;

In connection with a requested change we may void the policy or reform it as it existed immediately prior to the requested change. We may do this at any time, including after the occurrence of an accident or loss.

When we have not voided or reformed the policy, we may still deny coverage for an accident or loss if you, in connection with the policy application, in connection with any requested change, or at any time during the policy period, have concealed or misrepresented any material fact or circumstance or engaged in fraudulent conduct and that concealment, misrepresentation, or fraudulent conduct was material to a risk we assumed.

We may deny coverage for an accident or loss if you or a person seeking coverage has concealed or misrepresented any material fact or circumstance, or engaged in fraudulent conduct, in connection with the presentation or settlement of a claim. However, this shall not affect coverage under Part I—Liability To Others up to the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina, for any injured person who has not knowingly concealed or misrepresented any material fact or circumstance.

PAYMENT OF PREMIUM AND FEES

If your initial premium payment is by check, draft, electronic funds transfer, or similar form of remittance, coverage under this policy is conditioned on payment to us by the financial institution. If the financial institution upon presentment does not honor the check, draft, electronic funds transfer, or similar form of remittance, this policy may, at our option, be cancelled from its inception by notice of cancellation or rescission. This means we will not be liable under this policy for any claims or damages that would otherwise be covered if the check, draft, electronic funds transfer, or similar form of remittance had been honored by the financial institution. Any action by us to present the remittance for payment more than once shall not affect our right to void this policy.

In addition to premium, fees may be charged on your policy. We may charge fees for installment payments, late payments, and other transactions. Payments made on your policy will be applied first to fees, then to premium due.

CANCELLATION

You may cancel this policy during the policy period by calling or writing us and stating the future date you wish the cancellation to be effective.

We may cancel this policy during the policy period by mailing a notice of cancellation to the named insured shown on the declarations page at the last known address appearing in our records, stating the specific reason for cancellation. Notice will be mailed at least 15 days before the date of cancellation.

We may cancel this policy for any of the following reasons within the first 60 days of the initial policy period:

1. a premium payment by check, draft, electronic funds transfer, or similar form of remittance is not honored upon presentment;
2. you produce proof that you have sold or otherwise disposed of a covered auto, or surrendered its tags and registration;
3. you have secured another policy that satisfies the financial responsibility laws of the State of South Carolina; or
4. you fail to pay when due:
 - a. the premium for the policy;
 - b. an installment of the premium; or
 - c. an installment payment under a premium service contract.

After the policy has been in effect for more than 60 days, but before the policy has been in effect for more than 90 days, we may cancel this policy for any reason.

After this policy is in effect for more than 90 days, or if this is a renewal or continuation policy, we may cancel only for one or more of the following reasons:

1. nonpayment of premium;
2. loss of driving privileges through suspension or revocation of an operator's license issued to you, any driver in your household, or any regular operator of a covered auto; or
3. any other reason permitted by law.

Proof of mailing will be sufficient proof of notice. If this policy is cancelled, coverage will not be provided as of the effective date and time shown in the notice of cancellation. For purposes of cancellation, this policy is neither severable nor divisible. Any cancellation will be effective for all coverages for all persons and all vehicles.

CANCELLATION REFUND

Upon cancellation, you may be entitled to a premium refund. However, our making or offering of a refund is not a condition of cancellation.

If this policy is cancelled, any refund due will be computed on a daily pro rata basis. However, if this policy is cancelled at your request any refund due will be computed on a 90% of a daily pro rata basis. Earned premium is calculated on a daily basis. We will supply a copy of the table to you on request.

When you renew this policy, we will waive our right under the policy to calculate cancellation refunds on a 90% of a daily pro rata basis; instead, any refund of premium following a cancellation that may apply to the renewal policy will be calculated on a daily pro rata basis.

NONRENEWAL

If neither we nor one of our affiliates offers to renew or continue this policy, we will mail notice of nonrenewal stating the specific reason for nonrenewal to the named insured shown on the declarations page at the last known address appearing in our records. Proof of mailing will be sufficient proof of notice. Notice will be mailed at least 15 days before the end of the policy period.

LEGAL ACTION AGAINST US

We may not be sued unless there is full compliance with all the terms of this policy.

We may not be sued for payment under Part I—Liability To Others until the obligation of an insured person under Part I to pay is finally determined either by judgment after trial against that person or by written agreement of the insured person, the

claimant, and us. No one will have any right to make us a party to a lawsuit to determine the liability of an insured person.

If we retain salvage, we have no duty to preserve or otherwise retain the salvage for any purpose, including evidence for any civil or criminal proceeding.

OUR RIGHTS TO RECOVER PAYMENT

We are entitled to the rights of recovery that the insured person to whom payment was made has against another, to the extent of our payment. That insured person may be required to sign documents related to the recovery and must do whatever else we require to help us exercise those recovery rights, and do nothing after an accident or loss to prejudice those rights.

However, we may not assert rights of recovery:

1. for amounts paid as Underinsured Motorist Coverage benefits; or
2. for amounts paid as Medical Payments Coverage benefits.

When an insured person has been paid by us and also recovers from another, the amount recovered will be held by the insured person in trust for us and reimbursed to us to the extent of our payment. If we are not reimbursed, we may pursue recovery of that amount directly against that insured person.

If an insured person recovers from another without our written consent, the insured person's right to payment under any affected coverage will no longer exist.

If we elect to exercise our rights of recovery against another, we will also attempt to recover any deductible incurred by an insured person under this policy unless we are specifically instructed by that person not to pursue the deductible. We have no obligation to pursue recovery against another for any loss not covered by this policy.

We reserve the right to compromise or settle the deductible and property damage claims against the responsible parties for less than the full amount. We also reserve the right to incur reasonable expenses and attorney fees in pursuit of the recovery.

If the total recovery is less than the total of our payment and the deductible, we will reduce reimbursement of the deductible based on the proportion that the actual recovery bears to the total of our payment and the deductible. A proportionate share of collection expenses and attorney fees incurred in connection with these recovery efforts will also reduce reimbursement of the deductible.

These provisions will be applied in accordance with state law.

JOINT AND INDIVIDUAL INTERESTS

If there is more than one named insured on this policy, any named insured may cancel or change this policy. The action of one named insured will be binding on all persons provided coverage under this policy.

BANKRUPTCY

The bankruptcy or insolvency of an Insured person will not relieve us of any obligations under this policy.

PROGRESSIVE
AUTO

RECEIVED

MAY 16 2025

S.C. SUPREME COURT

9811A SC 1014



Medical Payments Coverage Endorsement

Your policy is amended as follows:

Part II - Medical Payments Coverage

The following is deleted under the Limits of Liability provision.

No one will be entitled to duplicate payments under this policy for the same elements of damages.

Any amount payable to an insured person under this Part II will be reduced by any amount paid or payable for the same expense under Part I - Liability To Others or Part III - Uninsured/Underinsured Motorist Coverage.

All other terms, limits and provisions of this policy remain unchanged.

Form A048 SC (07/11)

ELECTRONICALLY FILED - 2020 May 11 3:45 PM - CHESTER - COMMON PLEAS - CASE#2020CP1200207

STATE OF SOUTH CAROLINA
COUNTY OF CHESTER

IN THE COURT OF COMMON PLEAS
FOR THE SIXTH JUDICIAL CIRCUIT

Alexis Jones and Willie Brown,
Plaintiffs,

Civil Case #: 2020-CP-12-00207

-vs-

Progressive Northern Insurance Company,
Defendant.

**PLAINTIFFS' MOTION IN OPPOSITION
TO DEFENDANT'S MOTION FOR
SUMMARY JUDGMENT**

Now come the Plaintiffs by through the undersigned counsel, hereby submit their Memorandum of Law in Opposition to Defendant's Motion to Dismiss:

SUMMARY OF FACTS

This action arises out of Progressive's failure to pay Plaintiff Alexis Jones the full \$10,000 in medical payments coverage owed to her under Plaintiff Willie Brown's auto policy as a result of an auto accident on October 8, 2019. Compl. ¶¶ 10-14. The policy includes a \$10,000.00 medical payments coverage limit for "reasonable expenses incurred for necessary medical services" sustained by an insured as a result of an accident. Compl. ¶ 8; Def.'s Mem. In Supp. Of Its Mot. To Dismiss Ex. A, at 14 [hereinafter Def.'s Mot. To Dismiss]. Plaintiff Jones is a Medicaid recipient. Progressive made payments to Plaintiff Jones for the amount Medicaid paid to satisfy the medical bills (\$1,323.60) rather than the original listed charges of \$27,786.17 which exceeded the \$10,000.00 limit. See Compl. ¶¶ 12, 25.b. Defendant wrongly argues Plaintiff Jones neither "incurred" the full charges of the bills nor do the state statutes argued in the Complaint apply to the alleged conduct. Def.'s Mot. To Dismiss, at 3-12.

STANDARD OF REVIEW

Defendant brought this motion pursuant to Rule 12(b)(6), SCRCP. However, when considering a Rule 12(b)(6) motion, the court is concerned only with whether the allegations of the complaint, which it must accept as true, state a cause of action. Doe v. Bishop of Charleston, 407 S.C. 128, 754 S.E.2d 494 (2014). See Chestnut v. AVX Corp., 413 S.C. 224, 227, 776 S.E.2d 82, 84 (2015). Additionally, “[t]he 12(b)(6) motion may not be sustained if the facts alleged and inferences therefrom would entitle the plaintiff to any relief on any theory.” Baird v. Charleston Cty., 333 S.C. 519, 527, 511 S.E.2d 69, 73 (1999) (citing Stiles v. Onorato, 318 S.C. 297, 457 S.E.2d 601 (1995)). “If on a motion under 12(b)(6) matters outside the pleadings are presented and not excluded, the motion shall be treated as one for summary judgment.” McDonnell v. Consol. Sch. Dist. of Aiken, 315 S.C. 487, 489 n.2, 445 S.E.2d 638, 639 n.2 (1994). “[Rule 12(b)(6)] specifically provides for conversion, provided the parties, upon compliance with the notice provisions of Rule 56, are afforded a reasonable opportunity to introduce evidentiary matters.” Johnson v. Dailey, 318 S.C. 318, 321, 457 S.E.2d 613, 615 (1995). The pertinent portion of Rule 12(b) allowing conversion provides:

If, on a motion asserting the defense numbered (6) to dismiss for failure of the pleading to state facts sufficient to constitute a cause of action, matters outside the pleading are presented to and not excluded by the Court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent to such a motion by Rule 56.

Defendant converted its Rule 12(b)(6) motion to a motion for summary judgment the moment it filed its motion based on the insurance policy and attached it as an exhibit for the court’s review. Plaintiffs cannot defend the motion without also pointing to evidence outside the

pleadings. However, Plaintiffs object to the court hearing Defendant's motion for summary judgment before the parties have had a fair opportunity to conduct discovery.

"Summary judgment is a drastic remedy and must not be granted until the opposing party has had a full and fair opportunity to complete discovery." Dawkins v. Fields, 354 S.C. 58, 69, 580 S.E.2d 433, 439 (2003). Plaintiffs served discovery requests on Defendant on May 5, 2020, which have not been answered within thirty (30) days as required by SCRCP 34. Plaintiffs therefore object to proceeding with the motion for summary judgment until they have been given a full and fair opportunity to conduct discovery.

- I. Plaintiff concedes there is no violation of the South Carolina Unfair Trade Plaintiff Practices Act and that claim must be dismissed.
- II. Defendant's Actions are a clear violation of South Carolina Code Section 38-77-144.

South Carolina Code Section 38-77-144 states, "If 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." Progressive's attempt to reduce the amount paid to Ms. Jones under the medical payments portion of Mr. Brown's policy based on the amount her Medicaid paid to her healthcare providers is a setoff. This is a clear violation of South Carolina law.

In Cothran v. State Farm Mutual Auto Insurance Co., 427 S.C. 545, 546-47, 831 S.E.2d 919, 920 (2019), State Farm tried to reduce their obligation to pay PIP coverage by the amount a worker's compensation carrier paid for the insured's medical expenses. The Supreme Court in South Carolina found "[w]hen an insurer seeks to reduce its obligation to pay benefits based on a third party's previous payment for the same claim, it is a setoff." Cothran, 427 S.C. at 555, 831

S.E.2d at 924. Further, the legislative intent of section 38-77-144 is "to prevent an insurance company that sells [MedPay] coverage from reducing the amount of [MedPay] it is obligated to pay because the insured received a third-party payment for the same expenses." Cothran, 427 S.C. at 550, 831 S.E.2d at 921. Specifically, the Court stated, "Because that is the precise effect of State Farm's "Coordination" provision, section 38-77-144 prohibits the provision from reducing State Farm's obligation to pay PIP benefits to the Cothrans." Cothran, 427 S.C. at 555, 831 S.E.2d at 924. Cothran is analogous to the case at hand. Progressive's attempt to pay benefits for "reasonable expenses incurred" is equal to a setoff because Progressive uses a third-party payment to determine what defines "reasonable expenses incurred." This use of a third-party payment goes to the crux of the statute.

Likewise, the Court in Cothran further defined the term "setoff" to mean "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 a payment from a third party." Cothran, 427 S.C. at 548, 831 S.E.2d at 921. The plaintiff in Cothran incurred medical expenses totaling \$40,000, which her workers' compensation benefits covered completely; therefore, State Farm declared they had no obligation to pay any PIP benefits. 427 S.C. at 550 n.2, 831 S.E.2d at 921 n.2. Of importance, however, the Court noted that had the plaintiff's workers' compensation benefits only paid \$37,500, State Farm would have then owed the plaintiff \$2,500. Id. Similarly, Ms. Jones accrued medical expenses in excess of \$10,000, while Medicaid paid \$1,323,60 to satisfy those expenses. Had Medicaid paid more or less Progressive would have paid that amount. Progressive is using a third party's payment to reduce the amount it owes the Plaintiff, therefore the "reasonable expenses incurred" provision is a setoff.

Progressive tries to argue in its brief the Plaintiffs have not alleged Progressive has reduced its medical payments benefits by the amount paid by Medicaid. Defendant hinges on the Plaintiffs specifically alleging Progressive has "violated Sections 38-77-144 by refusing to pay Plaintiff any amount above what Medicaid paid to Plaintiff Jones's health care providers." Compl. ¶ 25.b. This is simply a repackaging of the same argument. Defendant is correct in that the Plaintiff did not allege Progressive specifically reduced the amount owed by subtracting the amount paid by Medicaid from the policy limit ($\$10,000 - \$1,323.60 = \$8,676.40$ benefits owed). Rather, Plaintiff alleged Progressive was even *more egregious* in their position by refusing to pay more than the \$1,323.60 Medicaid paid. The bottom line is both positions reduce the amount of benefits paid by an amount paid by a third party which is a violation of Section 38-77-144.

III. The Collateral Source Rule prohibits Progressive from basing its payment to Plaintiff on what Medicaid, a wholly independent source, has already paid.

The collateral source rule affirms "that compensation received by an injured party from a source wholly independent of the wrongdoer will not reduce the amount of damages owed by the wrongdoer." In re W.B. Easton Const. Co., Inc., 320 S.C. 90, 92, 463 S.E.2d 317, 318 (1995). This rule has long been followed and is liberally applied in South Carolina. Id. "The only requirement for qualification as a collateral source is that the source be 'wholly independent of the wrongdoer'." Id. A source is wholly independent and, therefore, collateral when "the wrongdoer has not contributed to it and when payments to the injured party were not made on behalf of the wrongdoer." Pustaver v. Gooden, 350 S.C. 409, 413, 566 S.E.2d 199, 201 (Ct. App 2002). Ms. Jones's Medicaid is the very definition of a collateral source. The South Carolina Supreme Court declared that "to hold that the plaintiff is limited to damages in the amount

Page 5 of 13

actually paid by Medicaid is contrary to the purposes behind the collateral source rule" See Haselden v. Davis, 353 S.C. 481, 485, 579 S.E.2d 293, 295 (2003)

Additionally, in Covington v. George, 359 S.C. 100, 597 S.E.2d 142 (2004), the question presented to the Court was "whether a [defendant] can introduce evidence of the actual payment amount to challenge the reasonableness of the medical expenses sought by the plaintiff." 359 S.C. at 103, 597 S.E.2d at 144. The Court found that the collateral source was directly implicated, and the actual payment was properly excluded, insofar as inquiry into the payments made would lead to the introduction of contractual arrangements between health insurers and health care providers. 359 S.C. at 103-104, 597 S.E.2d at 144.

By limiting payment to what Medicaid paid, Progressive violated the collateral source rule. Plaintiff submitted bills from her medical providers which exceeded the coverage limit of \$10,000. As such, Plaintiff was entitled to \$10,000.00. Medicaid's payment of \$1,323.60 represents compensation from a wholly independent party and, therefore, meets the requirements to qualify as a collateral source. Accordingly, Progressive is not entitled to reduce the payment it owes the Plaintiff to the amount of expenses paid out by Medicaid. Progressive's assertion that it only owes the Plaintiff \$1,323.60 does precisely what the collateral source rule seeks to prevent—a windfall to an insurer.

That windfall results from Progressive taking advantage of the contract between the Plaintiff and Medicaid. The Plaintiff responsibly applied for Medicaid and as such, she received the benefit of lower medical costs; Progressive should not reap the rewards of that decision. As Haselden points out, limiting the Plaintiff's payment to the amount actually paid by Medicaid is contrary to the purposes behind the collateral source rule.

Similarly, like the defendant in Covington, Progressive attempts to rely on the actual Medicaid payment amount to challenge the reasonableness of the medical expenses. However, in seeking to reduce its amount to what Medicaid paid, Progressive attempts to benefit from the contractual relationship between Medicaid and the Plaintiff's medical providers. By limiting its payment to the Plaintiff to only what Medicaid paid and ignoring the actual amounts billed for, Progressive has violated the collateral source rule and used a third-party payment to reduce its damages.

IV. Progressive misreads and misapplies Gordon and Barker.

Progressive has misplaced reliance upon Gordon v. Fidelity & Casualty Co. of N.Y., 238 S.C. 438, 120 S.E.2d 509 (1961), and Barker v. Washington National Insurance, No. 9:12-cv-1909-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013), to support its position that Plaintiff Jones incurred no expense above the Medicaid reduced rates, therefore, is not entitled to Progressive's MedPay coverage limits. Progressive does not place any importance on the factual distinctions between Gordon and Barker and this matter and how such factual distinctions are critical to the ultimate outcome. *See* Def.'s Mot. To Dismiss, at 6-7; 9-12. The facts and circumstances of both Gordon and Barker differ substantially from both each other as well as this matter. Even with the critical distinctions, these two cases are useful in showing how Progressive should have unambiguously written its policy to achieve its desire to reduce medical payments to policyholders who had Medicaid.

A. Gordon defines "expense incurred" consistent with Plaintiff's reading of the policy.

Gordon analyzed the meaning of "expense incurred." In Gordon, there were never any expenses because the medical services provided at the military base hospital were always free.

Page 7 of 13

Gordon, 238 S.C. at 446, 120 S.E.2d at 513. Hence, an expense was not incurred, ever. Gordon was trying to collect the value of medical services which differs substantially from a bill or charge for medical services. *See Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. Plaintiff Jones, on the other hand, incurred an expense on the date of service because she was charged for the medical services she obtained. By virtue of being billed for the medical services, Plaintiff Jones "incurred" an "expense." This is a key factual distinction between Gordon and Plaintiff Jones' claim which was overlooked in Progressive's brief.

B. Progressive should look to Barker for instruction on how a policy should be written to properly explain to its policyholders its payment methodology.

Progressive failed to consider broad factual distinctions when proclaiming Barker is indistinguishable from this case.¹ Once again when considering Progressive's cited cases, factual distinctions are key.

The facts in Barker cannot be reconciled with the facts of Plaintiff Jones's case. In Barker, the plaintiff obtained a "Limited Benefit Health Coverage" insurance policy. Barker, 2013 WL 1767620, at *1. The policy promised payments to the insured for the "expenses incurred" for medical services. Id. at *4. Early in the life of the policy, the carrier tried to reduce the amount paid to Barker by taking advantage of his health insurance discounts. Id. at *1. Barker complained to the insurance company and ultimately to the South Carolina Department of Insurance, which resolved the issue in Barker's favor. Id. Thereafter, he

¹ Additionally, Barker is a federal district court case and, therefore, any decision in that case is not binding on this Court. *See Bazzle v. Green Tree Fin. Corp.*, 351 S.C. 244, 264, 569 S.E.2d 349, 359 (2002).

continued to receive payments based upon the full amount of the charges by the medical provider.² Id.

At a later date, Barker became eligible for Medicare. Id. His policy had a Medicare endorsement which provided a specific formula for payment of benefits that differed from the previous formula. Id. at *7. The policy paid less to the insured because it took advantage of the Medicare write down. *See id.* To compensate the insured for the reduction in benefit, the policy also provided for a premium reduction. Id. In Progressive's policy there is no such written policy provision or reduced premium for those with Medicaid.

Despite a clear policy endorsement which changed the policy payment formula, Barker tried to decline the mandatory policy change. Id. at *1, *7. The insurance company implemented the change despite Barker's protest, so Barker filed suit. Id. at *2. The Barker decision enforced the endorsement's express language which specifically addressed Medicare benefits. Id. at *7. There was no ambiguity in the Barker endorsement language because the insurance carrier took the time to expressly articulate its calculation methodology in its endorsement language. Id. at *7-*8.

Notwithstanding Progressive's assertion that Barker is factually similar to this case, it excludes critical facts which validate the Plaintiff's position. The Barker policy contained a policy endorsement that changed its terms once a policyholder became eligible for Medicare. There is no such endorsement or change in policy terms regarding Medicaid recipients in Progressive's policy. In fact, the insurance company in Barker, Washington National Insurance

² After hearing the appeal, the South Carolina Insurance Commission enforced the contract whereby Barker received payment for the amount of the entire medical bill. The District Court did not provide any additional details about the issue.

Company, was astute enough to know that policy interpretation would be held against it as the policy drafter,³ so it included the change as part of the policy terms. It recognized that some policyholders would eventually qualify for Medicare, so it ensured the policyholder knew when, how, and why they were being treated differently. *See id.* Unlike Washington National Insurance Company, Progressive did not take the time to draft an endorsement. In addition, Progressive did not inform its policyholders when, how, or why they would be treated differently if they had Medicaid. Although Progressive informed policyholders how additional applicable auto MedPay insurance would affect their coverage, they failed to address Medicaid's impact.⁴

Washington National Insurance Company took further steps to make sure its insureds understood the policy terms. It reduced its premiums because it anticipated that reduced benefits would be paid when it took advantage of the Medicare write downs. *See id.* at *7. No such reduced premiums were suggested or mandated by Progressive. Instead, Progressive wants to retain the short-pay benefits it derives from Plaintiff Jones' utilization of Medicaid benefits.

Another distinguishing factor is that Barker tried to reject the mandatory policy endorsement. *Id.* at *1, *7. Rejecting the endorsement was not an option available to Barker, hence, the determination by the Court that Washington National could, pursuant to the policy terms, take advantage of the Medicare write downs. *Id.* at *7. The Progressive policy has no such policy terms although, like Washington National, it could have written the terms into the policy.

³ *Gordon*, 238 S.C. at 444, 120 S.E.2d at 512 (noting that "it is a well settled rule that the terms of an insurance policy must be construed most liberally in favor of the insured . . ." (citing *Pitts v. Glens Falls Indemnity Co.*, 222 S.C. 133, 72 S.E.2d 174 (1952))).

⁴ *See* Def.'s Mot. To Dismiss Ex. A, at 17.

There is one final distinction between Barker and this matter. The Barker insurance policy provided a payment formula within the policy. See id. at *7. This formula allowed the policyholder to understand, without any question, the amount of benefit to be paid and the basis for such payments. In this case, however, Progressive offers no such explanatory or unambiguous policy language. Instead, it relies on several non-binding case definitions of “expenses incurred,” see Def.’s Mot. To Dismiss, at 11 n.7, and it completely omits the reductions in coverage if a policyholder has Medicaid. Once again, Progressive chose not to enlighten its policyholders on its methodology. While Progressive’s position that the use of Medicare and Medicaid may make the two cases factually similar, it ignores the fact that the two policies are distinguishably written—a critical fact in determining the outcome of the issue.

Progressive’s Motion to Dismiss, to its detriment, misreads and misapplies Gordon and Barker. Barker supports the fact that Progressive should have clearly written its policy to inform it policyholders of its desires to pay less to those who have Medicaid. It should have provided premium reductions for those with such health insurance and informed its insureds of such reductions. It should have provided a payment formula within the policy like in Barker to further its policyholders’ understanding. Simply stated, Progressive had every opportunity to write its policy so its insureds would understand its MedPay payment methodology but failed to do so at its own peril.

- V. **Progressive carried out its insurance policy in a manner violative of South Carolina Code, Section 38-77-144, thereby entitling the Plaintiff to recovery under her Breach of Contract and accompanying claims.**

Progressive asserts that the breach Plaintiff complains of was an action taken in accordance with the policy terms and allowed under South Carolina law and, therefore, the breach of

contract claims must be dismissed. However, Progressive's action of relying on a third-party payment to determine what is reasonably owed to the Plaintiff equates to a setoff in violation of Section 38-77-144.

Furthermore, Progressive relies on the language in its policy—"reasonable expenses incurred"—to argue that its decision to proffer payment in the amount paid by Medicaid was not a breach of the insurance policy. Def.'s Mot. to Dismiss, at 8-11. Moreover, Progressive avers the Plaintiff sets forth no alleged breach of the insurance contract. *Id.* at 8. Notwithstanding Progressive's assertion, Plaintiff's Complaint alleges the Defendant unreasonably and unjustifiably denied payment in full of the Medicaid claim, Compl. ¶ 14, despite Plaintiff having performed all conditions precedent to Defendant's obligations to pay the full amount of all reasonable and necessary health care and other MedPay benefits, *Id.* at ¶ 19 a-c. Progressive failed to live up to its end of the bargain when it refused to pay the Plaintiff the full amount of all reasonable and necessary health care and other MedPay benefits, despite the premiums Plaintiff paid for consideration.

Progressive's policy represents a legal contract when made, but then performed the contract in violation of Section 38-77-144. "[A] remedy may be had by the person who may be damaged by misconduct, but not by one seeking to disaffirm obligations under the fully performed agreement resulting in benefit to that person and without such person suffering damage of any kind." McConnell v. Commonwealth Pictures Corp., 7 N.Y.2d 465, 467-468, 166 N.E.2d 494 (1960). The Court in McConnell held that "a party will be denied recovery even on a contract valid on its face, if it appears that he has resorted to gravely immoral and illegal conduct in accomplishing its performance." 7 N.Y.2d at 471, 166 N.E.2d 494. Although the plaintiff in

McConnell was the party accused of wrongdoing, the underlying premise applies to the case at hand. In performing its portion of the contract, Progressive relied on a third-party payment, in violation of section 38-77-144. Accordingly, the Plaintiff has been damaged in that she did not recover the full amount of her MedPay claim. As a result, Progressive has sustained a benefit because they do not have to pay out the full \$10,000; instead, they have limited their payment to \$1,323.60. Progressive's decision to perform the contract in violation of South Carolina's statute and in a manner disaffirming its obligation to pay out the Plaintiff's MedPay claim entitles the Plaintiff to recovery under her breach of contract and accompanying claims.

VI. Plaintiffs concede that Willie Brown is not a proper Plaintiff in this lawsuit.

Respectfully submitted,

s/J. Logan Cannon
J. Logan Cannon, SC Bar #101688
Shaw Law Firm
Post Office Drawer 36250
Rock Hill, South Carolina 29732
(803) 329-4200
Attorney for the Plaintiff

June 18, 2020

STATE OF SOUTH CAROLINA
COUNTY OF CHESTER

IN THE COURT OF COMMON PLEAS
CIVIL ACTION NO: 2020-CP-12-00207

Alexis Jones and Willie Brown,
Plaintiffs,
v.
Progressive Northern Insurance Company,
Defendant.

MOTION TO RECONSIDER

**TO: J. LOGAN CANNON, ESQUIRE, ATTORNEY FOR PLAINTIFFS AND TO
PLAINTIFFS ABOVE-NAMED:**

YOU WILL PLEASE TAKE NOTICE that the undersigned, as attorneys for the Defendant, Progressive Northern Insurance Company, will move before the presiding judge of the Chester County Court of Common Pleas at the Chester County Courthouse at 10:00 a.m. on the tenth (10th) day after service hereof, or as soon thereafter as counsel may conveniently be heard, for an Order altering or amending the Order denying the Defendant's Motion to Dismiss in this case on the grounds that the order failed to grant certain relief that was consented to by Plaintiffs and the court failed to follow established precedent from the S.C. Supreme Court in denying the motion in full which constitutes a manifest error of law.

This Motion is made pursuant to Rule 59 of the South Carolina Rules of Civil Procedure and will be based upon the pleadings, case decisions and motions previously filed. Counsel for the undersigned received written notice of the Order denying the motion to dismiss from the Court on August 10, 2020.

Therefore, based on the above, Progressive Northern requests that the Court reconsider its denial of motion to dismiss and alter or amend its ruling and grant judgment in favor of Progressive Northern as to all claims.

MURPHY & GRANTLAND, P.A.

s/J.R. Murphy
J.R. Murphy, Esquire (SC Bar #7941)
P.O. Box 6648
Columbia, SC 29260
(803) 782-4100
Attorneys for Defendant Progressive
Northern Insurance Company

Columbia, South Carolina
August 20, 2020

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STATE OF SOUTH CAROLINA: COURT OF COMMON PLEAS
SIXTH JUDICIAL CIRCUIT: CHESTER COUNTY

ALEXIS JONES and WILLIE)
BROWN,) Docket No.
) 2020-CP-12-00207
PLAINTIFF,)
)
V.)
)
PROGRESSIVE NORTHERN) BENCH TRIAL
INSURANCE COMPANY,)
)
DEFENDANT,)

March 27, 2023
Chester, South Carolina

B-E-F-O-R-E:

THE HONORABLE BRIAN M. GIBBONS

A-P-P-E-A-R-A-N-C-E-S:

JEFFREY CANNON, ESQ.
Attorney for the Plaintiff

JOHN MURPHY, ESQ.
Attorney for the Defendant

Maria DiScioscia, RPR
Official Court Reporter

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I N D E X

<u>WITNESS</u>	<u>EXAMINATION BY</u>	<u>PAGE</u>
WILLIE BROWN	DIRECT EXAM - JEFFERY CANNON	9
ALEXIS JONES	DIRECT EXAM - JEFFREY CANNON	13
	CROSS EXAM - JOHN MURPHY	14

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E X H I B I T S

COURT'S

DESCRIPTION

PAGE

1

Attorney Affidavit fees

27

1 THE BAILIFF: All rise.

2 THE COURT: Good morning, ladies and
3 gentlemen. We'll go ahead and get started with the
4 case. It's 20-CP-12-0207, Alexis Jones versus
5 Progressive Northern Insurance Company. Prior to
6 commencing testimony this morning, the parties have
7 filed a stipulation of fact with the Court, on May 28,
8 2021.

9 Gentlemen, have those facts changed?

10 MR. CANNON: No, your Honor. They have not.

11 MR. MURPHY: No, your Honor. Thank you.

12 THE COURT: And I've received it this morning
13 and I have plaintiff's pretrial brief, as well as, the
14 defense's memorandum as well. I understand there's some
15 witnesses we're going to hear from?

16 MR. CANNON: Yes, your Honor. There's a total
17 of maybe 30 questions.

18 THE COURT: Not a problem. This is their day
19 in Court and I'll let y'all make whatever arguments you
20 need to make, make a record and then we'll go from
21 there.

22 Call your witness.

23 MR. CANNON: Your Honor, do you mind if I say
24 something beforehand?

25 THE COURT: No, go head.

1 MR. CANNON: I just wanted to re-raise my
2 objections to the causes of actions that were previously
3 dismissed in Mr. Murphy's motion to reconsider. But to
4 lay before the Court your Honor, just to reiterate a
5 little bit.

6 We're here to decide -- left to decide,
7 whether Progressive breach it's contract it had with the
8 insured when it decided to interpret, we think the word
9 "incurred", arbitrarily in a way that it was outside the
10 scope in terms of the contract, your Honor. And we're
11 specifically looking at the phrase on Page 7 of the
12 contract, that says: *"We will pay for reasonable*
13 *expenses incurred for necessary medical services."*
14 That's on page 7, your Honor, of the policy, which was
15 stipulated -- it was Exhibit A to the stipulation of
16 facts on Page 7 of the policy, your Honor.

17 We asked the Court, when we move forward
18 today, here, is right under the section that we're
19 looking in, Progressive interestingly enough, says that
20 they will hire someone -- someone on their behalf will
21 determine if those expenses were reasonable and it says
22 that they will determine whether those services were
23 necessary. However, your Honor, nowhere under that does
24 it say that Progressive will determine if someone
25 incurred those expenses.

1 Your Honor, further, Progressive neglects to
2 define the word "incur" anywhere in the definition
3 section of the policy earlier or in the additional
4 definition section right under the "Med-pay coverage"
5 section right there on Page 7, your Honor.

6 So to simply put it, your Honor. We believe
7 the Plaintiff incurred the full sticker price of the
8 hospital bill when she received medical services when
9 she walked in the door. Progressive believes that she
10 only incurred what Medicaid paid to satisfy the bill.

11 Your Honor, the legal argument before the
12 Court is: The term "incurred" is vague and ambiguous,
13 your Honor. And under South Carolina law, vague and
14 ambiguous terms must be construed in favor of the
15 insured and not the insurer. And we believe this will
16 be supported by testimony today.

17 Your Honor, it's our contention that if
18 Progressive wanted to pay people less because they have
19 health insurance or because they received some sort of
20 gratuitous gift towards the bill, they should put that
21 in their policies, your Honor. As this contract was
22 written, we don't believe Progressive should be allowed
23 to define or redefine executed portions of the policy on
24 the fly after someone has incurred a loss.

25 So your Honor, we're asking -- we believe that

1 by denying the full Medicaid coverage, they breached the
2 contract. And we're asking the Court today for the
3 remaining balance of the Med-pay coverage, plus
4 attorneys fee and I did bring an affidavit today. And
5 any interest on, from the day of the accident filed,
6 your Honor.

7 THE COURT: I got it. I understand your
8 argument as to breach of contract. We're gonna hear
9 testimony on that. I will read the stipulation of fact.
10 And of course, I'll hear from Mr. Murphy in reply.

11 MR. CANNON: Yes, sir.

12 THE COURT: But are you -- you started off
13 your argument objecting to the Court's prior decision
14 dismissing the bad faith cause of action.

15 MR. CANNON: That was just for the record,
16 your Honor.

17 THE COURT: Okay. You're protected in the
18 record on that.

19 MR. CANNON: Yes, sir.

20 THE COURT: I'll respectfully deny that.

21 MR. CANNON: Right.

22 THE COURT: Again, I think this is a breach of
23 contract action. I don't know if there's any evidence
24 in the record to sustain a bad faith action going
25 forward when there -- it was a legitimate legal issue

1 concerning what "expense incurred" means. And that's
2 the basis of the Court's decision previously.

3 But I understand, you're protected in the
4 record.

5 MR. CANNON: Yes, sir.

6 THE COURT: Mr. Murphy, anything from you
7 before we hear testimony?

8 MR. MURPHY: Yes, sir. Just briefly. It is a
9 pure legal issue. It's on that phrase. The South
10 Carolina Supreme Court answered that question in 1961,
11 the year I was born. It seems ancient, but I don't feel
12 ancient. But apparently, it feels ancient when you read
13 a case from back then.

14 Basically, you'll hear our arguments. I don't
15 think there's any dispute that there was an amount on
16 the sticker. Those rates were reduced because of
17 Medicaid. I get EOB's all the time and because I'm with
18 Humana now or United Health Care or Blue Cross, they
19 negotiate rates in advance. And the doctor who sees you
20 agrees to that rate instead of the rate the doctor's
21 would like to charge. And in the case law, we believe,
22 will be clear. And the amount that is actually paid or
23 that the insured is legally obligated to pay or the
24 beneficiary, the recipient which could be a deductible
25 if it's private health care. Obviously with Medicaid

1 there's no deductibles. That's the amount that triggers
2 the reimbursement coverage and expenses incurred. Yes,
3 it's not defined in the policy, but the Gordon case
4 involving a soldier who's treated in Fort Jackson
5 clearly defines it. There are other cases that we'll
6 mention at the end, your Honor, in more detail that
7 indicates that.

8 But it's a twofold aspect of it. One is, the
9 insured actually paid it, which is not in evidence here.
10 And two is, an amount an insured is legally obligated to
11 pay. And with Medicaid, there is no further ongoing
12 legal obligation. Once the provider accepts the
13 Medicaid payment, that's it in terms of what the patient
14 might owe. So that's our legal position on it.

15 THE COURT: I got it.

16 Call your first witness.

17 MR. CANNON: Your Honor, Lee Brown.

18 THE COURT: All right. Sir, come on around.

19

20 W-I-L-L-I-E B-R-O-W-N, the Witness herein, having been
21 sworn by the Clerk of Court, was examined and testified
22 as follows:

23

24

DIRECT EXAMINATION

25

BY MR. CANNON:

1 Q. Mr. Brown, did you purchase an auto policy
2 which covered you and Alexis Jones for a wreck that
3 occurred on October 8, 2019?

4 A. Yes, sir.

5 Q. Where did you purchase this policy?

6 A. In Lancaster County, South Carolina.

7 Q. Did you purchase this from an insurance
8 broker?

9 A. Yes, sir.

10 Q. Tell us what happened when you went to buy the
11 policy?

12 A. I walked in, I stated that I wanted to get
13 some auto insurance on a vehicle that I just purchased.
14 I had signed some papers. I paid the money and I had
15 insurance.

16 Q. Let me ask you. You had to sign and execute
17 some documents right there when you were in the store?

18 A. Yes, sir.

19 Q. Were you given an opportunity to write any
20 portions of the policy?

21 A. No, sir.

22 Q. Were you given an opportunity to revise or
23 edit any portion of the policy?

24 A. No, sir.

25 Q. Was there anyway to dispute any terms of the

1 A. No, sir.

2 Q. Let me ask. When you purchased the policy,
3 did you tell Progressive that you or Alexis had
4 Medicaid?

5 A. No, sir.

6 Q. Did they ask if you or Alexis had Medicaid?

7 A. No, sir.

8 Q. Did you ever miss a premium payment for your
9 policy during the entire time that you've had the
10 policy?

11 A. No, sir.

12 Q. Did you ever miss any premiums before the
13 wreck?

14 A. No, sir.

15 MR. CANNON: Your Honor, I don't have anymore
16 questions.

17 THE COURT: Mr. Murphy?

18 MR. MURPHY: No questions, your Honor.

19 THE COURT: Thank you, sir. You can step
20 down.

21 You may call your next witness.

22 MR. CANNON: Next and last witness is the
23 plaintiff, Alexis Jones, your Honor.

24 THE COURT: Ms. Jones.
25

1 A-L-E-X-I-S J-O-N-E-S, the Witness herein, having been
2 sworn by the Clerk of Court, was examined and testified
3 as follows:

4
5 DIRECT EXAMINATION

6 BY MR. CANNON:

7 Q. Ms. Jones, you were involved in an accident on
8 October 8, 2019. You were hurt and incurred medical
9 bills; correct?

10 A. Yes.

11 Q. Let me ask you. Did you have Medicaid at the
12 time, which paid those bills?

13 A. Yes.

14 Q. Let me ask you this. You actually were
15 charged for your medical services, but Medicaid paid
16 them?

17 A. Yes.

18 Q. Let me ask you. Is your contract with
19 Medicaid separate than your insurance policy with
20 Progressive?

21 A. Yes, they're separate.

22 Q. So Progressive isn't a party to your contract
23 with Medicaid?

24 A. No..

25 Q. You have two different contracts with two

1 different businesses to pay your medical expenses in the
2 event that you have a car wreck?

3 A. Yes.

4 Q. And also, injured in that car wreck?

5 A. Uh-huh.

6 Q. At any point in time, did you do a joint
7 contract with Medicaid and Progressive to cover your
8 medical expenses incase of car wreck?

9 A. No.

10 Q. Did you ever discuss your agreement or the
11 fact that you had Medicaid with Progressive at any time?

12 A. No.

13 Q. Ms. Jones, were you charged medical bills
14 which exceeded the Med-pay coverage limit of \$10,000?

15 A. Yes.

16 Q. Have you received the full \$10,000 for this
17 medical payments coverage?

18 A. No.

19 Q. Do you believe that Progressive owes you the
20 remaining balance of your Med-pay coverage at this time?

21 A. Yes.

22 MR. CANNON: Your Honor, I don't have any
23 questions.

24 MR. MURPHY: Just briefly, your Honor.

25 THE COURT: All right.

CROSS-EXAMINATION

MR. MURPHY:

Q. Ms. Jones, as I understand it. Medicaid paid the hospital bill at MUSC and all the other doctors you went to from the accident on your behalf?

A. Yes.

Q. You've paid no money yourself?

A. No.

Q. Is that correct?

A. Correct.

Q. And you're not legally obligated to pay any money to any of those by virtue of you being a Medicaid beneficiary. The hospital and doctors that you saw have agreed to accept what Medicaid paid them for a payment in full?

A. Yes.

Q. And we've agreed to that before we came here today, between your counsel and myself?

A. Uh-huh.

Q. And you had no deductibles, out-of-pockets, nothing. Everything that you owed the doctors have been paid for by Medicaid?

A. Yes,

MR. MURPHY: Thank you.

1 THE COURT: Any redirect?

2 MR. CANNON: No, your Honor. No redirect.

3 THE COURT: Thank you, ma'am. You can step
4 down.

5 So once Progressive paid, not to her --

6 MR. MURPHY: Approximately, \$1300 was what was
7 paid -- is the full amount of what the Medicaid payments
8 were on her behalf.

9 MR. CANNON: That's correct, your Honor.

10 THE COURT: I guess what I'm asking is. If I
11 find in favor of the plaintiff after hearing from
12 arguments and stuff --

13 MR. MURPHY: -- It's \$8,300 and some change. I
14 had it in --

15 MR. CANNON: -- I thought it was 86.

16 MR. MURPHY: I might be 86 and change. Yes,
17 your Honor.

18 THE COURT: Let me hear argument then.

19 Mr. Cannon, any further argument?

20 I understand your point and your position that
21 the contract, what reasonable expenses incurred -- I
22 think we talked about this 2 or 3 years ago, whenever we
23 heard this thing.

24 MR. CANNON: Right.

25 THE COURT: I understand your argument that

1 it's vague and ambiguous and as such it should be
2 construed against the insurance company and now facts
3 have been established in the record that the insurance
4 agent who sold the policy to the insured did not explain
5 what that meant to him. Okay.

6 I understand what you're saying and I
7 understand what you're trying to get me to find.
8 Mr. Murphy in his memorandum cites a South Carolina
9 Supreme Court case, 62 years ago said: "Expenses
10 incurred is already been defined."

11 MR. CANNON: Right.

12 THE COURT: What's your response to that?

13 MR. CANNON: Your Honor, I would also refer
14 back to my memo that I submitted in opposition, is the
15 motion for summary judgment 3 years ago that we redid.
16 He mentioned the Gordon and the Barker case.
17 Specifically, you know, the Gordon case was won on a VA,
18 but that was different because no one ever incurs an
19 expense when they go to the VA. VA -- Army members, you
20 go into the VA you just receive your medical services.
21 That's different then this case. The moment she walked
22 in the door and saw the doctor, Cha-Ching you are
23 charged. She incurs that bill. With her, she just had
24 contracts with two separate companies that paid her
25 bill. She could have chosen not to use her Medicaid,

1 but she did. She's not precluded from one from using
2 one or the other.

3 THE COURT: So is that like an unjust
4 enrichment argument you're making? Because she choose
5 to turn it in on Medicaid, Progressive had been unjustly
6 enriched because she could have incurred the full amount
7 in sticking it to them.

8 MR. CANNON: I think the underlining argument,
9 your Honor. Is that Progressive is using a contract
10 that they're not privy to or a party too, to define and
11 interpret their own policy. They didn't even ask if she
12 had Medicaid, they never did. Until she incurred a loss
13 and made a claim after she had medical services down the
14 road. Now, it's just like, in the policy where it says:
15 "We will define what's reasonable." "We will define
16 what's necessary," which means, they'll tell you your
17 bill is to high if it's not reasonable. They'll tell
18 you if you were referred by your doctor for PT. They'll
19 have another doctor come in and say, "It wasn't
20 necessary." They find ways not to pay. That's all they
21 do. Now, after she's incurred a loss, now, they're
22 redefining their policy based on something she chose
23 outside that policy, to now find another way not to pay.
24 This is just another example of an insurance -- that's
25 the whole reason they can define that they can determine

1 what's reasonable and necessary. They're doing that so
2 they can pay less. And here, they're defining
3 "incurred" on the fly to pay less.

4 So I think the argument is, they're using an
5 outside contract that they're not even a party too to
6 redefine they're won policy. If they wanted to do that,
7 put it in the policy. At least ask them before you take
8 out the policy. But instead now, forcing the clients to
9 file a lawsuit three and-a-half years later to get a day
10 in court to interpret that. And once again, going back
11 to the beginning, that we're sitting here arguing what
12 "incurred" means, that shows that the term, I think, is
13 vague and ambiguous and should be construed in their
14 favor.

15 THE COURT: Thank you. Mr. Murphy?

16 MR. MURPHY: Your Honor, just briefly. Our
17 case does involve a soldier ^ HOSPITAL. There's a case
18 in Virginia and we follow Virginia statutes and Virginia
19 is very -- we defer to them in auto insurance law
20 before. There is a case in Virginia that we cited in
21 our brief as well, the Bowers case. Statefarm V Bowers.
22 And I'm going to quote from that case. I think it just
23 nails it right on the head. So the Court saying: "An
24 expense can only be incurred when one has paid it or
25 become legally obligated to pay it." And then in the

1 Bowers case it said, "Bowers would never be liable for
2 any amount greater than which the various health care
3 providers accept it as full payment for their services
4 based on the Blue Cross fee scheduled." Or in this case
5 the Medicaid fee schedule. "Stated differently, the
6 health care providers agreements with Blue Cross
7 prevented them from collecting more than the scheduled
8 fee and any required co-pay. Therefore, we conclude
9 that the medical expenses Bowers incurred were the
10 amounts that the health care providers accepted as full
11 payment for their services rendered to him. Bowers has
12 not paid, nor is he legally obligated to paid the
13 amounts written off by the provider." Then it sites
14 cases from New Hampshire, New Jersey, North Carolina and
15 Louisiana. This is a 1998 case from the Supreme Court
16 of Virginia. "To decide other wise would be to grant
17 Bowers a windfall because he would be receiving an
18 amount greater then which he could ever be legally
19 obligated to pay." And Ms. Jones and in the stipulation
20 confirmed that the amount that has been paid to date is
21 the full amount that she would have ever been legally
22 obligated to pay. If she did not want to take Medicaid
23 then she might habe a judgement against her from MUSC
24 for \$23,000 which was the sticker price of that bill far
25 in excess of her medical payments. Most people don't

1 have \$10,000 medical payments coverage. So they're
2 always going to be better off using Medicaid for any
3 charge like this and they have no further ongoing legal
4 obligation to reimburse. This is an incurred expense
5 coverage, it is not a flat price. Send in a bill and if
6 it's reasonable, will do that. So when it's reduced
7 like this by a prior agreement, that is the amount that
8 the insurance is entitled to receive.

9 And so she got \$1300 and some change on the
10 bills, which she did not pay. That was a windfall so to
11 speak. But it represented the amount that had been paid
12 on her behalf by her Medicaid. And that's how incurred
13 is. That's how it's done in every state. There been
14 not one case cited to this court, 3 years ago or today,
15 to say that the word incurred means something other than
16 that or means the sticker price. This is uniformly
17 accepted in courts and in the way that medical payments,
18 PIP payments work. They are incurred expense. They are
19 not just sticker price and that's very clear.

20 And of course, in the Virginia case was about
21 the same amount of money and they reserved it because
22 they gave -- they granted a judgement for amounts that
23 the insured in that situation would never have been
24 obligated today pay. The write-downs or the write-offs
25 which would have been on the EOB.

1 So it's not ambiguous. It's been clearly
2 defined by our supreme court. It's followed by many
3 other courts that I would urge this court to give
4 indifference too. And also Judge Duffy's opinion
5 involving a medicare recipient and how he went through
6 something in quite detail. It's not a complex issue.
7 And for that reason, we ask the Court to grant judgment
8 in favor of Progressive, that it fully complied and
9 reimbursed Ms. Jones all the amounts she was entitled to
10 under the contract.

11 THE COURT: Coming back to you and I'll come
12 back to you Mr. Cannon. This came up 2 years ago. I
13 think y'all, you argued collateral source and you said,
14 if I'm remembering right. No, this isn't collateral
15 source. This is, like you just said, this is incurred
16 expense or reimbursement of coverage.

17 I wanted the record to be clear on this now.
18 So let's revisit that argument. Typically, in a typical
19 personal injury case, I'll instruct the jury that you go
20 by the actual expense incurred or the cost of services,
21 reasonable service for medical expenses, not what was
22 contracted to be paid. Talk to me about that.

23 MR. MURPHY: Yes. So this is contract and not
24 tort law, which is the first thing. The second thing
25 is, there is a statute that was talked about earlier.

1 It's Section 144-38 and I believe 77 and 144 that
2 prohibits a setoff. A setoff would be saying: Because
3 medicaid paid you, we don't even own you the \$1,300.
4 That would be a setoff. Progressive is not asserting a
5 setoff. They're not asserting it because some of it was
6 paid, but the collateral source is not the -- does not
7 come into effect because this is a direct party action.
8 This is a contract. She's a beneficiary under this
9 contract. She's a beneficiary under Medicaid.
10 Progressive is not a tortfeasor and therefore, not
11 subject to a collateral source, something that a
12 plaintiff or injured claimant did for themselves. So
13 the collateral source was not applicable.

14 THE COURT: And that went to the bad faith
15 argument.

16 MR. MURPHY: Yeah. So the setoff issue, which
17 is statutory would apply to prevent Progressive from
18 saying: Because this collateral source paid, we don't
19 even have to pay you anything. And no. What the
20 collateral source paid determined what the incurred
21 expense was and Progressive reimbursed that amount. So
22 there was a double payment. There was payment by
23 Medicaid to the providers. There was payment of the
24 identical amount from Progressive to Ms. Jones. But the
25 reduction by the providers is on the first issue, which

1 is: Is it an expense incurred? And Progressive did not
2 attempt to take a setoff. But the collateral source so
3 to speak. The payment by Medicaid or Blue Cross or
4 Medicare or whoever, that would only go as to
5 determining the amount of the expenses incurred. Once
6 those are incurred, they are owned and in this case,
7 they were paid. To further reduce it because a
8 secondary source paid them would violate the statute on
9 the setoff. But this is all contract law. So a
10 tortfeasor trying to take advantage of a collateral
11 source, that rule of law would not apply in a contract
12 case like this. But even if it did, it's not been
13 violated because they were reimbursed for the full
14 amount of the collateral source.

15 THE COURT: Mr. Cannon, do you wish to speak
16 to that?

17 MR. CANNON: Your Honor, I would refer back to
18 my -- and I went through this at length. We went
19 through the statute and went through the Cothran case.

20 THE COURT: This was back 2 years ago?

21 MR. CANNON: Yes. About 3 honestly. You
22 know, in speaking of how the setoff would apply.
23 Specifically, I guess we're revisiting one of the
24 actions that you dismissed.

25 Ms. Jones, when we were here, accrued the

1 \$10,000. Medicaid paid the \$1,300 to satisfy the
2 expenses. Had Medicaid paid more or less, Progressive
3 would have paid that amount. We argue here it's using a
4 third party payment to reduce it's amount that it owns
5 to the plaintiff. And therefore, we believe the that
6 reasonable expenses incurred provision is a setoff, your
7 Honor.

8 Progressive argued in it's brief and today,
9 that -- believe that the plaintiff's have not alleged
10 Progressive has reduce it's medical payments by
11 Medicaid. The defendant hinges specific on or alleges
12 that Progressive has violated its section. We believe
13 the defendant is correct in that the plaintiff did not
14 allege that Progressive specifically reduced the amount
15 owned by subtracting the amount paid by Medicaid from
16 it's policy limit. Rather, your Honor, we allege that
17 Progressive was more egregious in their position by
18 refusing to pay more than the \$1,323 that it paid.

19 Your Honor, we believe that both positions
20 reduced the amount of benefits paid by a third party,
21 which is a violation. We think it's still a violation
22 of the statute.

23 But your Honor, he cited several cases Gordon
24 and Barker. I know we talked about Gordon. The Barker
25 case, which is also reiterated in his brief that he

1 submitted, Mr. Murphy submitted this morning. That was
2 a medicare case and he made the same argument. A person
3 has medicare, they don't incur the cost. He's making
4 the same argument. The difference here in the Barker
5 case, is that Barker later become eligible for medicare.
6 That policy in there had medicare endorsement which had
7 specific formula for payments and benefits that
8 different from another formula. So basically, the
9 premiums in the Barker case became less if they had
10 medicare. Here, there were no premium difference. That
11 why I'm going back to the fact this is how it differs
12 from Barker, is that they didn't ask them if they had
13 Medicaid. If they had had Medicaid or asked or reduced
14 premiums, there would be a benefit for the bargain
15 exchange in that regard.

16 In this case, once again, they're choosing to
17 define "incurred" at the very end of the finish line.
18 After they've incurred, based on a contract that they
19 were not even privy to. That's what I'm going back to
20 your Honor and that's all I got.

21 THE COURT: Gentleman, obviously, I'm going to
22 take the matter under advisement. I appreciate y'all
23 being here today. Sorry it's taken this long to get
24 this thing scheduled. And Ms. Jones, I know you want it
25 over with. It's been a long time going. I promise you

1 I'm not gonna sit on it for a long time. Okay. I do
2 want to thoroughly read your lawyer's position and do a
3 little bit more legal research, consider Mr. Murphy's
4 position as well, then I'll issue a decision and we'll
5 go from there.

6 MR. CANNON: Your Honor, I did know I did ask
7 in my -- not to cut you off. I know I did ask at the
8 end for the balance in attorney fees. I did bring the
9 affidavit of attorney fees.

10 THE COURT: You can hand that up. I'll
11 consider it.

12 MR. MURPHY: I think you struck all any cause
13 of action that would allow that. It has to be under the
14 statute which --

15 THE COURT: Let's make that apart of the
16 record.

17 MR. MURPHY: You can rule on that. I don't
18 know amount. I think statutorily they're limited as
19 well to one-third of the amount.

20 THE COURT: Go ahead and introduce that now as
21 Court Exhibit 1.

22 (Court's Exhibit 1, Attorney fees
23 affidavit, was marked for
24 Identification.)

25 THE COURT: Anything else?

1 MR. CANNON: No, your Honor.

2 THE COURT: Thank you. That concludes the
3 hearing in this case.

4 (Whereupon, Bench trial was concluded.)
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C E R T I F I C A T E

I, the undersigned Maria DiScioscia, Official Court Reporter for the Sixth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate, and complete transcript of the record of all the proceedings in the captioned case, in the Circuit Court for Chester, South Carolina, on the 27th day of March, 2023.

I do further certify that I am not related, either by blood or marriage, to any of the parties in this action; and that I am in no way interested in the outcome of this matter.



Maria DiScioscia
Official Court Reporter

STATE OF SOUTH CAROLINA
COUNTY OF CHESTER

IN THE COURT OF COMMON PLEAS
CIVIL ACTION NO: 2020-CP-12-00207

Alexis Jones,
v.
Progressive Northern Insurance Company,
Plaintiffs,
Defendant.

STIPULATION OF FACT

The parties hereby submit this Stipulation of Fact in lieu of deposition or other testimony for purposes of cross-motions for judgment.

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. A complete copy of the policy along with the declarations page is attached to this Stipulation as **Exhibit A**.

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. MUSC bill is attached hereto as **Exhibit B**.

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. The total charges were \$883.63. App of South Carolina ED bill is attached hereto as **Exhibit C**.

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 \$1,726.09.00. Bill for this date of service is attached hereto as **Exhibit D**.

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. Bill is attached hereto as **Exhibit E**.

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. (Medicaid lien and payment information attached hereto as Exhibit F.) 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.

s/J. Logan Cannon

J. Logan Cannon, Esquire
Shaw Law Firm
Post Office Drawer 36250
Rock Hill, SC 29732
803-329-4200
Attorney for Plaintiff

s/J.R. Murphy

J.R. Murphy, Esquire
Murphy & Grantland, P.A.
P.O. Box 6648
Columbia, SC 29260
803-782-4100
Attorney for Defendant

Dated: May 28, 2021

AUTO PLUS INS GRP
PO BOX 10
LANCASTER, SC 29721

WILLIE BROWN
2663 GEORGETOWN ROAD
GREAT FALLS, SC 29055

PROGRESSIVE
AUTO

Policy Number: 930693102
Underwritten by:
Progressive Northern Insurance Co
October 2, 2019
Policy Period: Jun 21, 2019 - Dec 21, 2019
Page 1 of 2

1-803-289-1169
AUTO PLUS INS GRP
Contact your agent for personalized service

progressiveagent.com
Online Service
Make payments, check billing activity, update
policy information or check status of a claim.

1-800-274-4499
To report a claim.

Auto Insurance Coverage Summary

This is your Declarations Page
Your policy information has changed

Your coverage began on June 21, 2019 at the later of 12:01 a.m. or the effective time shown on your application. This policy period ends on December 21, 2019 at 12:01 a.m.

This coverage summary replaces your prior one. Your insurance policy and any policy endorsements contain a full explanation of your coverage. The policy contract is form 9611A SC (10/14). The contract is modified by form A048 SC (07/11).

Policy changes effective October 1, 2019

Changes requested on:	Oct 1, 2019 12:34 p.m.
Requested by:	WILLIE BROWN
Premium change:	-\$429.71
Changes:	The 2001 GMC SIERRA C1500/K1500 has been removed. The Multi-Car discount has been removed from your policy.

The changes take effect as of the date and time requested shown above.

Underwriting Company

Progressive Northern Insurance Co
P.O. Box 6807
Cleveland, OH 44101
1-800-876-5581

Drivers and resident relatives

	Additional Information
WILLIE BROWN	Named Insured
ALEXIS JONES	

Form 8469 SC 10/2/18



APPENDIX - 00142

PNIC000006

ELECTRONICALLY FILED - 2021 May 28 1:26 PM - CHESTER - COMMON PLEAS - CASE#2020CP1200207

Policy Number: 930693102

WILLIE BROWN

Page 2 of 2

ELECTRONICALLY FILED - 2021 May 28 1:26 PM - CHESTER - COMMON PLEAS - CASE#2020CP1200207

Outline of coverage

2005 CHEVROLET TAHOE C1500/K1500 4 DOOR WAGON

VIN: 1GNEK13TX5R101102

Garaging ZIP Code: 29055

Primary use of the vehicle: Commute

Length of vehicle ownership when policy started or vehicle added: At least 3 years but less than 5 years

	Units	Deductible	Premium
Liability To Others			\$1,030
Bodily Injury Liability	\$25,000 each person/\$50,000 each accident		
Property Damage Liability	\$25,000 each accident		
Uninsured Motorist			44
Bodily Injury	\$25,000 each person/\$50,000 each accident		
Property Damage	\$25,000 each accident	\$200	
Underinsured Motorist Bodily Injury	Rejected		
Medical Payments	\$10,000 each person		489
Subtotal policy premium			\$1,554.00
South Carolina Uninsured Motorist Fund charge			1.00
Total 6 month policy premium and fees			\$1,555.00

Premium discount

Policy	
930693102	Continuous Insurance: Gold

Medical Payments Coverage Endorsement

Your policy is amended as follows:

Part II - Medical Payments Coverage

The following is deleted under the Limits of Liability provision:

No one will be entitled to duplicate payments under this policy for the same elements of damages.

Any amount payable to an insured person under this Part II will be reduced by any amount paid or payable for the same expense under Part I - Liability To Others or Part III - Uninsured/Underinsured Motorist Coverage.

All other terms, limits and provisions of this policy remain unchanged.

Form AQ4S SC (07/11)

PNIC000008

8611A SC 1014



SOUTH CAROLINA

AUTO POLICY

Form 8611A SC 1014 06/20
Version 2.0

PROGRESSIVE
AUTO
PNIC000009

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IMPORTANT NOTICE

IN ADDITION TO THE INSURANCE COVERAGE REQUIRED BY LAW TO PROTECT YOU AGAINST A LOSS CAUSED BY AN UNINSURED MOTORIST, IF YOU HAVE PURCHASED LIABILITY INSURANCE COVERAGE THAT IS HIGHER THAN THAT REQUIRED BY LAW TO PROTECT YOU AGAINST LIABILITY ARISING OUT OF THE OWNERSHIP, MAINTENANCE, OR USE OF THE MOTOR VEHICLES COVERED BY THIS POLICY, AND YOU HAVE NOT ALREADY PURCHASED UNINSURED MOTORIST INSURANCE COVERAGE EQUAL TO YOUR LIABILITY INSURANCE COVERAGE:

1. YOUR UNINSURED AND UNDERINSURED MOTORIST INSURANCE COVERAGE HAS INCREASED TO THE LIMITS OF YOUR LIABILITY COVERAGE AND THIS INCREASE WILL COST YOU AN EXTRA PREMIUM CHARGE; AND
2. YOUR TOTAL PREMIUM CHARGE FOR YOUR MOTOR VEHICLE INSURANCE COVERAGE WILL INCREASE IF YOU DO NOT NOTIFY YOUR AGENT OR INSURER OF YOUR DESIRE TO REDUCE COVERAGE WITHIN TWENTY DAYS OF THE MAILING OF THE POLICY OR THE PREMIUM NOTICE, AS THE CASE MAY BE;
3. IF THIS IS A NEW POLICY AND YOU HAVE ALREADY SIGNED A WRITTEN REJECTION OF SUCH HIGHER LIMITS IN CONNECTION WITH IT, PARAGRAPHS (1) AND (2) OF THIS NOTICE DO NOT APPLY.

PNIC000011

CONTENTS

INSURING AGREEMENT	1
GENERAL DEFINITIONS	1
PART I—LIABILITY TO OTHERS	
Insuring Agreement.....	3
Additional Definition	3
Additional Payments	3
Exclusions.....	4
Limits of Liability.....	5
Financial Responsibility Laws	6
Other Insurance	6
Out-of-State Coverage	6
Arbitration of Property Damage Liability Claims.....	7
PART II—MEDICAL PAYMENTS COVERAGE	
Insuring Agreement.....	7
Additional Definitions	7
Exclusions.....	8
Limits of Liability.....	9
Unreasonable or Unnecessary Medical Expenses	9
Other Insurance	10
PART III—UNINSURED/UNDERINSURED MOTORIST COVERAGE	
Insuring Agreement—Uninsured Motorist Coverage	10
Insuring Agreement—Underinsured Motorist Coverage	10
Notice Requirement	11
Additional Definitions	11
Exclusions.....	12
Limits of Liability.....	13
Other Insurance	15
Arbitration for Bodily Injury Claims.....	15
Arbitration for Property Damage Claims	16
PART IV—DAMAGE TO A VEHICLE	
Insuring Agreement—Collision Coverage	16
Insuring Agreement—Comprehensive Coverage	16
Insuring Agreement—Additional Custom Parts or Equipment Coverage.....	17
Insuring Agreement—Rental Reimbursement Coverage.....	17
Insuring Agreement—Loan/Lease Payoff Coverage	18
Insuring Agreement—Pet Injury Coverage	19
Additional Definitions	19
Exclusions.....	19

PNIC000012

Limits of Liability.....	21
Payment of Loss	22
No Benefit to Bailee	23
Loss Payable Clause	23
Other Sources of Recovery.....	23
Appraisal	23
PART V—ROADSIDE ASSISTANCE COVERAGE	
Insuring Agreement.....	24
Additional Definitions	24
Exclusions.....	24
Unauthorized Service Provider	25
Other Insurance	25
PART VI—DUTIES IN CASE OF AN ACCIDENT OR LOSS	25
PART VII—GENERAL PROVISIONS	
Policy Period and Territory.....	26
Changes.....	26
Duty to Report Changes	27
Settlement of Claims.....	27
Terms of Policy Conformed to Statutes	27
Transfer of Interest.....	28
Fraud or Misrepresentation.....	28
Payment of Premium and Fees	29
Cancellation	29
Cancellation Refund.....	30
Nonrenewal.....	30
Legal Action Against Us.....	30
Our Rights to Recover Payment	31
Joint and Individual Interests	31
Bankruptcy	32

III

PNIC000013

SOUTH CAROLINA AUTO POLICY

INSURING AGREEMENT

In return for your payment of the premium, we agree to insure you subject to all the terms, conditions and limitations of this policy. We will insure you for the coverages and the limits of liability shown on this policy's declarations page. Your policy consists of the policy contract, your insurance application, the declarations page, and all endorsements to this policy.

GENERAL DEFINITIONS

The following definitions apply throughout the policy. Defined terms are printed in bold-face type and have the same meaning whether in the singular, plural, or any other form.

1. **"Additional auto"** means an auto you become the owner of during the policy period that does not permanently replace an auto shown on the declarations page if:
 - a. we insure all other autos you own;
 - b. the additional auto is not covered by any other insurance policy;
 - c. you notify us within 30 days of becoming the owner of the additional auto; and
 - d. you pay any additional premium due.

An additional auto will have the broadest coverage we provide for any auto shown on the declarations page. If you ask us to insure an additional auto more than 30 days after you become the owner, any coverage we provide will begin at the time you request coverage.

2. **"Auto"** means a land motor vehicle:
 - a. of the private passenger, pickup body, or cargo van type;
 - b. designed for operation principally upon public roads;
 - c. with at least four wheels; and
 - d. with a gross vehicle weight rating of 12,000 pounds or less, according to the manufacturer's specifications.

However, "auto" does not include step-vans, parcel delivery vans, or cargo cut-away vans or other vans with cabs separate from the cargo area.

3. **"Auto business"** means the business of selling, leasing, repairing, parking, storing, servicing, delivering or testing vehicles.
4. **"Bodily Injury"** means bodily harm, sickness, or disease, including death that results from bodily harm, sickness, or disease.
5. **"Covered auto"** means:
 - a. any auto or trailer shown on the declarations page for the coverages applicable to that auto or trailer;
 - b. any additional auto;
 - c. any replacement auto; or
 - d. a trailer owned by you.
6. **"Declarations page"** means the document showing your coverages, limits of liability, covered autos, premium, and other policy-related information. The declarations page may also be referred to as the Auto Insurance Coverage Summary.

PNIC000014

7. "Occupying" means in, on, entering or exiting.
8. "Personal vehicle sharing program" means a system or process, operated by a business, organization, network, group, or individual, that facilitates the sharing of private passenger motor vehicles for use by individuals, businesses, or other entities.
9. "Property damage" means physical damage to, destruction of, or loss of use of, tangible property.
10. "Rated resident" means a person residing in the same household as you at the time of the loss who is not a relative, but only if that person is both:
 - a. listed in the "Drivers and household residents" section on the declarations page; and
 - b. not designated as either an "Excluded" or a "List Only" driver.
11. "Relative" means a person residing in the same household as you, and related to you by blood, marriage or adoption, and includes a ward, stepchild, or foster child. Your unmarried dependent children temporarily away from home will qualify as a relative if they intend to continue to reside in your household.
12. "Replacement auto" means an auto that permanently replaces an auto shown on the declarations page. A replacement auto will have the same coverage as the auto it replaces if the replacement auto is not covered by any other insurance policy. However, if the auto being replaced had coverage under Part IV—Damage To A Vehicle, such coverage will apply to the replacement auto only during the first 30 days after you become the owner unless you notify us within that 30-day period that you want us to extend coverage beyond the initial 30 days. If the auto being replaced did not have coverage under Part IV—Damage To A Vehicle, such coverage may be added, but the replacement auto will have no coverage under Part IV until you notify us of the replacement auto and ask us to add the coverage.
13. "Ride-sharing activity" means the use of any vehicle to provide transportation of persons or property in connection with a transportation network company from the time a user logs on to, or signs in to, any online-enabled application, software, website or system until the time the user logs out of, or signs off of, any such online-enabled application, software, website or system, whether or not the user has accepted any passenger(s) or delivery assignment, including the time the user is on the way to pick up any passenger(s) or property, or is transporting any passenger(s) or property.
14. "Trailer" means a non-motorized trailer, including a farm wagon or farm implement, designed to be towed on public roads by an auto and not being used:
 - a. for commercial purposes;
 - b. as an office, store, or for display purposes; or
 - c. as a passenger conveyance.
15. "Transportation network company" means a corporation, partnership, sole proprietorship, or other entity that uses any online-enabled application, software, website or system to connect drivers with clients or passengers to facilitate and/or provide transportation or delivery services for compensation or a fee.
16. "We," "us" and "our" mean the underwriting company providing the insurance, as shown on the declarations page.

17. "You" and "your" mean:
- a person shown as a named insured on the declarations page; and
 - the spouse of a named insured if residing in the same household at the time of the loss.

PART I—LIABILITY TO OTHERS

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay damages for bodily injury and property damage for which an insured person becomes legally responsible because of an accident.

Damages include prejudgment interest awarded against an insured person.

We will settle or defend, at our option, any claim for damages covered by this Part I.

ADDITIONAL DEFINITION

When used in this Part I:

"insured person" means:

- you, a relative, or a rated resident with respect to an accident arising out of the ownership, maintenance or use of an auto or a trailer;
- any person with respect to an accident arising out of that person's use of a covered auto with the permission of you, a relative, or a rated resident;
- any person or organization with respect only to vicarious liability for the acts or omissions of a person described in a. or b. above; and
- any "Additional Interest" shown on the declarations page with respect only to its liability for the acts or omissions of a person described in a. or b. above.

ADDITIONAL PAYMENTS

In addition to our limit of liability, we will pay for an insured person:

- all expenses we incur in the settlement of any claim or defense of any lawsuit;
- interest accruing after entry of judgment, until we have paid, offered to pay, or deposited in court, that portion of the judgment which does not exceed our limit of liability. This does not apply if we have not been given notice of suit or the opportunity to defend an insured person;
- the premium on any appeal bond or attachment bond required in any lawsuit we defend. We have no duty to purchase a bond in an amount exceeding our limit of liability, and we have no duty to apply for or furnish these bonds;
- up to \$250 for a bail bond required because of an accident resulting in bodily injury or property damage covered under this Part I. We have no duty to apply for or furnish this bond; and
- reasonable expenses, including loss of earnings up to \$200 per day, incurred at our request.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART I.

Coverage under this Part I, including our duty to defend, will not apply to any Insured person for:

1. **bodily injury or property damage arising out of the ownership, maintenance or use of any vehicle or trailer while being used:**
 - a. to carry persons or property for compensation or a fee; or
 - b. for retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food.

For damages arising out of the ownership, maintenance, or use of a covered auto, this exclusion applies only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina. This exclusion does not apply to shared-expense car pools;
2. any liability assumed under any contract or agreement by you, a relative, or a rated resident;
3. **bodily injury to an employee of that Insured person arising out of or within the course of employment.** This exclusion does not apply to domestic employees if benefits are neither paid nor required to be provided under workers' compensation, disability benefits, or similar laws;
4. **bodily injury or property damage arising out of an accident involving any vehicle while being maintained or used by a person while employed or engaged in any auto business.** For damages arising out of the ownership, maintenance, or use of a covered auto, this exclusion applies only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina. This exclusion does not apply to you, a relative, a rated resident, or an agent or employee of you, a relative, or a rated resident, when using a covered auto;
5. **bodily injury or property damage resulting from, or sustained during practice or preparation for:**
 - a. any pre-arranged or organized racing, stunting, speed or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
6. **bodily injury or property damage due to a nuclear reaction or radiation;**
7. **bodily injury or property damage for which insurance:**
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
8. any obligation for which the United States Government is liable under the Federal Tort Claims Act;
9. **bodily injury or property damage caused by an intentional act of that Insured person, or at the direction of that Insured person, even if the actual injury or damage is different than that which was intended or expected.** For damages arising out of the ownership, maintenance, or use of a covered auto, this exclu-

PNIC000017

sion applies only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina;

10. **property damage** to any property owned by, rented to, being transported by, or in the charge of that insured person. This exclusion does not apply to a rented residence or a rented garage;
11. **bodily injury or property damage** arising out of the ownership, maintenance or use of any vehicle owned by you or furnished or available for your regular use, other than a covered auto for which this coverage has been purchased;
12. **bodily injury or property damage** arising out of the ownership, maintenance or use of any vehicle owned by a relative or a rated resident or furnished or available for the regular use of a relative or a rated resident, other than a covered auto for which this coverage has been purchased. This exclusion does not apply to your maintenance or use of such vehicle;
13. **bodily injury or property damage** arising out of your, a relative's, or a rated resident's use of a vehicle, other than a covered auto, without the permission of the owner of the vehicle or the person in lawful possession of the vehicle;
14. **bodily injury or property damage** arising out of the use of a covered auto while leased or rented to others or given in exchange for any compensation, including while being used in connection with a personal vehicle sharing program. This exclusion does not apply to the operation of a covered auto by you, a relative, or a rated resident;
15. **bodily injury or property damage** caused by, or reasonably expected to result from, a criminal act or omission of that insured person. This exclusion applies regardless of whether that insured person is actually charged with, or convicted of, a crime. However, this exclusion will apply only to those damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina. For purposes of this exclusion, criminal acts or omissions do not include traffic violations; or
16. **bodily injury or property damage** arising out of the ownership, maintenance or use of any vehicle or trailer while being used for ride-sharing activity. This exclusion does not apply to shared-expense car pools.

LIMITS OF LIABILITY

The limit of liability shown on the declarations page for liability coverage is the most we will pay regardless of the number of:

1. claims made;
2. covered autos;
3. insured persons;
4. lawsuits brought;
5. vehicles involved in the accident; or
6. premiums paid.

If your declarations page shows a split limit:

1. the amount shown for "each person" is the most we will pay for all damages due to bodily injury to one person resulting from any one accident;

PNIC000018

2. subject to the "each person" limit, the amount shown for "each accident" is the most we will pay for all damages due to **bodily injury** sustained by two or more persons in any one accident; and
3. the amount shown for "property damage" is the most we will pay for the total of all property damage resulting from any one accident.

The "each person" limit of liability applies to the total of all claims made for **bodily injury** to a person and all claims of others derived from such **bodily injury**, including, but not limited to, loss of society, loss of companionship, loss of services, loss of consortium, and wrongful death.

If the declarations page shows that "combined single limit" or "CSL" applies, the amount shown is the most we will pay for the total of all damages resulting from any one accident. However, without changing this limit of liability, we will comply with any law that requires us to provide any separate limits.

The limits of liability under this Part I shall not be reduced by payments made under Part II—Medical Payments Coverage. However, no one is entitled to duplicate payments for the same elements of damages.

We will not pay under this Part I any expenses paid or payable under Part II—Medical Payments Coverage.

If multiple auto policies issued by us are in effect for you, we will pay no more than the highest limit of liability for this coverage available under any one policy.

An auto and attached trailer are considered one auto. Therefore, the limits of liability will not be increased for an accident involving an auto that has an attached trailer.

FINANCIAL RESPONSIBILITY LAWS

When we certify this policy as proof of financial responsibility, this policy will comply with the law to the extent required. The insured person must reimburse us if we make a payment that we would not have made if this policy was not certified as proof of financial responsibility.

OTHER INSURANCE

If there is any other applicable liability insurance or bond, we will pay only our share of the damages. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide for a vehicle or trailer, other than a covered auto, will be excess over any other collectible insurance, self-insurance, or bond.

OUT-OF-STATE COVERAGE

If an accident to which this Part I applies occurs in any state, territory or possession of the United States of America or any province or territory of Canada, other than the

PNIC000019

one in which a covered auto is principally garaged, and the state, province, territory or possession has:

1. a financial responsibility or similar law requiring limits of liability for bodily injury or property damage higher than the limits shown on the declarations page, this policy will provide the higher limits; or
2. a compulsory insurance or similar law requiring a non-resident to maintain insurance whenever the non-resident uses an auto in that state, province, territory or possession, this policy will provide the greater of:
 - a. the required minimum amounts and types of coverage; or
 - b. the limits of liability under this policy.

ARBITRATION OF PROPERTY DAMAGE LIABILITY CLAIMS

Any party to a disputed property damage liability claim may submit the claim to arbitration in accordance with South Carolina law.

PART II—MEDICAL PAYMENTS COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury:

1. sustained by an insured person; and
2. caused by that motor vehicle accident.

We, or someone on our behalf, will determine:

1. whether the expenses for medical services are reasonable; and
2. whether the medical services are necessary.

ADDITIONAL DEFINITIONS

When used in this Part II:

1. "Insured person" means:
 - a. you, a relative, or a rated resident:
 - (i) while occupying an auto; or
 - (ii) when struck by a motor vehicle or a trailer while not occupying a self-propelled motorized vehicle; and
 - b. any other person while occupying a covered auto with the permission of you, a relative, or a rated resident.
2. "Medical services" means medical, surgical, dental, x-ray, ambulance, hospital, professional nursing, and funeral services, and includes the cost of eyeglasses, hearing aids, pharmaceuticals, orthopedics, and prosthetic devices.
3. "Motor vehicle" means a land motor vehicle designed for use principally on public roads.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART II.

Coverage under this Part II will not apply to bodily injury:

1. sustained by any person while occupying a covered auto while it is being used.
 - a. to carry persons or property for compensation or a fee;
 - b. for retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food; or
 - c. for ride-sharing activity.

This exclusion does not apply to shared-expense car pools;
2. arising out of an accident involving a vehicle while being maintained or used by a person while employed or engaged in any auto business. This exclusion does not apply to you, a relative, a rated resident, or an agent or employee of you, a relative, or a rated resident, when using a covered auto;
3. to any person resulting from, or sustained during practice or preparation for:
 - a. any pre-arranged or organized racing, stunting, speed or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
4. due to a nuclear reaction or radiation;
5. for which insurance:
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
6. for which the United States Government is liable under the Federal Tort Claims Act;
7. sustained by any person while occupying any vehicle or trailer while located for use as a residence or premises;
8. if workers' compensation benefits are available for the bodily injury;
9. sustained by any person while occupying or when struck by any vehicle owned by you or furnished or available for your regular use, other than a covered auto for which this coverage has been purchased;
10. sustained by any person while occupying or when struck by any vehicle owned by a relative or a rated resident or furnished or available for the regular use of a relative or a rated resident, other than a covered auto for which this coverage has been purchased. This exclusion does not apply to you;
11. to you, a relative, or a rated resident, while occupying any vehicle, other than a covered auto, without the permission of the owner of the vehicle or the person in lawful possession of the vehicle;
12. to any person while occupying a covered auto while leased or rented to others or given in exchange for any compensation, including while being used in connection with a personal vehicle sharing program. This exclusion does not apply to the operation of a covered auto by you, a relative, or a rated resident;
13. caused directly or indirectly by:
 - a. war (declared or undeclared) or civil war;

- b. warlike action by any military force of any government, sovereign or other authority using military personnel or agents. This includes any action taken to hinder or defend against an actual or expected attack; or
 - c. insurrection, rebellion, revolution, usurped power, or any action taken by a governmental authority to hinder or defend against any of these acts;
14. caused directly or indirectly by:
- a. any accidental or intentional discharge, dispersal or release of radioactive, nuclear, pathogenic or poisonous biological material; or
 - b. any intentional discharge, dispersal or release of chemical or hazardous material for any purpose other than its safe and useful purpose; or
15. caused by, or reasonably expected to result from, a criminal act or omission of an insured person. This exclusion applies regardless of whether the insured person is actually charged with, or convicted of, a crime. For purposes of this exclusion, criminal acts or omissions do not include traffic violations.

LIMITS OF LIABILITY

The limit of liability shown on the declarations page for Medical Payments Coverage is the most we will pay for each insured person injured in any one accident, regardless of the number of:

- 1. claims made;
- 2. covered autos;
- 3. insured persons;
- 4. lawsuits brought;
- 5. vehicles involved in the accident; or
- 6. premiums paid.

No one will be entitled to duplicate payments under this policy for the same elements of damages.

Any amount payable to an insured person under this Part II will be reduced by any amount paid or payable for the same expense under Part I—Liability To Others or Part III—Uninsured/Underinsured Motorist Coverage.

If multiple auto policies issued by us are in effect for you, we will pay no more than the highest limit of liability for this coverage available under any one policy.

UNREASONABLE OR UNNECESSARY MEDICAL EXPENSES

If an insured person incurs expenses for medical services that we deem to be unreasonable or unnecessary, we may refuse to pay for those expenses and contest them.

If the medical service provider sues the insured person because we refuse to pay expenses for medical services that we deem to be unreasonable or unnecessary, we will pay any resulting defense costs, and any resulting judgment against the

PNIC000022

Insured person, subject to the limit of liability for this coverage. We will choose the counsel. We will also pay reasonable expenses, including loss of earnings up to \$200 per day, incurred at our request.

The Insured person may not sue us for expenses for medical services we deem to be unreasonable or unnecessary unless the Insured person paid the entire disputed amount to the medical service provider or the medical service provider has initiated collection activity against the Insured person for the unreasonable or unnecessary expenses.

OTHER INSURANCE

If there is other applicable auto medical payments insurance, we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide for an Insured person occupying a vehicle or trailer, other than a covered auto, will be excess over any other auto insurance providing payments for medical services.

PART III—UNINSURED/UNDERINSURED MOTORIST COVERAGE

INSURING AGREEMENT—UNINSURED MOTORIST COVERAGE

If you pay the premium for this coverage, we will pay for damages that an Insured person is legally entitled to recover from the owner or operator of:

1. an uninsured motor vehicle because of bodily injury:
 - a. sustained by an Insured person;
 - b. caused by an accident; and
 - c. arising out of the ownership, maintenance or use of an uninsured motor vehicle; or
2. an uninsured motor vehicle because of property damage:
 - a. caused by an accident; and
 - b. arising out of the ownership, maintenance, or use of an uninsured motor vehicle.

INSURING AGREEMENT—UNDERINSURED MOTORIST COVERAGE

If you pay the premium for this coverage, we will pay for damages that an Insured person is legally entitled to recover from the owner or operator of:

1. an underinsured motor vehicle because of bodily injury:
 - a. sustained by an Insured person;
 - b. caused by an accident; and
 - c. arising out of the ownership, maintenance, or use of an underinsured motor vehicle; or
2. an underinsured motor vehicle because of property damage:
 - a. caused by an accident; and
 - b. arising out of the ownership, maintenance, or use of an underinsured motor vehicle.

We will pay under this Part III only after the limits of liability under all applicable liability bonds and policies have been exhausted by payment of judgments or settlements.

NOTICE REQUIREMENT

Any judgment or settlement for damages against an owner or operator of an uninsured motor vehicle or an underinsured motor vehicle that arises out of a lawsuit brought for which we have not received notice in accordance with South Carolina law is not binding on us.

ADDITIONAL DEFINITIONS

When used in this Part III:

1. "Insured person" means:
 - a. you, a relative, or a rated resident;
 - b. any person while operating a covered auto with the permission of you, a relative, or a rated resident;
 - c. any person occupying, but not operating, a covered auto; and
 - d. any person who is entitled to recover damages covered by this Part III because of bodily injury sustained by a person described in a., b. or c. above.
2. "Underinsured motor vehicle" means a land motor vehicle or trailer of any type to which liability insurance or a bond applies at the time of the accident with limits of liability that equal or exceed the minimum amounts required by the South Carolina motor vehicle financial responsibility law, but which are less than the amount of the damages sustained by the insured person in the accident.
 An "underinsured motor vehicle" does not include any vehicle or equipment:
 - a. operated on rails or crawler treads;
 - b. designed mainly for use off public roads, while not on public roads;
 - c. while located for use as a residence or premises; or
 - d. that is an uninsured motor vehicle.
3. "Uninsured motor vehicle" means a land motor vehicle or trailer of any type:
 - a. to which no liability bond, cash deposit, security, or liability policy in at least the amounts of coverage required by South Carolina law applies at the time of the accident;
 - b. to which a liability bond or policy applies at the time of the accident, but the bonding or insuring company:
 - (i) denies coverage;
 - (ii) is or becomes insolvent;
 - (iii) is in delinquency proceedings, suspension, or receivership; or
 - (iv) is financially unable to fully satisfy a judgment rendered in favor of an insured person;
 - c. to which a liability bond or policy applies at the time of the accident, but its limit of liability is less than the minimum limit of liability specified by the financial responsibility law of the state in which the covered auto is principally garaged; or

- d. that is a hit-and-run vehicle whose owner or operator cannot be identified and which causes an accident resulting in bodily injury to an insured person, or property damage to the property of an insured person, provided:
 - (i) the insured person, or someone on his or her behalf, reports the accident to the police or civil authority within 24 hours or as soon as practicable after the accident; and
 - (ii) if the bodily injury or property damage was not caused by physical contact between the vehicle operated by the unidentified operator and the insured person, or a vehicle occupied by the insured person, there must be independent corroborative evidence by a witness to the accident who executes a signed affidavit attesting to the truth of the accident to prove that the bodily injury or property damage was proximately caused by the negligent or intentional actions of the unidentified operator of the motor vehicle. The testimony of the owner or operator of the covered auto shall not constitute independent corroborative evidence. No recovery will be provided under this Part III if the insured person was negligent in failing to determine the identity of the other motor vehicle and its driver at the time of the accident.

An "uninsured motor vehicle" does not include any vehicle or equipment:

- a. owned or operated by a self-insurer under any applicable motor vehicle law, except a self-insurer that:
 - (i) is or becomes insolvent; or
 - (ii) fails to qualify as a self-insurer under South Carolina law;
- b. owned by any governmental unit or agency, except when:
 - (i) operated by a person without proper authorization; or
 - (ii) a cause of action against that governmental unit or agency arising out of a motor vehicle accident is barred by the Tort Claims Act of South Carolina;
- c. operated on rails or crawler treads;
- d. designed mainly for use off public roads, while not on public roads;
- e. while located for use as a residence or premises;
- f. that is an underinsured motor vehicle; or
- g. that is a covered auto.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART III.

Coverage under this Part III will not apply:

- 1. to bodily injury sustained by any person while using or occupying a covered auto while being used:
 - a. to carry persons or property for compensation or a fee;
 - b. or retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food; or
 - c. for ride-sharing activity.

This exclusion does not apply to shared-expense car pools;

2. to bodily injury sustained by the owner of a motor vehicle if:
 - a. the bodily injury is sustained while using or occupying that owned motor vehicle; and
 - b. if uninsured motorist coverage or underinsured motorist coverage, as the case may be, has not been purchased for that motor vehicle;
3. to bodily injury sustained by you, a relative, or a rated resident while using any vehicle, other than a covered auto, without the permission of the owner of the vehicle or the person in lawful possession of the vehicle;
4. to bodily injury arising out of the use of a covered auto while being used in connection with a personal vehicle sharing program. This exclusion does not apply to the operation of a covered auto by you, a relative, or a rated resident; or
5. directly or indirectly to benefit any insurer or self-insurer under any of the following or similar laws:
 - a. workers' compensation law; or
 - b. disability benefits law.

Coverage under this Part III will not apply to property damage:

1. sustained while a covered auto is being used:
 - a. to carry persons or property for compensation or a fee;
 - b. for retail or wholesale delivery, including but not limited to, the pickup, transport, or delivery of magazines, newspapers, mail, or food; or
 - c. for ride-sharing activity.

This exclusion does not apply to shared-expense car pools;
2. resulting from, or sustained during practice or preparation for:
 - a. any pre-arranged or organized racing, stunting, speed, or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
3. to a covered auto for which insurance:
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
4. to a trailer;
5. to any motor vehicle owned by you, a relative, or a rated resident if uninsured motorist coverage or underinsured motorist coverage, as the case may be, has not been purchased for that motor vehicle; or
6. sustained while a covered auto is being used in connection with a personal vehicle sharing program. This exclusion does not apply to the operation of a covered auto by you, a relative, or a rated resident.

LIMITS OF LIABILITY

The limit of liability shown on the declarations page for Uninsured Motorist Coverage or Underinsured Motorist Coverage, as the case may be, is the most we will pay regardless of the number of:

1. claims made;

2. covered autos, but only with respect to insured persons other than you, a relative, or a rated resident;
3. insured persons;
4. lawsuits brought;
5. vehicles involved in the accident; or
6. premiums paid, but only with respect to insured persons other than you, a relative, or a rated resident.

When you, a relative, or a rated resident are not occupying an auto and sustain bodily injury caused by the owner or operator of an uninsured motor vehicle or underinsured motor vehicle, our limit of liability shall not exceed the limit of liability shown on the declarations page for any one covered auto.

If your declarations page shows a split limit:

1. the amount shown for "each person" for "bodily injury" is the most we will pay for all damages due to bodily injury to one person;
2. subject to the "each person" limit, the amount shown for "each accident" is the most we will pay for all damages due to bodily injury sustained by two or more persons in any one accident; and
3. the amount shown for "property damage" is the most we will pay for the aggregate of all property damage caused by any one accident.

The "each person" limit of liability includes the total of all claims made for bodily injury to an insured person and all claims of others derived from such bodily injury, including, but not limited to, loss of society, loss of companionship, loss of services, loss of consortium, and wrongful death.

If the declarations page shows that "combined single limit" or "CSL" applies, the amount shown is the most we will pay for the total of all bodily injury damages resulting from any one accident. However, without changing this total limit of liability, we will comply with any law that requires us to provide any separate limits.

The amount of damages payable for bodily injury under this Part III will be reduced by all sums:

1. paid because of bodily injury by or on behalf of any persons or organizations that may be legally responsible;
2. paid under Part I—Liability To Others; and
3. paid or payable because of bodily injury under any disability benefits law or similar law.

We will not pay under this Part III any expenses paid or payable under Part II—Medical Payments Coverage.

The limit of liability for property damage to a covered auto is the lowest of:

1. the actual cash value of the covered auto at the time of the accident;
2. the amount necessary to replace the covered auto;

3. the amount necessary to repair the covered auto to its pre-loss condition; or
4. the limit of liability shown on the declarations page for Uninsured Motorist Property Damage or Underinsured Motorist Property Damage, whichever applies.

The amount of damages payable for property damage under this Part III will be reduced by all sums paid because of property damage by or on behalf of any persons or organizations that may be legally responsible, including, but not limited to, all sums paid under Part I—Liability To Others.

We shall not pay for property damage to the extent that such damages are paid or payable under any other property damage or physical damage insurance, including all sums paid or payable under Part IV—Damage To A Vehicle.

Payments for property damage under this Part III are subject to the following provisions:

1. any amount payable under this Part III for property damage shall be subject to the applicable deductible shown on the declarations page; and
2. no more than one deductible shall be applied to any one accident.

No one will be entitled to duplicate payments for the same elements of damages.

OTHER INSURANCE

If there is other applicable uninsured or underinsured motorist coverage, we will pay only our share of the damages. Our share is the proportion that our limit of liability bears to the total of all available coverage limits. However, when you, a relative, or a rated resident are occupying a motor vehicle other than a covered auto and sustain bodily injury covered under this Part III, our coverage shall be excess to the coverage applicable to the motor vehicle that you, the relative, or the rated resident are occupying, and our total limit of liability under this policy shall not exceed our limit of liability for one auto.

However, when you, a relative, or a rated resident are operating, or occupying, a motor vehicle that is owned by you, a relative, or a rated resident but is not a covered auto, in that case, our total limit of liability will be the lesser of the limit of liability listed on the declarations page or the amount of Uninsured Motorist Coverage or Underinsured Motorist Coverage, as the case may be, on the vehicle involved in the accident.

ARBITRATION FOR BODILY INJURY CLAIMS

If we and an Insured person cannot agree on:

1. the legal liability of the operator or owner of an uninsured motor vehicle or underinsured motor vehicle; or
 2. the amount of the damages sustained by the Insured person;
- this will be determined by arbitration if we and the Insured person mutually agree to arbitration prior to the expiration of the bodily injury statute of limitations in the state in which the accident occurred.

If we and the Insured person mutually agree to arbitration, each party will select an arbitrator. The two arbitrators will select a third. If the two arbitrators cannot agree on a third arbitrator within 30 days, then on joint application by the Insured person and us, the third arbitrator will be appointed by a court having jurisdiction.

Each party will pay the costs and fees of its arbitrator and any other expenses it incurs. The costs and fees of the third arbitrator will be shared equally.

Unless both parties agree otherwise, arbitration will take place in the county in which the Insured person resides. Local rules of procedure and evidence will apply.

A decision agreed to by two of the arbitrators will be binding with respect to a determination of:

1. the legal liability of the operator or owner of an uninsured motor vehicle or underinsured motor vehicle; and
 2. the amount of the damages sustained by the Insured person.
- The arbitrators will have no authority to award an amount in excess of the limit of liability.

We and an Insured person may agree to an alternate form of arbitration.

ARBITRATION FOR PROPERTY DAMAGE CLAIMS

An Insured person may submit a disputed property damage claim to arbitration in accordance with South Carolina law.

PART IV—DAMAGE TO A VEHICLE

INSURING AGREEMENT—COLLISION COVERAGE

If you pay the premium for this coverage, we will pay for sudden, direct and accidental loss to a:

1. covered auto, including an attached trailer; or
 2. non-owned auto;
- and its custom parts or equipment, resulting from collision.

In addition, we will pay the reasonable cost to replace any child safety seat damaged in an accident to which this coverage applies.

INSURING AGREEMENT—COMPREHENSIVE COVERAGE

If you pay the premium for this coverage, we will pay for sudden, direct and accidental loss to a:

1. covered auto, including an attached trailer; or
 2. non-owned auto;
- and its custom parts or equipment, that is not caused by collision.

PNIC000029

A loss not caused by collision includes:

1. contact with an animal (including a bird);
2. explosion or earthquake;
3. fire;
4. malicious mischief or vandalism;
5. missiles or falling objects;
6. riot or civil commotion;
7. theft or larceny;
8. windstorm, hail, water or flood; or
9. breakage of glass not caused by collision.

In addition, we will pay for:

1. reasonable transportation expenses incurred by you if a covered auto is stolen; and
2. loss of use damages that you are legally liable to pay if a non-owned auto is stolen.

A combined maximum of \$900, not exceeding \$30 per day, will apply to these additional benefits. The additional benefit for transportation expenses will not apply if you purchased Rental Reimbursement Coverage for the stolen covered auto.

Coverage for transportation expenses and loss of use damages begins 48 hours after you report the theft to us and ends the earliest of:

1. when the auto has been recovered and returned to you or its owner;
2. when the auto has been recovered and repaired;
3. when the auto has been replaced; or
4. 72 hours after we make an offer to settle the loss if the auto is deemed by us to be a total loss.

We must receive written proof of transportation expenses and loss of use damages.

INSURING AGREEMENT—ADDITIONAL CUSTOM PARTS OR EQUIPMENT COVERAGE

We will pay for sudden, direct and accidental loss to custom parts or equipment on a covered auto for which this coverage has been purchased. This coverage applies only if you have purchased both Comprehensive Coverage and Collision Coverage for that covered auto and the loss is covered under one of those coverages. This coverage applies in addition to any coverage automatically provided for custom parts or equipment under Comprehensive Coverage or Collision Coverage.

INSURING AGREEMENT—RENTAL REIMBURSEMENT COVERAGE

We will reimburse rental charges incurred when you rent an auto from a rental agency or auto repair shop due to a loss to a covered auto for which Rental Reimbursement Coverage has been purchased. This coverage applies only if you have

PNIC000030

purchased both Comprehensive Coverage and Collision Coverage for that covered auto and the loss is covered under one of those coverages.

Additional fees or charges for insurance, damage waivers, optional equipment, fuel, or accessories are not covered.

This coverage is limited to the each day limit shown on the declarations page for a maximum of 30 days.

If Rental Reimbursement Coverage applies, no other coverage under this policy for rental expenses will apply.

Rental charges will be reimbursed beginning:

1. when the covered auto cannot be driven due to a loss; or
2. if the covered auto can be driven, when you deliver the covered auto to an auto repair shop or one of our Service Centers for repairs due to the loss; and ending the earliest of:
 1. when the covered auto has been returned to you;
 2. when the covered auto has been repaired;
 3. when the covered auto has been replaced;
 4. 72 hours after we make an offer to settle the loss if the covered auto is deemed by us to be a total loss; or
 5. when you incur 30 days worth of rental charges.

You must provide us written proof of your rental charges to be reimbursed.

INSURING AGREEMENT—LOAN/LEASE PAYOFF COVERAGE

If you pay the premium for this coverage, and the covered auto for which this coverage was purchased is deemed by us to be a total loss, we will pay, in addition to any amounts otherwise payable under this Part IV, the difference between:

1. the actual cash value of the covered auto at the time of the total loss; and
2. any greater amount the owner of the covered auto is legally obligated to pay under a written loan or lease agreement to which the covered auto is subject at the time of the total loss, reduced by:
 - a. unpaid finance charges or refunds due to the owner for such charges;
 - b. excess mileage charges or charges for wear and tear;
 - c. charges for extended warranties or refunds due to the owner for extended warranties;
 - d. charges for credit insurance or refunds due to the owner for credit insurance;
 - e. past due payments and charges for past due payments; and
 - f. collection or repossession expenses.

However, our payment under this coverage shall not exceed the limit of liability shown on the declarations page. The limit of liability is a percentage of the actual cash value of the covered auto at the time of the loss.

This coverage applies only if you have purchased both Comprehensive Coverage and Collision Coverage for that covered auto and the loss is covered under one of those coverages.

INSURING AGREEMENT—PET INJURY COVERAGE

If you have purchased Collision coverage for at least one covered auto under your policy, and if your pet sustains injury or death while inside a covered auto or non-owned auto at the time of a loss covered under Collision or Comprehensive coverage, we will provide:

1. up to \$1,000 for reasonable and customary veterinary fees incurred by you, a relative, or a rated resident if your pet is injured in, or as a direct result of, the covered loss; or
2. a \$1,000 death benefit if your pet dies in, or as a direct result of, the covered loss, less any payment we made toward veterinary expenses for your pet.

In the event of a covered loss due to the theft of a covered auto or non-owned auto, we will provide the death benefit provided your pet is inside that auto at the time of the theft and your pet is not recovered.

ADDITIONAL DEFINITIONS

When used in this Part IV:

1. "Collision" means the upset of a vehicle or its impact with another vehicle or object.
2. "Custom parts or equipment" means equipment, devices, accessories, enhancements and changes, other than those that are offered by the manufacturer specifically for that auto model, or that are installed by the auto dealership as part of the original sale of a new auto, that:
 - a. are permanently installed or attached; and
 - b. alter the appearance or performance of the auto.
3. "Mechanical parts" means operational parts on a vehicle that wear out over time or have a finite useful life or duration typically shorter than the life of the vehicle as a whole. Mechanical parts do not include external crash parts, wheels, paint, or windshields and other glass.
4. "Non-owned auto" means an auto that is not owned by or furnished or available for the regular use of you, a relative, or a rated resident while in the custody of or being operated by you, a relative, or a rated resident with the permission of the owner of the auto or the person in lawful possession of the auto.
5. "Your pet" means any dog or cat owned by you, a relative, or a rated resident.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART IV.

Coverage under this Part IV will not apply for loss:

1. to any vehicle while being used:
 - a. to carry persons or property for compensation or a fee;

PNIC000032

- b. for retail or wholesale delivery, including, but not limited to, the pickup, transport or delivery of magazines, newspapers, mail or food; or
 - c. for ride-sharing activity.
- This exclusion does not apply to shared-expense car pools;
- 2. to a non-owned auto while being maintained or used by a person while employed or engaged in any auto business;
 - 3. to any vehicle resulting from, or sustained during practice or preparation for:
 - a. any pre-arranged or organized racing, stunting, speed or demolition contest or activity; or
 - b. any driving activity conducted on a permanent or temporary racetrack or racecourse;
 - 4. to any vehicle for which insurance:
 - a. is afforded under a nuclear energy liability insurance contract; or
 - b. would be afforded under a nuclear energy liability insurance contract but for its termination upon exhaustion of its limit of liability;
 - 5. to any vehicle caused by an intentional act committed by or at the direction of you, a relative, a rated resident, or the owner of a non-owned auto, even if the actual damage is different than that which was intended or expected;
 - 6. to a covered auto while it is leased or rented to others or given in exchange for compensation, including while being used in connection with a personal vehicle sharing program. This exclusion does not apply to the operation of a covered auto by you, a relative, or a rated resident;
 - 7. due to destruction or confiscation by governmental or civil authorities of any vehicle because you, any relative, or any rated resident engaged in illegal activities;
 - 8. to any vehicle that is due and confined to:
 - a. wear and tear;
 - b. freezing;
 - c. mechanical, electrical or electronic breakdown or failure; or
 - d. road damage to tires.

This exclusion does not apply if the damage results from the theft of a vehicle;
 - 9. to portable equipment, devices, accessories, and any other personal effects that are not permanently installed. This includes, but is not limited to:
 - a. tapes, compact discs, cassettes, DVDs, and other recording or recorded media;
 - b. any case or other container designed for use in storing or carrying tapes, compact discs, cassettes, DVDs, or other recording or recorded media;
 - c. any device used for the detection or location of radar, laser, or other speed measuring equipment or its transmissions; and
 - d. CB radios, telephones, two-way mobile radios, DVD players, personal computers, personal digital assistants, or televisions;
 - 10. to any vehicle for diminution of value;
 - 11. to any vehicle caused directly or indirectly by:
 - a. war (declared or undeclared) or civil war;
 - b. warlike action by any military force of any government, sovereign, or other authority using military personnel or agents. This includes any action taken to hinder or defend against an actual or expected attack; or

PNIC000033

- c. insurrection, rebellion, revolution, usurped power, or any action taken by a governmental authority to hinder or defend against any of these acts;
- 12. to any vehicle caused directly or indirectly by:
 - a. any accidental or intentional discharge, dispersal or release of radioactive, nuclear, pathogenic or poisonous biological material; or
 - b. any intentional discharge, dispersal or release of chemical or hazardous material for any purpose other than its safe and useful purpose; or
- 13. to any vehicle caused by, or reasonably expected to result from, a criminal act or omission of you, a relative, a rated resident, or the owner of a non-owned auto. This exclusion applies regardless of whether you, the relative, the rated resident, or the owner of the non-owned auto is actually charged with, or convicted of, a crime. For purposes of this exclusion, criminal acts or omissions do not include traffic violations.

LIMITS OF LIABILITY

- 1. The limit of liability for loss to a covered auto, non-owned auto, or custom parts or equipment is the lowest of:
 - a. the actual cash value of the stolen or damaged property at the time of the loss reduced by the applicable deductible;
 - b. the amount necessary to replace the stolen or damaged property reduced by the applicable deductible;
 - c. the amount necessary to repair the damaged property to its pre-loss condition reduced by the applicable deductible; or
 - d. the Stated Amount shown on the declarations page for that covered auto.
 However, the most we will pay for loss to:
 - a. custom parts or equipment is \$1,000 unless you purchased Additional Custom Parts or Equipment Coverage ("ACPE"). If you purchased ACPE, the most we will pay is \$1,000 plus the amount of ACPE you purchased.
 - b. a trailer is the limit of liability shown on the declarations page for that trailer. If the trailer is not shown on the declarations page, the limit of liability is \$500.
- 2. Payments for loss to a covered auto, non-owned auto, or custom parts or equipment are subject to the following provisions:
 - a. If coverage applies to a non-owned auto, we will provide the broadest coverage applicable to any covered auto shown on the declarations page.
 - b. If you have elected a Stated Amount for a covered auto, the Stated Amount is the most we will pay for all loss to that covered auto, including its custom parts or equipment.
 - c. Coverage for custom parts or equipment will not cause our limit of liability for loss to an auto under this Part IV to be increased to an amount in excess of the actual cash value of the auto, including its custom parts or equipment.
 - d. In determining the amount necessary to repair damaged property to its pre-loss condition, the amount to be paid by us:
 - (i) will not exceed the prevailing competitive labor rates charged in the area where the property is to be repaired and the cost of repair or replacement parts and equipment, as reasonably determined by us; and

PNIC000034

- (ii) will be based on the cost of repair or replacement parts and equipment which may be new, reconditioned, remanufactured or used, including, but not limited to:
 - (a) original manufacturer parts or equipment; and
 - (b) nonoriginal manufacturer parts or equipment.
- e. To determine the amount necessary to repair or replace the damaged property as referred to in subsection 1., the total cost of necessary repair or replacement may be reduced by unrepaired prior damage. Unrepaired prior damage includes broken, cracked or missing parts; rust; dents; scrapes; gouges; and peeling paint. The reduction for unrepaired prior damage is the cost of labor, parts and materials necessary to repair or replace damage, deterioration, defects, or wear and tear on exterior body parts, windshields and other glass, wheels, and paint, that existed prior to the accident and that is eliminated as a result of the repair or replacement of property damaged in the loss.
- f. To determine the amount necessary to repair or replace the damaged property as referred to in subsection 1., an adjustment may be made for betterment or depreciation and physical condition on:
 - (i) batteries;
 - (ii) tires;
 - (iii) engines and transmissions, if the engine has greater than 80,000 miles; and
 - (iv) any other mechanical parts that are nonfunctioning or inoperative.
 We will not make an adjustment for the labor costs associated with the replacement or repair of these parts.
- g. The actual cash value is determined by the market value, age, and condition of the vehicle at the time the loss occurs.
- 3. No deductible will apply with respect to damage to automobile safety glass.
- 4. Duplicate recovery for the same elements of damages is not permitted.
- 5. Any amount paid or payable to a person under this Part IV for property damage to an auto shall be reduced by any amount paid for that property damage to the auto under Part III—Uninsured/Underinsured Motorist Coverage.
- 6. The following additional limits of liability apply to Pet Injury coverage:
 - a. The most we will pay for all damages in any one loss is a total of \$1,000 regardless of the number of dogs or cats involved.
 - b. If your pet dies in, or as a direct result of, a covered loss, we will provide a death benefit of \$1,000, less any payment we made toward veterinary expenses for your pet.
 - c. No deductible shall apply to this coverage.

PAYMENT OF LOSS

We may, at our option:

- 1. pay for the loss in money; or
- 2. repair or replace the damaged or stolen property.

At our expense, we may return any recovered stolen property to you or to the address shown on the declarations page, with payment for any damage resulting from the theft. We may keep all or part of the property at the agreed or appraised value.

We may settle any loss with you or the owner or lienholder of the property.

NO BENEFIT TO BAILEE

Coverage under this Part IV will not directly or indirectly benefit any carrier or other bailee for hire.

LOSS PAYABLE CLAUSE

Payment under this Part IV for a loss to a covered auto will be made according to your interest and the interest of any lienholder shown on the declarations page or designated by you. At our option, payment may be made to both jointly, or to either separately. However, if the covered auto is not a total loss, we may make payment to you and the repairer of the auto.

The lienholder's interest will not be protected:

1. where fraud, misrepresentation, material omission, or intentional damage resulting in a denial of coverage by us has been committed by or at the direction of you or any person seeking coverage; or
2. where the loss is otherwise not covered under the terms of this policy.

If this policy is cancelled, nonrenewed or voided, the interest of any lienholder under this agreement will also terminate.

OTHER SOURCES OF RECOVERY

If other sources of recovery also cover the loss, we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide for a non-owned auto, or trailer not shown on the declarations page, will be excess over any other collectible source of recovery including, but not limited to:

1. any coverage provided by the owner of the non-owned auto or trailer;
2. any other applicable physical damage insurance; and
3. any other source of recovery applicable to the loss.

APPRAISAL

If we cannot agree with you on the amount of a loss, then we or you may demand an appraisal of the loss. Within 30 days of any demand for an appraisal, each party shall appoint a competent appraiser and shall notify the other party of that appraiser's identity. The appraisers will determine the amount of loss. If they fail to agree, the disagreement will be submitted to a qualified umpire chosen by the appraisers.

If the two appraisers are unable to agree upon an umpire within 15 days, we or you may request that a judge of a court of record, in the county where you reside, select an umpire. The appraisers and umpire will determine the amount of loss. The amount of loss agreed to by both appraisers, or by one appraiser and the umpire, will be binding. You will pay your appraiser's fees and expenses. We will pay our appraiser's fees and expenses. All other expenses of the appraisal, including payment of the umpire if one is selected, will be shared equally between us and you. Neither we nor you waive any rights under this policy by agreeing to an appraisal.

PART V—ROADSIDE ASSISTANCE COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay for our authorized service representative to provide the following services when necessary due to a covered emergency:

1. towing of a covered disabled auto to the nearest qualified repair facility; and
2. labor on a covered disabled auto at the place of disablement.

If a covered disabled auto is towed to any place other than the nearest qualified repair facility, you will be responsible for any additional charges incurred.

ADDITIONAL DEFINITIONS

When used in this Part V:

1. "Covered disabled auto" means a covered auto for which this coverage has been purchased that sustains a covered emergency.
2. "Covered emergency" means a disablement that is a result of:
 - a. mechanical or electrical breakdown;
 - b. battery failure;
 - c. insufficient supply of fuel, oil, water, or other fluid;
 - d. flat tire;
 - e. lock-out; or
 - f. entrapment in snow, mud, water or sand within 100 feet of a road or highway.

EXCLUSIONS—READ THE FOLLOWING EXCLUSIONS CAREFULLY. IF AN EXCLUSION APPLIES, COVERAGE WILL NOT BE AFFORDED UNDER THIS PART V.

Coverage under this Part V will not apply to:

1. more than three covered emergencies for any single covered auto in a six-month period;
2. the cost of purchasing parts, fluid, lubricants, fuel, or replacement keys, or the labor to make replacement keys;
3. installation of products or material not related to the disablement;

PNIC000037

4. labor not related to the disablement;
5. labor on a covered disabled auto for any time period in excess of 60 minutes per disablement;
6. towing or storage related to impoundment, abandonment, illegal parking, or other violations of law;
7. assistance with jacks, levelers, airbags or awnings;
8. labor or repair work performed at a service station, garage, or repair shop;
9. auto storage charges;
10. disablement that occurs on roads not regularly maintained, sand beaches, open fields, or areas designated as not passable due to construction, weather, or earth movement;
11. mounting or removing of snow tires or chains;
12. tire repair;
13. disablement that results from an intentional or willful act or action by you, a relative, or the operator of a covered disabled auto;
14. any covered auto while being used in connection with ride-sharing activity;
15. any covered auto while being used in connection with a personal vehicle sharing program; or
16. a trailer.

UNAUTHORIZED SERVICE PROVIDER

When service is rendered by a provider in the business of providing roadside assistance and towing services, other than one of our authorized service representatives, we will pay only reasonable charges, as determined by us, for:

1. towing of a covered disabled auto to the nearest qualified repair facility; and
 2. labor on a covered disabled auto at the place of disablement;
- which is necessary due to a covered emergency.

OTHER INSURANCE

Any coverage provided under this Part V for service rendered by an unauthorized service provider will be excess over any other collectible insurance or towing protection coverage.

PART VI - DUTIES IN CASE OF AN ACCIDENT OR LOSS

For coverage to apply under this policy, you or the person seeking coverage must promptly report each accident or loss even if you or the person seeking coverage is not at fault. You or the person seeking coverage must provide us with all accident or loss information, including time, place, and how the accident or loss happened. You or the person seeking coverage must also obtain and provide us the names and addresses of all persons involved in the accident or loss, the names and addresses of any witnesses, and the license plate numbers of the vehicles involved.

If you or the person seeking coverage cannot identify the owner or operator of a vehicle involved in the accident, or if theft or vandalism has occurred, you or the

PNIC000038

person seeking coverage must notify the police within 24 hours or as soon as practicable.

A person seeking coverage must:

1. cooperate with us in any matter concerning a claim or lawsuit;
2. provide any written proof of loss we may reasonably require;
3. allow us to take signed and recorded statements, including sworn statements and examinations under oath, which we may conduct outside the presence of you or any other person seeking coverage, and answer all reasonable questions we may ask as often as we may reasonably require;
4. promptly call to notify us about any claim or lawsuit and send us any and all legal papers relating to the claim or suit;
5. attend hearings and trials as we require;
6. take reasonable steps after a loss to protect the covered auto, or any other vehicle for which coverage is sought, from further loss. We will pay reasonable expenses incurred in providing that protection. If failure to provide such protection results in further loss, any additional damages will not be covered under this policy;
7. allow us to have the damaged covered auto, or any other damaged vehicle for which coverage is sought, inspected and appraised before its repair or disposal;
8. submit to medical examinations at our expense by doctors we select as often as we may reasonably require; and
9. authorize us to obtain medical and other records.

PART VII—GENERAL PROVISIONS

POLICY PERIOD AND TERRITORY

This policy applies only to accidents and losses occurring during the policy period shown on the declarations page and that occur within a state, territory or possession of the United States of America, or a province or territory of Canada, or while a covered auto is being transported between their ports.

CHANGES

This policy contract, your Insurance application (which is made a part of this policy as if attached hereto), the declarations page, and all endorsements to this policy issued by us, contain all the agreements between you and us. Subject to the following, the terms of this policy may not be changed or waived except by an endorsement issued by us.

The premium for this policy is based on information we received from you and other sources. You agree to cooperate with us in determining if this information is correct and complete, and to promptly notify us if it changes during the policy period. If this information is determined by us to be incorrect, incomplete, or if it changes during the policy period, you agree that we may adjust your policy information and premi-

PNIC000039

um accordingly. Changes that may result in a premium adjustment are contained in our rates and rules. These include, but are not limited to, you, a relative, or a rated resident obtaining a driver's license or operator's permit, or changes in:

1. the number, type or use classification of covered autos;
2. the persons who regularly operate a covered auto;
3. the persons of legal driving age residing in your household;
4. the residents in your household;
5. an operator's marital status;
6. your mailing address and your residence address;
7. the principal garaging address of any covered auto;
8. coverage, deductibles, or limits of liability; or
9. rating territory or discount eligibility.

The coverage provided in your policy may be changed only by the issuance of a new policy or an endorsement by us. However, if during the policy period we broaden any coverage afforded under the current edition of your policy without additional premium charge, that change will automatically apply to your policy as of the date the coverage change is implemented in your state.

If you ask us to delete a vehicle from this policy, no coverage will apply to that vehicle as of the date and time you ask us to delete it.

DUTY TO REPORT CHANGES

You must promptly report to us all changes, including additions and deletions, in policy information. This includes, but is not limited to, changes in:

1. your mailing address or your residence address;
2. the principal garaging address of any covered auto; — — — — —
3. the residents in your household;
4. the persons of legal driving age residing in your household;
5. the persons who regularly operate a covered auto;
6. an operator's marital status; or
7. the driver's license or operator's permit status of you, a relative, or a rated resident.

SETTLEMENT OF CLAIMS

We may use estimating, appraisal, or injury evaluation systems to assist us in adjusting claims under this policy and to assist us in determining the amount of damages, expenses, or loss payable under this policy. Such systems may be developed by us or a third party and may include computer software, databases, and specialized technology.

TERMS OF POLICY CONFORMED TO STATUTES

If any provision of this policy fails to conform to the statutes of the state listed on your application as your residence, the provision shall be deemed amended to conform

PNIC000040

to such statutes. All other provisions shall be given full force and effect. Any disputes as to the coverages provided or the provisions of this policy shall be governed by the law of the state listed on your application as your residence.

TRANSFER OF INTEREST

The rights and duties under this policy may not be transferred to another person without our written consent. However, if a named insured shown on the declarations page dies, this policy will provide coverage until the end of the policy period for the legal representative of the named insured, while acting as such, and for persons covered under this policy on the date of the named insured's death.

FRAUD OR MISREPRESENTATION

This policy was issued in reliance upon the information provided on your insurance application. We may void this policy at any time, including after the occurrence of an accident or loss, if you:

1. made incorrect statements or representations to us with regard to any material fact or circumstance;
2. concealed or misrepresented any material fact or circumstance; or
3. engaged in fraudulent conduct;

at the time of application. This means that we will not be liable for any claims or damages that would otherwise be covered unless we have certified this policy as proof of financial responsibility. If we have certified this policy as proof of financial responsibility, nothing in this provision shall affect coverage under Part I—Liability To Others up to the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina for an accident that occurs before we notify you that the policy is void. If we void this policy, you must reimburse us if we make a payment.

Any changes we make at your request to this policy after inception will be made in reliance upon information you provide. If you:

1. make incorrect statements or representations to us with regard to any material fact or circumstance;
2. conceal or misrepresent any material fact or circumstance; or
3. engage in fraudulent conduct;

in connection with a requested change we may void the policy or reform it as it existed immediately prior to the requested change. We may do this at any time, including after the occurrence of an accident or loss.

When we have not voided or reformed the policy, we may still deny coverage for an accident or loss if you, in connection with the policy application, in connection with any requested change, or at any time during the policy period, have concealed or misrepresented any material fact or circumstance or engaged in fraudulent conduct and that concealment, misrepresentation, or fraudulent conduct was material to a risk we assumed.

We may deny coverage for an accident or loss if you or a person seeking coverage has concealed or misrepresented any material fact or circumstance, or engaged in fraudulent conduct, in connection with the presentation or settlement of a claim. However, this shall not affect coverage under Part I—Liability To Others up to the minimum limit mandated by the motor vehicle financial responsibility law of South Carolina, for any injured person who has not knowingly concealed or misrepresented any material fact or circumstance.

PAYMENT OF PREMIUM AND FEES

If your initial premium payment is by check, draft, electronic funds transfer, or similar form of remittance, coverage under this policy is conditioned on payment to us by the financial institution. If the financial institution upon presentment does not honor the check, draft, electronic funds transfer, or similar form of remittance, this policy may, at our option, be cancelled from its inception by notice of cancellation or rescission. This means we will not be liable under this policy for any claims or damages that would otherwise be covered if the check, draft, electronic funds transfer, or similar form of remittance had been honored by the financial institution. Any action by us to present the remittance for payment more than once shall not affect our right to void this policy.

In addition to premium, fees may be charged on your policy. We may charge fees for installment payments, late payments, and other transactions. Payments made on your policy will be applied first to fees, then to premium due.

CANCELLATION

You may cancel this policy during the policy period by calling or writing us and stating the future date you wish the cancellation to be effective.

We may cancel this policy during the policy period by mailing a notice of cancellation to the named insured shown on the declarations page at the last known address appearing in our records, stating the specific reason for cancellation. Notice will be mailed at least 15 days before the date of cancellation.

We may cancel this policy for any of the following reasons within the first 60 days of the initial policy period:

1. a premium payment by check, draft, electronic funds transfer, or similar form of remittance is not honored upon presentment;
2. you produce proof that you have sold or otherwise disposed of a covered auto, or surrendered its tags and registration;
3. you have secured another policy that satisfies the financial responsibility laws of the State of South Carolina; or
4. you fail to pay when due:
 - a. the premium for the policy;
 - b. an installment of the premium; or
 - c. an installment payment under a premium service contract.

PNIC000042

29

After the policy has been in effect for more than 60 days, but before the policy has been in effect for more than 90 days, we may cancel this policy for any reason.

After this policy is in effect for more than 90 days, or if this is a renewal or continuation policy, we may cancel only for one or more of the following reasons:

1. nonpayment of premium;
2. loss of driving privileges through suspension or revocation of an operator's license issued to you, any driver in your household, or any regular operator of a covered auto; or
3. any other reason permitted by law.

Proof of mailing will be sufficient proof of notice. If this policy is cancelled, coverage will not be provided as of the effective date and time shown in the notice of cancellation. For purposes of cancellation, this policy is neither severable nor divisible. Any cancellation will be effective for all coverages for all persons and all vehicles.

CANCELLATION REFUND

Upon cancellation, you may be entitled to a premium refund. However, our making or offering of a refund is not a condition of cancellation.

If this policy is cancelled, any refund due will be computed on a daily pro rata basis. However, if this policy is cancelled at your request any refund due will be computed on a 90% of a daily pro rata basis. Earned premium is calculated on a daily basis. We will supply a copy of the table to you on request.

When you renew this policy, we will waive our right under the policy to calculate cancellation refunds on a 90% of a daily pro rata basis; instead, any refund of premium following a cancellation that may apply to the renewal policy will be calculated on a daily pro rata basis.

NONRENEWAL

If neither we nor one of our affiliates offers to renew or continue this policy, we will mail notice of nonrenewal stating the specific reason for nonrenewal to the named insured shown on the declarations page at the last known address appearing in our records. Proof of mailing will be sufficient proof of notice. Notice will be mailed at least 15 days before the end of the policy period.

LEGAL ACTION AGAINST US

We may not be sued unless there is full compliance with all the terms of this policy.

We may not be sued for payment under Part I—Liability To Others until the obligation of an insured person under Part I to pay is finally determined either by judgment after trial against that person or by written agreement of the insured person, the

30

PNIC000043

claimant, and us. No one will have any right to make us a party to a lawsuit to determine the liability of an insured person.

If we retain salvage, we have no duty to preserve or otherwise retain the salvage for any purpose, including evidence for any civil or criminal proceeding.

OUR RIGHTS TO RECOVER PAYMENT

We are entitled to the rights of recovery that the insured person to whom payment was made has against another, to the extent of our payment. That insured person may be required to sign documents related to the recovery and must do whatever else we require to help us exercise those recovery rights, and do nothing after an accident or loss to prejudice those rights.

However, we may not assert rights of recovery:

1. for amounts paid as Underinsured Motorist Coverage benefits; or
2. for amounts paid as Medical Payments Coverage benefits.

When an insured person has been paid by us and also recovers from another, the amount recovered will be held by the insured person in trust for us and reimbursed to us to the extent of our payment. If we are not reimbursed, we may pursue recovery of that amount directly against that insured person.

If an insured person recovers from another without our written consent, the insured person's right to payment under any affected coverage will no longer exist.

If we elect to exercise our rights of recovery against another, we will also attempt to recover any deductible incurred by an insured person under this policy unless we are specifically instructed by that person not to pursue the deductible. We have no obligation to pursue recovery against another for any loss not covered by this policy.

We reserve the right to compromise or settle the deductible and property damage claims against the responsible parties for less than the full amount. We also reserve the right to incur reasonable expenses and attorney fees in pursuit of the recovery.

If the total recovery is less than the total of our payment and the deductible, we will reduce reimbursement of the deductible based on the proportion that the actual recovery bears to the total of our payment and the deductible. A proportionate share of collection expenses and attorney fees incurred in connection with these recovery efforts will also reduce reimbursement of the deductible.

These provisions will be applied in accordance with state law.

JOINT AND INDIVIDUAL INTERESTS

If there is more than one named insured on this policy, any named insured may cancel or change this policy. The action of one named insured will be binding on all persons provided coverage under this policy.

31

PNIC000044

BANKRUPTCY

The bankruptcy or insolvency of an insured person will not relieve us of any obligations under this policy.

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PNIC000047

PROGRESSIVE
AUTO

6611A SC 1014



ENC000048



MUSC Health
PO Box 931736
Atlanta, Ga 31193-1736

Alexis Jones

Guarantor ID: 500033958

Visit Coverages:
Wellcare of SC Medicaid - Wellcare of SC Medicaid

This is not a bill. This is an itemization of your MUSC Health services for:

Patient: Jones, Alexis Admission Date: 10/08/19
Hospital Account: 300053282 Discharge Date: 10/08/19

R51 - Headache
F17.210 - Nicotine dependence, cigarettes, uncomplicated

Current Account Balance: 0.00

Hospital Charges

Date	Rev Code	Procedure Code	Description	Qty	Amount
10/08/19	0250	63700001	CYCLOBENZAPRINE 10 MG TAB	1	6.00
10/08/19	0250	63700001	ACETAMINOPHEN 325 MG TAB	3	1.00
10/08/19	0255	Q9967	IOHEXOL 350 MG IODINE/ML SOLN	100	673.00
10/08/19	0352	35200033	HB CT ABDOMEN & PELVIS W/CONTRAST	1	16,228.56
10/08/19	0450	45000005	HB ER VISIT COMPREHENSIVE	1	5,219.98
10/08/19	0306	85100170	HB C UR	1	719.54
10/08/19	0307	85340180	HB URINALYSIS	1	283.84
10/08/19	0307	85340131	HB PREGNANCY-QUALITATIVE URINE	1	610.90

Total Charges: 23,742.82

Page 1

For inquiries regarding this document, please call 1-843-792-2311.



Account # 7621910080077

ADOS: 10/08/2019

BDOS: 10/08/2019

10/17/2019

Patient Name: ALEXIS JONES

ALEXIS JONES

Group Information:

APP OF SOUTH CAROLINA ED PLLC

PO BOX 4458. DEPT 226

HOUSTON, TX 77210-4458

Tax ID: 82-2136565

Phone: (866) 434-3164

Doctor: 56 - CHRISTOPHER DAVIS, MD

Hospital: Springs Memorial Hospital

Patient Information:

Patient DOB: [REDACTED]

Patient Phone: [REDACTED]

Insurance Information:

Primary Insurance
Name: S2 - WELLCARE OF SC MCD
Insured: ALEXIS JONES
Policy: xxxxxx8522
GroupID:
File Date:

Secondary Insurance:

Tertiary Insurance:

FinClass

38 - MCD MANCR

Diagnosis:

S09.90XA - Unspecified injury of head, initial encounter

Charges

\$883.63

Payments:

\$0.00

Adjustments:

\$0.00

Balance:

\$883.63

Collection Balance:

\$0.00

CHARGES:

Date	Procedure Mod	Description	Charges	Medicare Payment	Insurance Payment	Patient Payment	Payments	Balance
10/08/2019	99284	AN EMERGENCY DEPT VISIT	\$883.63	\$0.00	\$0.00	\$0.00	\$0.00	\$883.63

TRANSACTIONS:

Actual Date

Transaction Type / Description

Ins Plan

Transaction Amount

ALEXIS JONES

If paying by a below listed Credit Card, please fill out below.

☐ AmEx☐ MasterCard☐ Visa☐ Discover

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Signature

Expires:

Amount:

☐ Check if address is incorrect, and make changes in the space above.

ALEXIS JONES

Balance:

\$883.63

APP OF SOUTH CAROLINA ED PLLC

PO BOX 4458. DEPT 226

HOUSTON, TX 77210-4458

7621910080077



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MUSC Health
PO Box 931736
Atlanta, Ga 31193-1736

Alexis Jones
[REDACTED]
[REDACTED]

Guarantor ID: 1658302

Visit Coverages:

Wellcare of SC Medicaid - Wellcare of SC Medicaid

~~This is not a bill. This is an itemization of your MUSC Health services for:~~

Patient: Jones, Alexis
Hospital Account: 300053717

Admission Date: 10/09/19
Discharge Date: 10/09/19

SI6.1XXA - Strain of muscle, fascia and tendon at neck level, initial encounter
R03.0 - Elevated blood-pressure reading, without diagnosis of hypertension
F17.210 - Nicotine dependence, cigarettes, uncomplicated

Current Account Balance: 0.00

Hospital Charges

Date	Rev Code	Procedure Code	Description	Qty	Amount
10/09/19	0250	63700001	IBUPROFEN 800 MG TAB	1	6.00
10/09/19	0450	45000003	HB ER VISIT INTERMEDIATE	1	1,720.09
Total hospital charges:					1,726.09

Hospital Payments and Adjustments

Date	Description	Amount
10/23/19	Wellcare of SC Medicaid Payments	-165.17
10/23/19	Wellcare of SC Medicaid Adjustments	-1,660.92
Total hospital payments and adjustments:		-1,726.09

For inquiries regarding this document, please call 1-843-792-2311.



CAROLINA RADIOLOGY ASSOCIATES, LLC
 1303 AZALEA COURT
 SUITE C
 MYRTLE BEACH, SC 29577-5765
 Phone: (866)264-3435
 Fax: (843)497-9566
 Tax ID:

Patient: 1292234 - JONES, ALEXIS

Date Created: Sunday, October 13, 2019 6:55 PM

DATE	REF	DOCTOR	DOCTOR	PROCEDURE	CHARGES	PAYMENTS	ADJUSTMENTS	BALANCE	PAYSOURCE	INS PLAN
10/09/2019	LANE, KRYSTAL	DEGN, CHRISTOP	74177 - CT, ABD A		\$550.00					
					\$550.00	\$0.00	\$0.00	\$550.00		
10/09/2019	LANE, KRYSTAL	DEGN, CHRISTOP	G9637 - FINAL REP		\$0.00					
10/11/2019	23569653		Adjustment			\$0.00	\$0.00		WELLCARE S CA	80420
					\$0.00	\$0.00	\$0.00	\$0.00		
Account Total:					\$550.00	\$0.00	\$0.00	\$550.00		

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APPENDIX - 00188

PNIC000084

Page 1 of 1



Please make check for \$439.97 payable to
Equian
 PO Box 32100
 Louisville, KY 40232
 TaxID - 27-0083277
 Please include patient's name and file number on check
ALEXIS JONES - 46361740
 Attn: Michael Zyrowski

Patient's Name: ALEXIS JONES

Equian #: 46361740

Provider of Service	Diagnosis Code	Claim Number
Date of Service	Procedure Code(s)	Charged
		Paid
	S3991XA UNSPECIFIED INJURY OF ABDOMEN, INITIAL ENCOUNTER	994123748
10/09/2019	74177 CT ABDOMEN&PELVIS W/CONTRAST	\$550.00
		\$70.14
	S0990XA UNSPECIFIED INJURY OF HEAD, INITIAL ENCOUNTER	996751822
10/06/2019	99284 EMERGENCY DEPT VISIT	\$883.63
		\$89.14
MUSC LANCASTER MEDICAL CENTER	S161XXA STRAIN OF MUSCLE, FASCIA AND TENDON AT NECK LEVEL, INIT	996268564
10/09/2019	SYSERLV2	\$0.00
		\$165.11
	R51 HEADACHE	998119609
10/08/2019	307 LABORATORY	\$610.90
10/08/2019	306 LABORATORY	\$719.54
10/08/2019	SYSERLV1	\$0.00
10/08/2019	307 LABORATORY	\$283.84
		\$422.22

Equian #: 46361740

Totals:

Charged	Paid	Amount Received	Balance Due
\$3,047.91	\$439.97	\$0.00	\$439.97

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 COMMON PLEAS - CASE#2020CP1200207

1/14/2020

Received Date: 01/14/2020

26555 Evergreen Rd. Suite 200, Southfield MI 48076
 Toll Free (800) 449-4200 - Phone (248) 443-4800 - Fax (248) 443-4804

188

APPENDIX - 00189



1

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

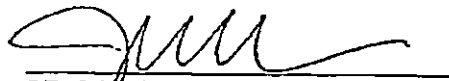
Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

CERTIFICATE OF COUNSEL

The undersigned certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.



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Attorneys for Appellant-Respondent

Columbia, South Carolina
November 8, 2023

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Nov 08 2023

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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MAY 16 2025

S.C. SUPREME COURT

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones Respondent – Appellant.

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

PROOF OF SERVICE

I certify that I have served the Record on Appeal on Alexis Jones by depositing a copy of it in the United States Mail, postage prepaid, on November 8, 2023, addressed to her attorneys of record, J. Logan Cannon, Esquire, P.O. Drawer 36250, Rock Hill, South Carolina 29732 and by electronic mail at cannon@shawlawfirm.net and John S. Nichols, Esquire, Bluestein Thompson Sullivan, LLC, PO Box 7965, Columbia, SC 29202, and by electronic mail at john@bluesteinattorneys.com.



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Attorneys for Appellant-Respondent

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Nov 29 2023

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

APPELLANT BRIEF OF APPELLANT-RESPONDENT

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TABLE OF CONTENTS

Table of Authorities	ii
Statement of Issue on Appeal	1
Statement of the Case.....	1
Factual and Procedural Background	1
A. The Progressive Policy.	1
B. The October 8, 2019 Accident and Jones Resulting Medical Payments Claim.	2
C. Motions and Circuit Court Orders.	3
Standard of Review.....	4
Argument	5
I. With respect to the breach of contract claim, the Circuit Court's Orders were in degradation of prior South Carolina Supreme Court precedent and should be reversed.....	5
II. With respect to the breach of contract claim, the Circuit Court's Orders should be reversed because its findings are inconsistent with the way Medicaid works.....	7
Conclusion	10

TABLE OF AUTHORITIES

Page Number

CASES

<i>Barker v. Washington Nat. Ins. Co.</i> , No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013)	8-10
<i>Clardy v. Bodolosky</i> , 383 S.C. 418, 679 S.E.2d 527 (Ct. App. 2009)	4
<i>Electro-Lab of Aiken, Inc. v. Sharp Constr. Co. of Sumter</i> , 357 S.C. 363, 593 S.E.2d 170 (Ct. App. 2004)	4-5
<i>Evans v. Liberty Nat. Life Ins. Co.</i> , No. 13-CV-0390-CVE-PJC, 2015 WL 1650192 (N.D. Okla. Apr. 14, 2015)	10
<i>Fesmire v. Digh</i> , 385 S.C. 296, 683 S.E.2d 803 (Ct. App. 2009)	4
<i>Gordon v. Fidelity & Cas. Co. of N. Y.</i> , 238 S.C. 438, 120 S.E.2d 509 (1961)	6-7
<i>Grimes v. Gov't Employees Ins. Co.</i> , No. 1:18-CV-798, 2019 WL 3425227 (M.D.N.C. July 30, 2019)	10
<i>Kay v. State Farm Mut. Auto. Ins. Co.</i> , 349 S.C. 446, 562 S.E.2d 676 (Ct. App. 2002)	6
<i>Metz v. U.S. Life Ins. Co.</i> , No. 09 Civ. 10250(BSJ), 2010 WL 3703810 (S.D.N.Y. Sept.21, 2010)	9
<i>Metz v. U.S. Life Ins. Co.</i> , 662 F.3d 600 (2d Cir. 2011)	9-10
<i>South Carolina Ins. Co. v. White</i> , 301 S.C. 133, 390 S.E.2d 471 (Ct. App. 1990)	5-6
<i>State Farm Mut. Auto. Ins. Co. v. Bowers</i> , 500 S.E.2d 212 (Va. 1998)	10
<i>State Farm Mut. Auto. Ins. Co. v. Richardson</i> , 313 S.C. 58, 437 S.E.2d 43 (1993)	6
<i>Steeger v. Otto Zollinger, Inc.</i> , 287 S.C. 207, 336 S.E.2d 870 (1985)	5
<i>Woodrich v. Farmers Ins. Co.</i> , 405 F.Supp.2d 1276 (N.D. Okla. 2004)	10

STATUTES

South Carolina Code Ann. § 38-77-144	6

42 U.S.C. § 1395.....	8
42 C.F.R. § 447.15.....	9

STATEMENT OF ISSUE ON APPEAL

- I. **Whether the Circuit Court should have found in favor of Progressive on Jones' breach of contract cause of action because Jones, a Medicaid recipient, only incurred medical expenses at the Medicaid-adjusted rates and Progressive paid all such expenses.**

STATEMENT OF THE CASE

This action arises out of Progressive's payment of Alexis Jones' Medical Payments claim for an October 8, 2019 auto accident. Jones submitted her Medical Payments claim under a personal auto policy issued to Willie Brown under which Jones is listed as a driver and resident relative. The policy includes a \$10,000 Medical Payments coverage limit for certain medical "expenses incurred" by an insured as a result of an accident. Jones is a Medicaid recipient. In South Carolina, Medicaid has agreements in place with medical service providers wherein the providers have agreed to accept reduced rates as payment-in-full prior to treating Medicaid recipients. Progressive based payment of Jones' Medical Payments claim on the Medicaid-adjusted rates actually charged by the medical providers and paid by Medicaid, rather than total charges listed on the medical providers' initial bills. In her Complaint, Plaintiff bases her various causes of action on Progressive's payment of the Medicaid-adjusted provider rates rather than the providers' "sticker price." Because the policy only provides Medical Payments coverage for certain medical "expenses incurred" by Jones and Jones did not incur expenses beyond the Medicaid-adjusted rates, Progressive paid her Medical Payments coverage for the Medicaid-adjusted rates.

FACTUAL AND PROCEDURAL BACKGROUND

A. The Progressive Policy

Progressive issued a personal auto policy, Policy No. 930693102, to Willie Brown with effective dates of June 21, 2019 to December 21, 2019 (the "Policy"). (R. p. 53). The Policy includes a Medical Payments coverage limit of \$10,000 each person. (R. p. 54). The Policy only provides

Medical Payments coverage for certain medical expenses actually incurred by an insured person. The Policy provides in pertinent part:

PART II – MEDICAL PAYMENTS COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary **medical services** received within three years from the date of a **motor vehicle** accident because of **bodily injury**:

1. Sustained by an **insured person**; and
2. Caused by that **motor vehicle** accident.

(R. p. 66). Thus, the Policy only provides Medical Payments coverage for certain “expenses incurred for necessary medical services.”

B. The October 8, 2019 Accident and Jones’ Resulting Medical Payments Claim

On October 8, 2019, Jones was involved in an auto accident. (R. p. 22 ¶ 11). Jones made a claim for Medical Payments coverage under the Progressive Policy. (R. p. 23 ¶ 13). With her claim, Jones submitted medical provider billing statements in excess of \$10,000. (R. pp. 22-23 ¶¶ 12-13). However, Jones is a Medicaid recipient. (R. pp. 5, 138 ¶ 4). Medicaid had agreements in place with medical service providers wherein the providers agreed to accept reduced rates as payment-in-full when treating Medicaid recipients. (Stipulation of Fact, R. pp. 138-140); (February 10, 2021 Circuit Court Order, R. p. 5). Medicaid paid \$1,323.60 total for the medical treatment Jones received, and the medical providers accepted this amount as payment-in-full for the treatment rendered. *See* (April 6, 2023 Circuit Court Order, R. p. 14). Progressive paid Medical Payments coverage to Jones in the amount of \$1,323.60 – the same amount her medical providers accepted as payment in full for the treatment rendered. (*Id.*). Jones “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....” (Stipulation of Fact, R. p. 140 ¶ 17). At the bench trial, Jones testified as follows:

Q. Ms. Jones, as I understand it, Medicaid paid the hospital bill at MUSC and all the other doctors you went to from the accident on your behalf?

A. Yes.

Q. You've paid no money yourself?

A. No.

Q. Is that correct?

A. Correct.

Q. And you're not legally obligated to pay any money to any of those by virtue of you being a Medicaid beneficiary. The hospital and doctors that you saw have agreed to accept what Medicaid paid them for a payment in full?

A. Yes.

Q. And you had no deductibles, out-of-pockets, nothing. Everything that you owed the doctors have been paid for by Medicaid?

A. Yes.

(R. p. 123, lines 4-24).

Despite the foregoing, Jones alleges she is owed the full \$10,000 Medical Payments coverage limit and that Progressive still owes her "\$8,676.40 in outstanding Medpay coverage." (Compl., R. pp. 23, 29-30 ¶¶ 14, 16, 25, Wherefore B.). Jones' Complaint asserted the following causes of action related to her Medical Payments coverage claim: (1) bad faith; (2) breach of contract; (3) breach of fiduciary duty; (4) breach of the covenant of good faith and fair dealing; (5) breach of contract accompanied by a fraudulent act; (6) violation of the South Carolina Unfair Trade Practice Act; and (7) violation of South Carolina Code § 38-77-144. (Compl., R. pp. 21-31).

C. Motions and Circuit Court Orders¹

On May 11, 2020, Progressive filed a Motion to Dismiss the Complaint and a Memorandum of Law in support. (R. pp. 38-52). On August 10, 2020, the Circuit Court entered an Order granting the Motion in part and dismissing Jones' South Carolina Unfair Trade Practices Act claim (R. pp. 2-4). On August 20, 2020, Progressive filed a Motion to Reconsider the August

¹ When the case was originally filed, Willie Brown was a plaintiff. On September 3, 2020, the parties filed a Stipulation wherein it was acknowledged that he is not a real party in interest, and he was dismissed from the case.

10, 2020 Order. (R. pp. 107-08). On February 10, 2021, the Circuit Court entered an Order granting the Motion to Reconsider in part and denying it in part. (R. pp. 5-9). In this Order, the Circuit Court dismissed all the causes of action except for the breach of contract cause of action. The Order states:

[T]he Court finds that based on the allegations of the Complaint, and the legal positions of the parties, that 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. Therefore, those causes of action in the Plaintiff's Complaint, are hereby dismissed.

(R. p. 7). The Order recognized that Progressive had submitted legal authority that the phrase "expenses incurred" meant the amount of money which an insured is legally obligated to pay for medical treatment and that South Carolina law allows an insurer to litigate a novel issue of law without fear of a bad faith or extra contractual claim. (R. p. 6). The Order also dismissed Jones' "violation of South Carolina Code § 38-77-144" claim because the statute does not create a private cause of action. (R. p. 7).

The Circuit Court then held a bench trial on the only remaining cause of action for breach of contract. By Orders filed March 29, 2023 and April 6, 2023, the Circuit Court found for Jones on her breach of contract cause of action, awarding her \$8,676.40. (R. pp. 10-19). The Circuit Court found the term "incurred" to be ambiguous. (R. p. 16). The Orders denied Jones' request for attorney's fees. (R. p. 17). Progressive's appeal and Jones' cross-appeal followed.

STANDARD OF REVIEW

"This Court reviews all questions of law de novo." *Fesmire v. Digh*, 385 S.C. 296, 302, 683 S.E.2d 803, 807 (Ct. App. 2009); *see also Clardy v. Bodolosky*, 383 S.C. 418, 425, 679 S.E.2d 527, 530 (Ct. App. 2009) ("Questions of law may be decided with no particular deference to the trial court."). "An action for breach of contract is an action at law." *Electro-Lab of Aiken, Inc. v.*

Sharp Constr. Co. of Sumter, 357 S.C. 363, 367, 593 S.E.2d 170, 172 (Ct. App. 2004). “[I]n order for this Court to affirm the circuit court's judgment, there must be evidence which reasonably supports the judge's findings.” *Steege v. Otto Zollinger, Inc.*, 287 S.C. 207, 208, 336 S.E.2d 870, 871 (1985).

ARGUMENT

The Complaint asserted a breach of contract claim premised on Progressive's payment of Jones' medical payments claim at the Medicaid-adjusted provider rates. Jones is a Medicaid recipient. Jones' providers agreed prior to her treatment to accept such amounts as payment in full. Because the Progressive Policy only provides Medical Payments coverage for “expenses incurred,” such claim should have been dismissed. Under both federal and state Medicaid provisions, Jones never incurred expenses beyond her medical providers' Medicaid-adjusted rates.

I. With respect to the breach of contract claim, the Circuit Courts' Orders were in degradation of prior South Carolina Supreme Court precedent and should be reversed.

The Circuit Court should have denied Jones' breach of contract claim because there was no breach of the insurance contract. Jones premised such claim on Progressive paying the reduced rates Medicaid previously negotiated with Jones' medical providers rather than the “sticker prices” on the providers' initial bills. (Tr. Transcript, R. pp. 113-15). The insurance contract only provides medical expenses coverage for “expenses incurred.” According to prior South Carolina Supreme Court precedent, for something to qualify as an “expense incurred,” there must be an obligation to pay it. Because Jones is a Medicaid beneficiary, neither Jones nor Medicaid ever had an obligation to pay these “sticker prices.” Consequently, these “sticker prices” were not “expenses incurred,” and Progressive did not breach the insurance contract by refusing to pay them.

An insurer's obligation under an insurance policy is defined by the terms of the policy and cannot be enlarged by judicial construction. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137,

390 S.E.2d 471, 474 (Ct. App. 1990). “[I]f the intention of the parties is clear, courts have no authority to torture the meaning of policy language to extend or defeat coverage that was never intended by the parties.” *Kay v. State Farm Mut. Auto. Ins. Co.*, 349 S.C. 446, 450, 562 S.E.2d 676, 679 (Ct. App. 2002).² The Policy provides Medical Payments coverage for certain “reasonable expenses incurred for necessary medical services.” (Policy, R. p. 66) (emphasis added). Under the South Carolina Supreme Court’s prior precedent, Jones did not incur expenses beyond the Medicaid-adjusted rates. Therefore, as to the breach of contract claim, the Circuit Courts Orders should be reversed.

In a similar Supreme Court case, *Gordon v. Fidelity & Cas. Co. of N. Y.*, the insured had an insurance policy that included medical expense coverage under which the insurer “agreed ‘to pay all reasonable expense incurred’ for necessary medical and surgical service.” 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961). The Court held the insurer was not required to provide any medical expense coverage to the insured because the insured did not incur any expenses for medical treatment. *Id.* at 446, 120 S.E.2d at 513. The insured was a soldier and received free medical treatment at an army hospital for injuries he sustained in a motor vehicle accident. *Id.* at 441, 120 S.E.2d at 510. Thus, the insured incurred no expense for his treatment. As the Court explained:

[T]he [insured] incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the [insurer] was not liable to the [insured] for the reasonable cost of his hospitalization, because the [insurer] had limited its liability to pay only ‘all reasonable expenses incurred’ by the [insured]. There being no obligation on the part of the [insured] to pay for the hospitalization he received at Fort Jackson hospital, he ‘incurred’ no expense within the meaning of the provision of the policy of insurance issued by the [insurer].

² Under South Carolina law, there is no statutorily mandated medical payments/personal injury protection coverage. S.C. Code § 38-77-144; *State Farm Mut. Auto. Ins. Co. v. Richardson*, 313 S.C. 58, 60, 437 S.E.2d 43, 45 (1993).

Id. at 446, 120 S.E.2d at 513. Likewise, when Medicaid negotiates with medical providers for reduced rates for medical services, the insured incurs no expense above the reduced rates negotiated with the providers, and the insurer has no duty to pay amounts the insured did not actually incur.

Unlike the Circuit Court here, the South Carolina Supreme Court in *Gordon* did not find the phrase “expenses incurred” to be ambiguous. *See* (April 6, 2023 Circuit Court Order, R. p. 16 (finding term “incurred” to be ambiguous)). The South Carolina Supreme Court clearly articulated that “expenses incurred” means there is an obligation on the part of the insured to pay that amount for the medical treatment or service received. *Id.* at 446, 120 S.E.2d at 513. It further explained that “a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an ‘expense incurred’.” *Id.* at 445, 120 S.E.2d at 512. Prior to the bench trial in this case, the parties stipulated that beyond the Medicaid-adjusted rates “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.” (Stipulation of Fact, R. p. 140 ¶ 17) (emphasis added). Thus, under South Carolina law, Jones has not incurred any medical expenses beyond those charged at the Medicaid-adjusted rates, which Progressive has already paid. Consequently, Progressive’s act of paying Medical Payments coverage based on the Medicaid-adjusted rates is not a breach of the Progressive insurance contract. Such conduct is consistent with the policy terms and South Carolina law. Therefore, the Circuit Court erred by finding for Jones on her breach of contract claim.

II. With respect to the breach of contract claim, the Circuit Courts’ Orders should be reversed because its findings are inconsistent with the way Medicaid works.

Jones argued and the Circuit Court found that “Plaintiff incurred the full cost of her medical treatment at the time services was rendered as she became obligated for that amount irrespective of

Medicaid.” (April 6, 2023 Circuit Court Order, R. pp. 16-17). This finding completely ignores and is inconsistent with the way Medicaid works. As shown below, Medicaid already has agreements in place with Medicaid providers before a Medicaid recipient ever receives any treatment. Under these agreements, the provider cannot bill, demand or receive more than the Medicaid-adjusted rate. Therefore, the patient does not incur medical expenses beyond these Medicaid-adjusted rates. Consequently, Jones’ breach of contract claim should have been denied because there was no breach under the policy terms and South Carolina law.

In a factually similar case, *Barker v. Washington Nat Ins. Co.*, the insured had a policy that provided coverage for “the expenses incurred” for certain medical services and materials. No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013). The insured was a Medicare beneficiary, and the insurer adjusted his claim “by paying benefits based only on the debt [the insured] owed to the medical provider.” *Id.* at *2. The insured brought a breach of contract claim and bad faith claim against the insurer arguing that the insurer was obligated to pay him the “total charges” on the medical bills “prior to any reductions resulting from any prior agreement between Medicare and the hospital.” *Id.* at *4. The insured argued that the insurer’s “use of Medicare adjustments was improper.” *Id.* at *2. The Court rejected the insured’s arguments and explained:

As a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital’s bill, i.e., \$55,241. Under 42 U.S.C. § 1395cc(a)(1)(A), a provider of services can participate in Medicare only if the provider files an agreement with the Secretary of Health and Human Services. Pursuant to this agreement, the participant accepts “assignment” of the Medicare payment, meaning that the provider must accept the Medicare approved charge as the full charge for the covered service and “shall not collect from the beneficiary ... more than the applicable deductible and coinsurance.” Medicare Participating Physician or Supplier Agreement, Form CMS-460 (04/10), available at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS-007566.html>; see Costs & Assignment, Medicare.gov, <http://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html> (last visited Apr. 24, 2013) (explaining that, under Medicare Part A, “Assignment means that your ... provider ... agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services” and can “charge

you only the Medicare deductible and coinsurance amount"). The Southern District of New York recently addressed the issue of whether a Medicare recipient can "incur" the full fee a medical provider lists on its bill prior to applying the agreed-upon Medicare reductions, concluding that "[w]here Medicare contracts with a medical provider to set fees for a given service, the Medicare beneficiary is never liable for the amount forgone by a doctor under that agreement." *Metz v. U.S. Life Ins. Co.*, No. 09 Civ. 10250(BSJ), 2010 WL 3703810, at *3 (S.D.N.Y. Sept. 21, 2010). The court further explained:

A doctor who accepts Medicare assignment has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. [He] agree[s] to ... charge [the beneficiary only] the Medicare deductible and coinsurance amount and wait for Medicare to pay its share. Given this agreement, it is essentially impossible that Plaintiff would ever face liability for a provider's hypothetical full fee.

Id. (internal quotations and citations omitted). The Second Circuit Court of Appeals affirmed, concluding that under New York law, the Medicare recipient "did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her." *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir. 2011). Similarly, **this Court concludes that under South Carolina law, Barker was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare**, which amount appears to be about \$15,929.29.

Id. at *5-6 (emphasis added). As a result, the Court granted the insurer summary judgment on the insured's breach of contract (and bad faith) claim. *Id.* at *9.

Medicaid works the same way as Medicare. A Medicaid provider is also required to accept the Medicaid payment as "payment in full." 42 C.F.R. § 447.15 (requiring state Medicaid agency to "limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayments required by the plan to be paid by the individual"). Jones stipulated that she "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...." (Stipulation of Fact, R. p. 140 ¶ 17). Pursuant to the South Carolina Medicaid provider agreement, the provider agrees before rendering treatment "that Medicaid reimbursement is

payment in full...for care or services to a recipient/patient” and “that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient....” Medicaid Participation and Payment Agreement, Form (07/17), available at <https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf>.

Therefore, like in the *Barker* case, Jones never “incurred” expenses for medical services beyond the Medicaid-adjusted rates. See *State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va. 1998) (holding insured did not “incur” expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers).³ Consequently, Jones’ breach of contract claim, which is based on this conduct, should have been dismissed. See *Grimes v. Gov’t Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019) (dismissing breach of contract claim based on the same theory alleged in Jones’ Complaint).

CONCLUSION

For the above-stated reasons, the Circuit Court’s ruling in favor of Jones on the breach of contract claim should be reversed. The policy only requires Progressive to pay for certain medical “expenses incurred” by the insured. The South Carolina Supreme Court has previously found the phrase “expenses incurred” to not be ambiguous and defined that phrase as requiring an obligation

³ See also *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015) (stating “[a] number of courts in other jurisdictions have found ‘expenses incurred’ to mean the amount actually paid, as opposed to the amount charged by the care provider” and holding “expenses incurred” meant amount insured actually paid to satisfy medical providers after “other insurance coverage...negotiated a lower rate of payment”); *Metz*, 662 F.3d at 602 (holding “incurred” for insurance coverage meant reduced rates negotiated by Medicare because insured “did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her”); *Woodrich v. Farmers Ins. Co.*, 405 F.Supp.2d 1276, 1279 (N.D. Okla. 2004).

on the part of the insured to pay such expense. Jones is a Medicaid recipient. Medicaid has agreements in place with its providers to accept certain rates as payment in full for treatment rendered. As a result, Jones never became obligated to pay any medical expenses beyond the Medicaid-adjusted rates, which Progressive has already paid. Therefore, Progressive did not breach the insurance contract by paying her claim at the Medicaid-adjusted rates.

Respectfully submitted,

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Nov 29 2023

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

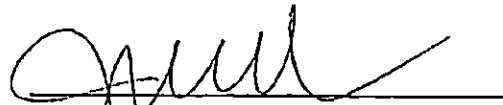
Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

CERTIFICATE OF COMPLIANCE

I, J.R. Murphy, attorney for Appellant-Respondent, certify that the Final Appellant Brief of Progressive Northern Insurance Company complies with the South Carolina Supreme Court Order of August 13, 2007 and Rule 211(b), SCACR.



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In the Court of Appeals

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SC Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

PROOF OF SERVICE

I certify that I have served the Final Appellant Brief of Appellant-Respondent on Alexis Jones by depositing a copy of it in the United States Mail, postage prepaid, on November 29, 2023, addressed to her attorneys of record, J. Logan Cannon, Esquire, P.O. Drawer 36250, Rock Hill, South Carolina 29732 and by electronic mail at cannon@shawlawfirm.net and John S. Nichols, Esquire, Bluestein Thompson Sullivan, LLC, PO Box 7965, Columbia, SC 29202, and by electronic mail at john@bluesteinattorneys.com.



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Nov 28 2023

SC Court of Appeals

**THE STATE OF SOUTH CAROLINA
In the Court of Appeals**

**Appeal from Chester County
Circuit Court**

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones, ...Respondent-Appellant,

v.

Progressive Northern Insurance Company,.....Appellant-Respondent.

**FINAL RESPONDENT'S BRIEF
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TABLE OF CONTENTS

Table of Contents	ii
Table of Authorities	iii
Statement of Issues on Appeal	1
Argument	1
Conclusion	7

TABLE OF AUTHORITIES

Cases

<i>Barker v. Wash. Nat'l. Ins. Co.</i> , No. 9:12-cv-1901-PMD, 2013 U.S. Dist. LEXIS 58437 (D.S.C. Apr. 24, 2013)	2
<i>Brandon HMA, Inc. v. Bradshaw</i> , 809 So. 2d 611 (Miss. 2001)	6
<i>Bynum v. Magno</i> , 106 Haw. 81, 101 P.3d 1149 (Haw. 2004)	6
<i>Cates v. Wilson</i> , 321 N.C. 1, 361 S.E.2d 734 (N.C. 1987)	6
<i>Covington v. George</i> , 359 S.C. 100, 597 S.E.2d 142 (2004)	4
<i>Ellis v. Oliver</i> , 335 S.C. 106, 515 S.E.2d 268 (Ct. App. 1999)	5
<i>Ellsworth v. Schelbrock</i> , 2000 WI 63, 235 Wis. 2d 678, 611 N.W.2d 764 (Wis. 2000)	6
<i>Gordon v. Fid. & Cas. Co.</i> , 238 S.C. 438, 120 S.E.2d 509 (1961)	1, 2
<i>Haselden v. Davis</i> , 353 S.C. 481, 579 S.E.2d 293 (2003)	1, 3, 4, 6
<i>Parker v. Spartanburg Sanitary Sewer Dist.</i> , 362 S.C. 276, 607 S.E.2d 711 (Ct. App. 2005)	4
<i>Pitts v. Glens Falls Indemnity Co.</i> , 222 S.C. 133, 72 S.E.2d 174 (1954)	3
<i>South Carolina Ins. Co. v. White</i> , 301 S.C. 133, 390 S.E.2d 471 (Ct. App. 1990)	3
<i>Wills v. Foster</i> , 372 Ill. App. 3d 670, 311 Ill. Dec. 237, 867 N.E.2d 1223 (Ill. App. 2007)	6

Statutes

S.C. Code Ann. § 38-77-144	4

STATEMENT OF ISSUES ON APPEAL

1. Whether the Circuit Court's ruling was legally sound and was supported to a reasonable degree by the evidence.

ARGUMENT

The Circuit Court correctly applied the law to the case at bar in determining Respondent's breach of contract claim could proceed against the Appellant because the Circuit Court correctly construed the term "incurred" in accordance with *Haselden* and its progeny. *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003).

First, the trial court properly distinguished the case at bar from the facts of *Gordon*. *Gordon v. Fid. & Cas. Co.*, 238 S.C. 438, 120 S.E.2d 509 (1961). In *Gordon*, the insured and the insurance carrier stipulated that "the plaintiff incurred no expense or made no cash outlay since he was a soldier and treated at the Fort Jackson hospital." *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. As a result, the *Gordon* court held:

Since the parties to this action stipulated that the respondent incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the appellant was not liable to the respondent for the reasonable cost of his hospitalization, because the appellant had limited its liability to pay only 'all reasonable expenses incurred' by the respondent.

Gordon, 238 S.C. at 446, 120 S.E.2d at 513. The trial court identified this distinction in its ruling, noting the medical providers did charge the Respondent "the full cost of her medical treatment at the time services was (sic) rendered as she became obligated for that amount irrespective of Medicaid." (R. p. 11). The court in *Gordon* highlighted numerous cases that illuminate this concept such as when a veteran is provided medical care through the Veterans'

Administration. *Gordon*, 238 S.C. at 445, 120 S.E.2d at 512. Looking to the federal statute, the court ruled the government "could not recover from [the] insurer, since, under statute, [the] veteran had incurred no liability" arising from their treatment. *Gordon*, 238 S.C. at 445-46, 120 S.E.2d at 512-13 (citing *United States v. St. Paul Mercury Indemnity Co.*, 8 Cir., 238 F.2d 594, 595 (8th Cir. 1956)). The court found this was an operative statute rendering the core element of the plaintiff's claim moot because the statute defined the veteran's medical care as incurring no obligation to the veteran. *Gordon*, 238 S.C. at 446, 120 S.E.2d at 513. Unlike in *Gordon*, there is no statute that renders the medical treatment free for the Respondent. (R. p. 11). The plaintiff did incur "the full amount charged at the time services were rendered and thus became entitled to the full amount of reimbursement coverage under the policy." (R. p. 11) (emphasis in original). The Circuit Court correctly applied the law and its order should be affirmed.

This is supported by the principles set forth in *Barker v. Wash. Nat'l. Ins. Co.*, where an insured sought the policy limits for expenses incurred when the insured was a Medicare recipient. No. 9:12-cv-1901-PMD, 2013 U.S. Dist. LEXIS 58437 (D.S.C. Apr. 24, 2013). Noting the statutory provision of 42 U.S.C. § 1395cc(a)(1)(A), the district court held "[a]s a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill." *Barker*, at *14. Unlike the plaintiff in *Barker*, Respondent was "charged for the services rendered at the time they were rendered," necessarily distinguishing the facts from *Gordon* and from *Barker*. (R. p. 11; R. pp. 138-140). Effectively, this is a collateral source case whereby Medicaid is used to reduce the insurance carrier's obligation to the insured Respondent.

In *Haselden*, the court considered whether it was appropriate to use the "amount paid by Medicaid (or similar programs) [a]s dispositive of the reasonable value of medical services." *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295. Considering the collateral source rule as a

limitation to overcompensating an injured plaintiff, the *Haselden* court ruled the "amount billed by [the doctor] was relevant to establish the reasonable value of the services provided" even though Medicaid ultimately paid less than what was billed. *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295. Furthermore, the argument raised by Appellant was resolved by the *Haselden* court regarding Medicaid when holding a plaintiff's recovery is not limited to damages in the amount actually paid by Medicaid. *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295.

From the outset, this case has been about interpretation to determine what financial obligation the insurance carrier can avoid because of third-party contribution. (R. p. 113, lines 6-25). As noted at trial, vague and ambiguous terms must be construed in favor of the insured. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137, 390 S.E.2d 471, 474 (Ct. App. 1990); *Pitts v. Glens Falls Indemnity Co.*, 222 S.C. 133, 72 S.E.2d 174 (1954). (R. p. 11). The core question posed to the trial court is whether South Carolina forbids an automobile insurance carrier from reducing their agreed-upon obligation to the insured when a third-party remits payment to the insured for the same expenses. Asserting a limiting definition of "incurred expenses" not found in the policy, Appellant only offered to satisfy the medical expenses after a third-party's payment had reduced them. (R. p. 11). The trial court correctly interpreted this as a setoff in violation of S.C. Code Ann. § 38-77-144. (R. p. 16).

"In *Haselden*, the question was whether the Plaintiff could recover the amounts 'written off' by healthcare providers. A majority of this Court held that those amounts are recoverable by a plaintiff in a personal injury suit." *Covington v. George*, 359 S.C. 100, 102, 597 S.E.2d 142, 143 (2004) (internal citations omitted). "While a defendant is permitted to attack the necessity and reasonableness of medical care and costs, he cannot do so using evidence of payments made by a collateral source." *Covington v. George*, 359 S.C. 100, 105, 597 S.E.2d 142, 145 (2004).

"*Covington*, however, specifically limited the holding in *Haselden*: 'The admissibility of the actual payment amount was not an appellate issue in *Haselden*, but rather the issue was Plaintiff's entitlement to *recover* the difference between the billed amount and the actual payment amount.'" *Parker v. Spartanburg Sanitary Sewer Dist.*, 362 S.C. 276, 288-89, 607 S.E.2d 711, 718 (Ct. App. 2005) (quoting *Covington v. George*, 359 S.C. at 103, 597 S.E.2d at 143-44) (emphasis in original).

Here, the collateral source rule is equally applicable as the Appellants are challenging the appropriateness of considering payments made by a third-party on behalf of an injured party. "We are cognizant that several courts hold that the amount paid by Medicaid (or similar programs) is dispositive of the reasonable value of medical services." *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295. This is not a matter of providing the Respondent a "windfall," as the dissent in *Haselden* urges, but a matter of correctly determining "the reasonable value of those medical services, not necessarily the amount paid." 353 S.C. at 484, 579 S.E.2d at 295 ("Clearly, the amount actually paid for medical services does not alone determine the reasonable value of those medical services. Nor does it limit the finder of fact in making such a determination.").

In *Cothran*, the Supreme Court determined an insurance carrier violated the setoff prohibition because the carrier reduced its payment by the remitted Workers' Compensation payment. *Cothran v. State Farm Mut. Auto. Ins. Co.*, 427 S.C. 545, 549, 831 S.E.2d 919, 921 (2019). Noting the lack of definition concerning a "setoff," the Supreme Court considered two definitions and defined a setoff when applying S.C. Code § 38-77-144. *Id.* 427 S.C. at 548-49, 831 S.E.2d at 920-21. The definition from *Cothran* is salient and succinct: a setoff arises when the insurer's obligation to the insured is reduced by the amount of a third-party's payment to the

insured, where the insurer's and the third-party's obligations to pay arose from the same transaction or subject matter. *Id.* 427 S.C. at 549, 831 S.E.2d at 921.

The Supreme Court further noted that the statute would apply when the insurance carrier's policy provisions have this effect. *Id.* 427 S.C. at 549, 831 S.E.2d at 921. The Supreme Court ruled the insurance policy was a first-party, primary, and no-fault policy with the Workers' Compensation payments being unable to limit the carrier's liability unless the policy provision had the effect of being a setoff. *Id.* 427 S.C. at 552-53, 831 S.E.2d at 923. The insurance carrier violated the statute because the effect of its policy provisions was to violate the legislative intent behind S.C. Code § 38-77-144. *Id.* 427 S.C. at 555, 831 S.E.2d at 924. The instruction in *Cothran* answers the case *sub judice* as the Medicaid provisions are neither primary nor does Medicaid achieve the same purpose as the insurance policy at issue here.

The *Cothran* court laid bare the mechanics of when insurance policy provisions have the effect of a setoff: an insurance carrier lessens the amount owed to the insured because of payments made by a third-party. *Id.* 427 S.C. at 549, 831 S.E.2d at 921. Appellant sought to reduce the amount owed under the policy "based on a third party's previous payment for the same claim." *Id.* 427 S.C. at 555, 831 S.E.2d at 924. Appellant cannot prevail because the third-party payor is Medicaid instead of Workers' Compensation as both remit obligated payments to the insured upon their claim for payment and serve similar purposes. *Id.* 427 S.C. at 548-49, 831 S.E.2d at 921. *See also, Ellis v. Oliver*, 335 S.C. 106, 109, 515 S.E.2d 268, 270 (Ct. App. 1999).

South Carolina, Mississippi, Wisconsin, North Carolina, and Hawaii, for example, have held that Medicaid payments *are* subject to the collateral-source rule. These courts have included gratuitous services in the rule's protection, reasoning that tortfeasors should be

liable for the *value* of medical services, rather than the cost. See *Haselden v. Davis*, 353 S.C. 481, 483, 579 S.E.2d 293, 294 (2003); *Brandon HMA, Inc. v. Bradshaw*, 809 So. 2d 611, 619 (Miss. 2001); *Ellsworth v. Schelbrock*, 2000 WI 63, 235 Wis. 2d 678, 685, 611 N.W.2d 764, 767 (2000); *Cates v. Wilson*, 321 N.C. 1, 6, 361 S.E.2d 734, 738 (1987); *Bynum v. Magno*, 106 Haw. 81, 88, 101 P.3d 1149, 1156 (2004)."

Wills v. Foster, 372 Ill. App. 3d 670, 675, 311 Ill. Dec. 237, 241, 867 N.E.2d 1223, 1227 (Ill. Ct. App. 2007) (emphasis in original). Determination of the reasonable value therefore requires defining "incurred expenses," a term not defined within the policy. *Haselden*, 353 S.C. at 485 n.4, 295. The evidence supports the trial court's ruling. The court's ruling is in accord with *Gordon* and *Haselden* by determining the amount incurred when the medical services were provided and limited by the explicit terms of the policy, which mandate a total obligation of no more than \$10,000.00 per person. (R. p. 17; R. p. 138; R. pp. 121-123).

Appellant urges a reading of *Gordon* inapposite to its holding by looking to the dissent in *Haselden* for the principle that a plaintiff has no "right to be reimbursed for money that will never be expended." 353 S.C. at 488, 579 S.E.2d at 297 (J. Pleicones, dissenting) (describing the majority opinion as obligating "doctors to bear the cost of reimbursing an injured party for a non-existent debt"). The stipulated facts of this case evidence medical bills being incurred following Respondent's medical treatment. (R. p. 138). Determination of the reasonableness of those fees is a question of fact for the trial court. *Haselden*, 353 S.C. at 484, 579 S.E.2d at 295. The trial court did not err in its determination and the ruling should be affirmed.

CONCLUSION

The policy issued by Progressive obligated the insurance carrier to the maximum extent of \$10,000.00 for "expenses incurred" by the insured and only after the insured's loss did Progressive seek to reframe the policy in its own interests. The trial court appropriately considered the South Carolina Supreme Court's holding that incurred expenses are not limited to the amount actually paid by Medicaid.

For the reasons stated, this Court should affirm the Circuit Court's rulings as they are correct under the law, appropriately applied to the facts, and substantially supported by the evidence.

Respectfully submitted,

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November 28, 2023

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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

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TABLE OF CONTENTS

Table of Authorities	ii
Summary	1
I. Because of the way Medicaid works, Jones never incurred medical expenses beyond the Medicaid-adjusted rates that her providers had agreed to accept as payment in full before rendering treatment	2
II. <i>Haselden</i> and its progeny answer the question of how the reasonable value of medical service is established – which is not the question at issue in this breach of contract case	7
III. Contrary to the red herring arguments in Jones’ Brief, there is no setoff or collateral source issue	9
Conclusion	13

TABLE OF AUTHORITIES

Page Number

CASES

<i>Bardsley v. Gov't Emps Ins. Co.</i> , 405 S.C. 68, 747 S.E.2d 436 (2013).....	12
<i>Barker v. Washington Nat. Ins Co.</i> , No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013).....	3-7
<i>Citizens & S. Nat'l Bank of S.C. v. Gregory</i> , 320 S.C. 90, 463 S.E.2d 317 (1995)	11
<i>Cothran v. State Farm Mut. Auto. Ins. Co.</i> , 427 S.C. 545, 550, 831 S.E.2d 919, 922 (2019).....	9-11
<i>Covington v. George</i> , 359 S.C. 100, 597 S.E.2d 142 (2004).....	12
<i>Dixon v. Besco Eng'g, Inc.</i> , 320 S.C. 174, 463 S.E.2d 636 (Cl. App. 1995)	12
<i>Estate of Rattenmi v. Grainger</i> , 298 S.C. 276, 379 S.E.2d 890 (1989).....	11
<i>Evans v. Liberty Nat. Life Ins. Co.</i> , No. 13-CV-0390-CVE-PJC, 2015 WL 1650192 (N.D. Okla. Apr. 14, 2015)	5
<i>Gordon v. Fidelity & Cas Co. of N. Y.</i> , 238 S.C. 438, 120 S.E.2d 509 (1961)	2-3, 5-7
<i>Grimes v. Gov't Employees Ins. Co.</i> , No. 1:18-CV-798, 2019 WL 3425227 (M.D.N.C. July 30, 2019)	5
<i>Haselden v. Davis</i> , 353 S.C. 481, 579 S.E.2d 293 (2003).....	7-9
<i>Metz v. U.S. Life Ins. Co.</i> , No. 09 Civ. 10250(BSJ), 2010 WL 3703810 (S D N.Y. Sept.21, 2010).....	4
<i>Metz v. U.S. Life Ins. Co.</i> , 662 F.3d 600 (2d Cir. 2011).....	4-5
<i>New Found. Baptist Church v. Davis</i> , 257 S.C. 443, 186 S.E.2d 247 (1972) ..	11
<i>State Farm Mut. Auto. Ins. Co. v. Bowers</i> , 500 S.E.2d 212 (Va. 1998).....	5
<i>Woodrich v Farmers Ins Co.</i> , 405 F.Supp.2d 1276 (N.D. Okla. 2004).....	5
<i>Young v. Warr</i> , 252 S.C. 179, 165 S.E.2d 797 (1969).....	11-12

STATUTES

South Carolina Code Ann. § 38-77-144	9-11
42 C.F.R. § 447.15.....	6

SUMMARY¹

This is a breach of contract action. The policy issued by Progressive Northern Insurance Company ("Progressive") limits its medical payments coverage to certain medical "expenses incurred" by an insured as a result of an accident. The sole question in this action is the amount of medical expenses Alexis Jones ("Jones") incurred as a result of an October 8, 2019 auto accident.

The answer is \$1,323.60 – the Medicaid-adjusted rates her providers agreed to accept as payment in full before rendering any treatment to her. According to well-established South Carolina Supreme Court precedent, an insured does not "incur" expenses within the meaning of a medical payments coverage provision unless she has an obligation to pay. Because of the way Medicaid works, Jones never became obligated to pay her medical providers for any other amount. Medicaid paid this amount to her providers as payment in full, and Progressive paid this amount to Jones. Thus, Progressive is entitled to judgment in its favor on Jones' breach of contract claim as there was no breach of the insurance contract.

Unable to answer the "expenses incurred" question in her favor, Jones' Brief instead focuses on the irrelevant question of the reasonable value of the medical services. Progressive's obligation is limited by contract to her medical "expenses incurred." Thus, this is the relevant question. Jones' Brief also makes red herring arguments about setoffs and the collateral source rule. As explained below, each of these arguments is also irrelevant and without merit in this breach of contract action.

¹ Jones' Brief did not include a "Statement of the Case." *See* (Jones Br.). Therefore, in accordance with Rule 208, Jones is bound by the matters stated and alleged in Progressive's statement of the case. Rule 208(b)(2). SCACR.

I. Because of the way Medicaid works, Jones never incurred medical expenses beyond the Medicaid-adjusted rates that her providers had agreed to accept as payment in full before rendering treatment.

According to longstanding South Carolina Supreme Court precedent, for something to qualify as an "expense incurred," there must be an obligation to pay it. Because Jones is a Medicaid beneficiary, neither Jones nor Medicaid ever had an obligation to pay her providers' "sticker prices." Consequently, these "sticker prices" were not "expenses incurred," and Progressive did not breach the insurance contract by paying the Medicaid-adjusted rates.

The Policy provides Medical Payments coverage for certain "reasonable expenses incurred for necessary medical services." (Policy, R. p. 66) (emphasis added). Under the South Carolina Supreme Court's prior precedent, Jones did not incur expenses beyond the Medicaid-adjusted rates. Therefore, as to the breach of contract claim, the Circuit Court's Orders should be reversed.

In a similar Supreme Court case, *Gordon v. Fidelity & Cas. Co. of N. Y.*, the insured had an insurance policy that included medical expense coverage under which the insurer "agreed 'to pay all reasonable expense incurred' for necessary medical and surgical service " 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961). The Court held the insurer was not required to provide any medical expense coverage to the insured because the insured did not incur any expenses for medical treatment. *Id.* at 446, 120 S.E.2d at 513. The insured was a soldier and received free medical treatment at an army hospital for injuries he sustained in a motor vehicle accident. *Id.* at 441, 120 S.E.2d at 510. Thus, the insured incurred no expense for his treatment. As the Court explained:

[T]he [insured] incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the [insurer] was not liable to the [insured] for the reasonable cost of his hospitalization, because the [insurer] had limited its liability to pay only 'all reasonable expenses incurred' by the [insured]. There being no obligation on the part of the [insured] to pay for the hospitalization he received at Fort

Jackson hospital, he 'incurred' no expense within the meaning of the provision of the policy of insurance issued by the [insurer].

Id. at 446, 120 S.E.2d at 513. Likewise, when Medicaid negotiates with medical providers for reduced rates for medical services, the insured incurs no expense above the reduced rates negotiated with the providers, and the insurer has no duty to pay amounts the insured did not actually incur.

The South Carolina Supreme Court clearly articulated that "expenses incurred" means there is an obligation on the part of the insured to pay that amount for the medical treatment or service received. *Id.* at 446, 120 S.E.2d at 513. It further explained that "a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'." *Id.* at 445, 120 S.E.2d at 512 (emphasis added). Prior to the bench trial in this case, the parties stipulated that beyond the Medicaid-adjusted rates "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." (Stipulation of Fact, R. p. 140 ¶ 17) (emphasis added). Thus, under established South Carolina law, Jones has not incurred any medical expenses beyond those charged at the Medicaid-adjusted rates, which Progressive has already paid. Consequently, Progressive's act of paying Medical Payments coverage based on the Medicaid-adjusted rates is not a breach of the Progressive insurance policy. Such conduct is consistent with the policy terms and South Carolina law.

In another factually similar case, *Barker v. Washington Nat. Ins. Co.*, the insured had a policy that provided coverage for "the expenses incurred" for certain medical services and materials. No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013). The insured was a Medicare beneficiary, and the insurer adjusted his claim "by paying benefits based only on the debt [the insured] owed to the medical provider." *Id.* at *2. The insured brought a breach of contract claim and bad faith

claim against the insurer, arguing that the insurer was obligated to pay him the "total charges" on the medical bills "prior to any reductions resulting from any prior agreement between Medicare and the hospital." *Id.* at *4. The insured argued (as Jones does here) that the insurer's "use of Medicare adjustments was improper." *Id.* at *2. The Court rejected the insured's arguments and explained:

As a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill, i.e., \$55,241. Under 42 U.S.C. § 1395cc(a)(1)(A), a provider of services can participate in Medicare only if the provider files an agreement with the Secretary of Health and Human Services. Pursuant to this agreement, the participant accepts "assignment" of the Medicare payment, meaning that the provider must accept the Medicare approved charge as the full charge for the covered service and "shall not collect from the beneficiary ... more than the applicable deductible and coinsurance." Medicare Participating Physician or Supplier Agreement, Form CMS-460 (04/10), available at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS-007566.html>; see Costs & Assignment, Medicare.gov, <http://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html> (last visited Apr. 24, 2013) (explaining that, under Medicare Part A, "Assignment means that your ... provider ... agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services" and can "charge you only the Medicare deductible and coinsurance amount"). The Southern District of New York recently addressed the issue of whether a Medicare recipient can "incur" the full fee a medical provider lists on its bill prior to applying the agreed-upon Medicare reductions, concluding that "[w]here Medicare contracts with a medical provider to set fees for a given service, the Medicare beneficiary is never liable for the amount forgone by a doctor under that agreement." *Metz v. U.S. Life Ins. Co.*, No. 09 Civ. 10250(BSJ), 2010 WL 3703810, at *3 (S.D.N.Y. Sept. 21, 2010). The court further explained:

A doctor who accepts Medicare assignment has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. [He] agree[s] to ... charge [the beneficiary only] the Medicare deductible and coinsurance amount and wait for Medicare to pay its share. Given this agreement, it is essentially impossible that Plaintiff would ever face liability for a provider's hypothetical full fee.

Id. (internal quotations and citations omitted). The Second Circuit Court of Appeals affirmed, concluding that under New York law, the Medicare recipient "did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her." *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir. 2011). Similarly, **this Court concludes that under South Carolina law, Barker was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare, which amount appears to be about \$15,929.29.**

Id. at *5-6 (emphasis added). As a result, the Court granted the insurer summary judgment on the insured's breach of contract (and bad faith) claim. *Id.* at *9.

As explained below, Medicaid works the same way as Medicare. Therefore, like in the *Barker* case, Jones never "incurred" expenses for medical services beyond the Medicaid-adjusted rates. See *State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va. 1998) (holding insured did not "incur" expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers).² Consequently, Jones' breach of contract claim should have been dismissed. See *Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019) (dismissing breach of contract claim based on the same theory alleged in Jones' Complaint).

In her Brief, Jones attempts to distinguish *Gordon* and *Barker* by repeatedly pointing to an erroneous finding made by the Circuit Court. See (Jones' Br., pp. 1-2). The Circuit Court found that "Plaintiff incurred the full cost of her medical treatment at the time services was rendered as she became obligated for that amount irrespective of Medicaid." (April 6, 2023 Circuit Court Order, R. pp. 16-17). This finding is incorrect. To reach this finding, the Circuit Court had to first make two erroneous legal conclusions. First, the Circuit Court had to determine that "incurred" within the Progressive policy means the "sticker price" regardless of whether the insured is actually obligated to pay that amount. This legal conclusion is inconsistent with the *Gordon* Supreme Court case, which

² See also *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015) (stating "[a] number of courts in other jurisdictions have found 'expenses incurred' to mean the amount actually paid, as opposed to the amount charged by the care provider" and holding "expenses incurred" meant amount insured actually paid to satisfy medical providers after "other insurance coverage...negotiated a lower rate of payment"); *Metz*, 662 F.3d at 602 (holding "incurred" for insurance coverage meant reduced rates negotiated by Medicare because insured "did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her"); *Woodrich v. Farmers Ins. Co.*, 405 F.Supp.2d 1276, 1279 (N.D. Okla. 2004).

held – in this context – that “incurred” means an “obligation on the part of the [insured] to pay.” 238 S.C. at 446, 120 S.E.2d at 513. Additionally, the Circuit Court had to determine that the providers’ “sticker prices” are the amounts a Medicaid beneficiary becomes legally obligated to pay, even if the Medicaid-adjusted rates are less. As explained in *Barker*, this legal conclusion is inconsistent with the way Medicare/Medicaid works. Medicaid already has agreements in place with Medicaid providers before a Medicaid recipient ever receives any treatment. Pursuant to the South Carolina Medicaid provider agreement, the provider agrees before rendering treatment “that Medicaid reimbursement is payment in full...for care or services to a recipient/patient” and “that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient...” Medicaid Participation and Payment Agreement, Form (07/17), available at <https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf> (emphasis added). Pursuant to the Code of Federal Regulations, a Medicaid provider is required to accept these previously-agreed-to amounts as “payment in full.” 42 C.F.R. § 447.15 (requiring state Medicaid agency to “limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayments required by the plan to be paid by the individual”).

To the extent this conclusion constitutes a factual finding, it should still be overturned. There is no evidence to support the Circuit Court’s finding that Jones became obligated to pay the “sticker prices” on her providers’ initial bills. At the bench trial, Jones testified as follows:

- Q. Ms. Jones, as I understand it, Medicaid paid the hospital bill at MUSC and all the other doctors you went to from the accident on your behalf?
- A. Yes.
- Q. You’ve paid no money yourself?
- A. No.
- Q. Is that correct?
- A. Correct.

Q. And you're not legally obligated to pay any money to any of those by virtue of you being a Medicaid beneficiary. The hospital and doctors that you saw have agreed to accept what Medicaid paid them for a payment in full?

A. Yes

Q. And you had no deductibles, out-of-pockets, nothing. Everything that you owed the doctors have been paid for by Medicaid?

A. Yes.

(R. p. 123, lines 4-24). Furthermore, before trial, Jones stipulated that she "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...." (Stipulation of Fact, R. p. 140 ¶ 17). Thus, Jones' purported distinction of the *Gordon* and *Barker* cases is without merit because it is premised on an erroneous finding by the Circuit Court. The *Gordon* case is controlling.

II. *Haselden* and its progeny answer the question of how the reasonable value of medical service is established – which is not the question at issue in this breach of contract case.

Jones' Brief repeatedly cites to *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003), stating that the "the Circuit Court correctly construed the term 'incurred' in accordance with *Haselden* and its progeny." (Jones Br., pp. 1-3, 4, 6 (citing to *Haselden* 10 times in her 6 ½ page Brief)). However, the Circuit Court Order does not even mention *Haselden* – likely because *Haselden* is not relevant to the issue in this case. (April 6, 2023 Circuit Court Order, R. pp. 14-19). Jones' Brief goes even further, stating that the Supreme Court in *Haselden* held "that incurred expenses are not limited to the amount actually paid by Medicaid." (Jones' Br., p. 7 ("The trial court appropriately considered the South Carolina Supreme Court's holding that incurred expenses are not limited to the amount actually paid by Medicaid.")). This is simply not true. There is no such holding in the *Haselden* case. The *Haselden* case did not deal with the term "incurred," much less issue a holding about expenses incurred.

Unlike the cases addressed in Progressive's Brief, *Haselden* is not an insurance breach of contract case. It is a personal injury case addressing the amount a plaintiff may recover from a tortfeasor for medical services, i.e., the reasonable value of those medical services.

In *Haselden*, an estate sued a doctor for medical negligence. 353 S.C. at 483, 579 S.E.2d at 294. The question was what evidence a jury could consider in determining the reasonable value of medical services rendered. *Id.* As the Court explained, "[a] plaintiff in a personal injury action seeking damages for the cost of medical services provided to him as a result of a tortfeasor's wrongdoing is entitled to recover the reasonable value of those medical services, not necessarily the amount paid." *Id.* at 484, 579 S.E.2d at 295. The Court's own analysis in *Haselden* makes clear that the analysis for "reasonable value" of medical services is not applicable to the question of "expenses incurred":

The measure of recovery is not the cost of services but their reasonable value. Recovery does not depend on whether there is any bill at all, and the tortfeasor is liable for the value of medical services even if they are given without charge, since it is their value and not their cost that counts. The value of medical services made necessary by the tort can ordinarily be recovered although they have created no liability or expense to injured person, as when a physician donates his services.

Id. at 484, 579 S.E.2d at 295 (cleaned up, citations omitted, emphasis added). Thus, in a personal injury case, "reasonable value" amounts can be recovered from the tortfeasor regardless of whether the patient ever became liable to the medical provider for such amounts. In contrast, this is a contract case. The insurer's liability to Jones is limited by the contract terms to the medical expenses she actually incurred – i.e., the amounts for which she was liable to her medical providers.

The holding in *Haselden* was that the amount billed was relevant to establishing the reasonable value of the medical services. *Id.* at 485, 579 S.E.2d at 295 ("Accordingly, we hold the amount billed by Davis was relevant to establish the reasonable value of the services provided to

Hill.”). This was the extent of the *Haselden* Court’s holding. This holding is not applicable to the contractual “expenses incurred” question at issue in the present case.³

Moreover, *Haselden* explains how Medicaid works, which supports Progressive’s position. According to the Court in *Haselden*, a physician “agrees to become a Medicaid provider, thereby agreeing to accept as compensation for medical services those amounts set forth in the Medicaid agreement.” *Id.* at 485, 579 S.E.2d at 295. Thus, prior to treating the Medicaid patient, a Medicaid provider has already agreed to the amount of compensation set forth in the Medicaid agreement. This previously-agreed-to amount is the medical expense incurred.

III. Contrary to the red herring arguments in Jones’ Brief, there is no setoff or collateral source issue.

Jones’ Brief contends that Progressive’s payment of medical payments coverage at the Medicaid-adjusted provider rates constitutes a setoff under South Carolina Code § 38-77-144, but it does not. (Jones Br., pp. 3-5). South Carolina Code § 38-77-144 provides that “medical payments coverage...is not subject to a setoff.” S.C. Code § 38-77-144. The South Carolina Supreme Court recently described what constitutes a “setoff” under South Carolina Code § 38-77-144. In *Cothran v. State Farm Mut. Auto. Ins. Co.*, a provision in the insurance policy purported to reduce the insurer’s obligation to pay PIP coverage to the insured by the amount the workers compensation carrier paid for the insured’s medical expenses. 427 S.C. 545, 550, 831 S.E.2d 919, 922 (2019) (“In this case, State Farm’s obligation to pay PIP coverage to Wadette is reduced—eliminated, in fact—by the

³ Jones Brief also cites to cases from several other jurisdictions for the proposition that “tortfeasors should be liable for the *value* of medical services, rather than the cost.” (Jones Br., pp. 5-6) (underline emphasis added). This is a breach of contract case. Progressive is not a tortfeasor. Progressive is an insurer whose obligation to Jones is determined and limited by the terms of the insurance contract. Consequently, these cases Jones cites are inapplicable.

amount her employer's workers' compensation carrier paid her for medical expenses.'). The Court held that this was a "setoff" in violation of § 38-77-144. *Id.*

As the Court explained: "The term 'setoff' is used universally to describe the reduction of PIP benefits by the amount of a third-party payment." *Id.* at 550 n.3, 831 S.E.2d at 922 n.3. A setoff under the statute occurs when the insurer's obligation to pay the insured is reduced by the amount of a third-party's payment to the insured. The Court used a mathematical calculation to describe a setoff scenario:

Wadette incurred approximately \$40,000 in medical expenses. Her PIP benefits policy limit is \$5,000....If her workers' compensation benefits were \$37,500, the "Coordination" provision would take effect and State Farm would owe her \$2,500. In this case, her workers' compensation benefits equaled the total amount of her medical expenses, so the effect of the "Coordination" provision would be to eliminate State Farm's obligation to pay any PIP benefits.

Id. at 550 n.2, 831 S.E.2d at 922 n.2. Given this example, a setoff occurs when the medical payments insurer takes the total medical expense amount the insured incurred and subtracts the benefit paid by a third-party to determine the amount of the policy limit it is required to pay (i.e., \$40,000 [incurred medical expenses] - \$40,000 [workers' compensation benefits] = \$0 [medical payments coverage]).

Thus, a "setoff," as that term has been defined by the South Carolina Supreme Court, would occur if Progressive attempted to reduce its medical payments coverage by the amounts paid by Medicaid – i.e., paid no medical payments coverage because Medicaid had already taken care of Jones' treatment expenses. That is not what Progressive did or even what Jones alleges Progressive did. (Compl., R. p. 29 ¶ 25); (April 6, 2023 Circuit Court Order, R. p. 14 (recognizing that Progressive paid Jones the same "amount Medicaid paid to satisfy the medical bills")). Her Complaint does not allege that Progressive had reduced its medical payments benefits by the amount of the Medicaid payment. *See* (Compl., R. p. 29 ¶ 25). Rather, Jones alleges that Progressive "violated Section 38-77-144 by refusing to pay Plaintiff *any amount above* what Medicaid paid to Plaintiff Jones's health care

providers.” (*Id.*) (emphasis added). Paying medical payments coverage at a Medicaid-adjusted provider rate does not constitute a “reduction of PIP benefits by the amount of a third-party payment.” *Cothran*, 427 S.C. at 550 n.3, 831 S.E.2d at 922 n.3.

Even Jones’ own definition of a setoff is not met in this case. Jones alleges that a setoff occurs when “an insurance carrier lessens the amount owed to the insured because of payments made by a third-party.” (Jones Br., p. 5). Progressive did not lessen the amount owed to Jones “because of payments made by a third-party.” If it had, Progressive would have paid Jones nothing because Medicaid had already fully covered her medical expenses. Instead, Medicaid’s prior agreements with its service providers fixed the amount of medical expenses Jones incurred – the first number in the above calculation. This is not a setoff as the South Carolina Supreme Court has defined that term.⁴

Jones’ Brief also makes another red herring argument about the collateral source rule. (Jones Br., pp. 2-4). The collateral source rule applies to a tortfeasor in a personal injury action, not an insurer in a contract action.⁵ Progressive is not a tortfeasor. Progressive did not cause the auto accident at

⁴ Moreover, Jones’ Complaint asserted a separate cause of action for “violation of South Carolina Code of Laws Section 38-77-144.” The Circuit Court dismissed this claim. (February 10, 2021 Circuit Court Order, R. p. 6). Jones’ Brief alleges that the “trial court correctly interpreted this as a setoff in violation of S.C. Code Ann. § 38-77-144.” (Jones Br., p. 3). The Circuit Court’s final Order and form 4 Order made no such finding. *See* (April 6, 2023 Circuit Court Order, R. pp. 14-19); (March 29, 2023 Circuit Court Form 4 Order, R. pp. 10-13).

⁵ *See, e.g., Citizens & S Nat’l Bank of S.C. v. Gregory*, 320 S.C. 90, 92, 463 S.E.2d 317, 318 (1995) (“The collateral source rule provides that compensation received by an injured party from a source wholly independent of the wrongdoer will not reduce the amount of damages *owed by the wrongdoer*.” (emphasis added)); *Estate of Rattenni v. Grainger*, 298 S.C. 276, 277, 379 S.E.2d 890, 890 (1989) (“South Carolina has long followed the collateral source rule that compensation received by an injured party from a source wholly independent of the wrongdoer should not be deducted from the amount of damages *owed by the wrongdoer* to the injured party.” (emphasis added)); *New Found. Baptist Church v. Davis*, 257 S.C. 443, 446, 186 S.E.2d 247, 249 (1972) (“[T]he ‘collateral source rule’ is that which holds that total or partial compensation for injury which an injured party receives from a collateral source, wholly independent of the wrongdoer, does not operate to lessen the damages recoverable *from the wrongdoer*.” (emphasis added)); *Young v. Warr*, 252 S.C. 179, 197, 165 S.E.2d 797, 806 (1969) (“Under the ‘collateral source rule’

issue. The South Carolina Supreme Court in *Bardsley v. Government Emps. Ins. Co.* made this distinction clear:

GEICO asserts the collateral source rule only applies to wrongdoers, it is not a wrongdoer....Francina counters that the collateral source rule applies to any party seeking to reduce obligations to a victim as a result of contributions made by others to the victim. In other words, she asserts the only requirement for the application of the collateral source rule is that the source is wholly independent of the wrongdoer.

We find this contention plainly contrary to our jurisprudence, which makes clear that the collateral source rule only applies to a "wrongdoer"/ "tortfeasor."

....Because UIM coverage is a source wholly independent of the wrongdoer, *a fortiori*, a UIM insurer is not a wrongdoer and the collateral source rule does not apply.

Moreover, we find applying the collateral source rule against GEICO as a UIM insurer is inappropriate because extending the collateral source rule to cover GEICO as a UIM insurer would not serve the policy behind the rule. As discussed, the purpose of the collateral source rule is to give the injured party the benefit of any windfall rather than allowing the tortfeasor to profit by his wrongful acts. Here, GEICO as a UIM insurer has not acted wrongly or tortiously towards Francina and would not experience a windfall by not having to pay the UIM property damage benefits.....Instead, this is merely a contractual issue, and GEICO should be treated according to the terms of the contract.

405 S.C. 68, 79–81, 747 S.E.2d 436, 441–42 (2013) (citations omitted). Like UIM coverage, medical payments coverage is a first-party insurance coverage. It "is a source wholly independent of the wrongdoer, *a fortiori*, a [medical payments] insurer is not a wrongdoer and the collateral source rule does not apply." *See id.* "Instead, this is merely a contractual issue, and [Progressive] should be treated according to the terms of the contract." *See id.*

a *tortfeasor* has no right to any mitigation of damages because of payments or compensation received by the injured person from an independent source." (emphasis added)); *Covington v. George*, 359 S.C. 100, 103, 597 S.E.2d 142, 144 (2004) (stating that the collateral source rule applies to "tortfeasors"); *Dixon v. Besco Eng'g, Inc.*, 320 S.C. 174, 181, 463 S.E.2d 636, 640 (Ct. App. 1995) ("The collateral source rule prevents a *tortfeasor* from receiving a reduction in damages due to payments or compensation received by the injured person from a source wholly independent of the *tortfeasor*." (emphasis added)).

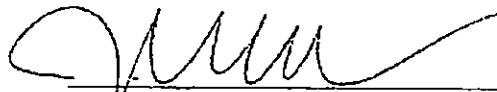
Under the terms of the contract, Progressive is only liable to Jones for certain medical expenses she "incurred." She did not incur medical expenses beyond the Medicaid-adjusted rates her providers agreed to accept as payment in full. Progressive has already paid this amount of medical payments coverage. Therefore, Progressive is entitled to judgment in its favor on the breach of contract cause of action.

CONCLUSION

For the above-stated reasons and those set forth in Progressive's Opening Brief, the Circuit Court's ruling in favor of Jones on the breach of contract claim should be reversed. The policy only requires Progressive to pay for certain medical "expenses incurred" by the insured. The South Carolina Supreme Court previously defined "expenses incurred" to require an obligation on the part of the insured to pay such expense. Because of the way Medicaid works, Jones never became obligated to pay any medical expenses beyond the Medicaid-adjusted rates. Prior to rendering treatment, her providers agreed to accept such amounts as payment in full and to not charge her any additional amounts. Therefore, Progressive did not breach the insurance contract by paying her claim at the Medicaid-adjusted rates.

Respectfully submitted.

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Nov 29 2023

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

CERTIFICATE OF COMPLIANCE

I, J.R. Murphy, attorney for Appellant-Respondent, certify that the Reply Brief of Appellant-Respondent complies with the South Carolina Supreme Court Order of August 13, 2007 and Rule 211(b), SCACR.



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Progressive Northern Insurance Company..... Appellant – Respondent.

PROOF OF SERVICE

I certify that I have served the Reply Brief of Appellant-Respondent on Alexis Jones by depositing a copy of it in the United States Mail, postage prepaid, on November 29, 2023, addressed to her attorneys of record, J. Logan Cannon, Esquire, P.O. Drawer 36250, Rock Hill, South Carolina 29732 and by electronic mail at cannon@shawlawfirm.net and John S. Nichols, Esquire, Bluestein Thompson Sullivan, LLC, PO Box 7965, Columbia, SC 29202, and by electronic mail at john@bluesteinattorneys.com.



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Progressive Northern Insurance Company.....Appellant-Respondent.

**FINAL APPELLANT'S BRIEF
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TABLE OF CONTENTS

Table of Authorities	ii
Statement of the Issues on Appeal	1
Statement of the Case	2
Standard of Review.....	6
Arguments.....	7
I. The Circuit Court Erred in Dismissing Ms. Jones's Claims for Bad Faith, Breach of the Duty of Good Faith and Fair Dealing, Breach of Fiduciary Duty, and Breach of Contract Accompanied by a Fraudulent Act Pursuant to Rule 12(b)(6), SCRCF	7
A. Standard of Review.....	7
B. Discussion.....	7
(1) Bad Faith/Breach of Duty of Good Faith and Fair Dealing/Breach of Fiduciary Duty	8
(2) Breach of Contract Accompanied by a Fraudulent Act.....	12
(3) Violation of South Carolina Code Ann. § 38-77-144 (2015)	13
II. The Circuit Court Erred in Dismissing Ms. Jones's Claims for Violation of S.C. Code Ann. § 38-77-144 (2015) Because the Statute Permits a Private Cause of Action	14
A. Standard of Review.....	14
B. Discussion.....	14
III. The Circuit Court Erred in Denying Ms. Jones's Claim for an Award of Attorney Fees Pursuant to S.C. Code Ann. § 38-59-40 (Supp. 2022)	16
A. Standard of Review.....	16
B. Discussion.....	17
Conclusion	20

TABLE OF AUTHORITIES

CASES

South Carolina

<i>16 Jade St. v. R. Design Constr. Co.</i> , 405 S.C. 384, 747 S.E.2d 770 (2013)	15
<i>Baker v. Pilot Life Insurance Company</i> , 268 S.C. 609, 235 S.E.2d 300 (1977).....	17
<i>Brown v. State Farm Mut. Ins. Co.</i> , 275 S.C. 276, 269 S.E.2d 769 (1980)	16, 17
<i>Citizens for Lee Cnty., Inc. v. Lee Cnty.</i> , 308 S.C. 23, 416 S.E.2d 641 (1992)	15
<i>Cock-N-Bull Steak House v. Generali Ins. Co.</i> , 321 S.C. 1, 466 S.E.2d 727 (1996)	8
<i>Coker v. Pilot Life Insurance Company</i> , 265 S.C. 260, 217 S.E.2d 784 (1975)	17
<i>Connor v. City of Forest Acres</i> , 348 S.C. 454, 560 S.E.2d 606 (2002)	12
<i>Cook v. Government Emp. Ins. Co.</i> , 266 S.C. 309, 223 S.E.2d 33 (1976)	19
<i>Covington v. George</i> , 359 S.C. 100, 597 S.E.2d 142 (2004)	10, 11, 19
<i>Crossley v. State Farm Mut. Auto. Ins. Co.</i> , 307 S.C. 354, 415 S.E.2d 393 (1992).....	8, 9
<i>Denson v. National Casualty Co.</i> , 439 S.C. 142, 886 S.E.2d 228 (2023)	15
<i>Doe v. Marion</i> , 373 S.C. 390, 645 S.E.2d 245 (2007)	15
<i>Dowling v. Home Buyers Warranty Corp.</i> , 303 S.C. 295, 400 S.E.2d 143 (1991).....	8
<i>Flynn v. Nationwide Mut. Ins. Co.</i> , 281 S.C. 391, 315 S.E.2d 817 (Ct. App. 1984)	16, 17, 18
<i>Fountain v. Fred's, Inc.</i> , 436 S.C. 40, 871 S.E.2d 166 (2022).....	17
<i>Georgetown Cnty. League of Women Voters v. Smith Land Co.</i> , 393 S.C. 350, 713 S.E.2d 287 (2011)	15
<i>Gilbert v. McLeod Infirmary</i> , 219 S.C. 174, 64 S.E.2d 524 (1951)	17
<i>Gordon v. Fidelity & Cas. Co. of N.Y.</i> , 238 S.C. 438, 120 S.E.2d 509 (1961).....	8, 9, 10, 11, 13

<i>Harper v. Ethridge</i> , 290 S.C. 112, 348 S.E.2d 374 (Ct. App. 1986)	12
<i>Haselden v. Davis</i> , 353 S.C. 481, 579 S.E.2d 293 (2003)	11, 19
<i>Helena Chem. Co. v. Allianz Underwriters Ins. Co.</i> , 357 S.C. 631, 594 S.E.2d 455 (2004)	9
<i>HHHunt Corp. v. Town of Lexington</i> , 389 S.C. 623, 699 S.E.2d 699 (Ct. App. 2010)	7
<i>Kleckley v. Northwestern Nat. Cas. Co.</i> , 338 S.C. 131, 526 S.E.2d 218 (2000)	8
<i>Kubic v. MERSCORP Holdings, Inc.</i> , 416 S.C. 161, 785 S.E.2d 595 (2016)	15
<i>Lewis v. Lewis</i> , 392 S.C. 381, 709 S.E.2d 650 (2011)	17
<i>Madden v. Pilot Life Insurance Company</i> , 272 S.C. 264, 251 S.E.2d 196 (1979)	18
<i>Nelson v. United Fire Ins. Co. of New York</i> , 275 S.C. 92, 267 S.E.2d 604 (1980)	18
<i>Nichols v. State Farm Mut. Auto. Ins. Co.</i> , 279 S.C. 336, 306 S.E.2d 616 (1983)	8, 12, 16
<i>Rayfield v. S.C. Dep't of Corr.</i> , 297 S.C. 95, 374 S.E.2d 910 (Ct. App. 1988)	15
<i>State Farm Mut. Auto. Ins. Co. v. Windham</i> , 438 S.C. 156, 882 S.E.2d 754 (2022)	14
<i>Sullivan v. Calhoun</i> , 117 S.C. 137, 108 S.E. 189 (1921)	12
<i>Varnadore v. Nationwide Mut. Ins. Co.</i> , 289 S.C. 155, 345 S.E.2d 711 (1986)	8
<i>Whitworth v. Fast Fare Mkts. of S.C., Inc.</i> , 289 S.C. 418, 338 S.E.2d 155 (1985)	15

Other Jurisdictions

<i>Barker v. Washington Nat. Ins. Co.</i> , 2013 WL 1767620, at *4 (D.S.C. April 24, 2013) ..	8, 11, 13

STATUTES

S.C. Code Ann. § 38-59-40 (2015)	16, 17, 18
S.C. Code Ann. § 38-77-144 (2015)	3, 7, 13, 14, 15, 16, 20

RULES

Rule 208(b)(1)(D), SCACR	6
Rule 12(b)(6), SCRCF	7
Rule 59, SCRCF	2
Rule 68, SCRCF	2

MISCELLANEOUS

73 Am. Jur. 2d. <i>Statutes</i> § 432 (1974)	15

STATEMENT OF THE ISSUES ON APPEAL

- I. Did the circuit court err in dismissing Ms. Jones's claims for bad faith, breach of the duty of good faith and fair dealing, breach of fiduciary duty, and breach of contract accompanied by a fraudulent act under the circumstances of this case?
- II. Did the circuit court err in dismissing Ms. Jones's claims for violation of S.C. Code Ann. § 38-77-144 (2015) because the statute does not create a private cause of action?
- III. Did the circuit court err in denying Ms. Jones's claim for an award of attorney fees pursuant to S.C. Code Ann. § 38-59-40 (Supp. 2022)?

STATEMENT OF THE CASE

Alexis Jones was injured in an automobile collision on October 8, 2019. (R. p. 22). She suffered bodily injury and 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 a Progressive policy covering the vehicle Ms. Jones was driving which included a limit of \$10,000 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.

On March 30, 2020, Ms. Jones filed an action against Progressive for a declaratory judgment 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 Ms. Jones "actually incurred," and thus Progressive only owed \$1,323.00, the amount Medicaid paid to Ms. Jones's medical providers. (R. pp. 32-38).

On May 11, 2020, Progressive moved to dismiss Ms. Jones's 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's 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, SCRPC for \$12,500. Thereafter, Progressive moved pursuant to Rule 59, SCRPC, 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 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 S.C. Code Ann. § 38-77-144 (2015) does not create a private cause of action. (*Id.*) The court dismissed Ms. Jones's causes of action except for a claim for breach of 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 PLLC 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 PLLC 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 PLLC 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 the full amount of the medical charges, not the amount reduced due to Medicaid payments. (R. pp. 10-13). The court denied Ms. Jones's claim for 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.

STANDARD OF REVIEW

There are separate standards of appellate review applicable to the issues Ms. Jones raises on appeal. Accordingly, Ms. Jones provides a separate discussion of the standard of review under each issue. Rule 208(b)(1)(D), SCACR.

ARGUMENTS

I. The Circuit Court Erred in Dismissing Ms. Jones's Claims for Bad Faith, Breach of the Duty of Good Faith and Fair Dealing, Breach of Fiduciary Duty, and Breach of Contract Accompanied by a Fraudulent Act Pursuant to Rule 12(b)(6), SCRPC

A. Standard of Review

The circuit court dismissed Ms. Jones's causes of action under Progressive's motion to dismiss pursuant to Rule 12(b)(6), SCRPC. This Court reviews the trial court's grant of Progressive's motion under the same standard as the circuit court when reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRPC. *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 631–32, 699 S.E.2d 699, 703 (Ct. App. 2010) ("In considering a motion to dismiss a complaint based on a failure to state facts sufficient to constitute a cause of action, the trial court must base its ruling solely on allegations set forth in the complaint.").

B. Discussion

Ms. Jones alleged causes of action for: (1) breach of contract; (2) bad faith/breach of duty of good faith and fair dealing/breach of fiduciary duty; (3) violation of the South Carolina Unfair Trade Practices Act (SCUTPA); (4) violation of South Carolina Code Ann. § 38-77-144 (2015); and (5) breach of contract accompanied by a fraudulent act. The circuit court initially dismissed only the SCUTPA claim and Ms. Jones does not appeal that ruling. However, on reconsideration, the circuit court also dismissed Ms. Jones's remaining claims except for the breach of contract claim. Ms. Jones contends dismissal of these other claims was in error.

(1) Bad Faith/Breach of Duty of Good Faith and Fair Dealing/Breach of Fiduciary Duty

The circuit court ruled as a matter of law that Ms. Jones could not pursue claims for bad faith against Progressive because Progressive had a "meritorious coverage defense" based upon Progressive's cite to *Gordon v. Fidelity & Cas. Co. of N.Y.*, 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961), *Barker v. Washington Nat. Ins. Co.*, 2013 WL 1767620, at *4 (D.S.C. April 24, 2013), and cases from foreign jurisdictions purporting to support Progressive's position. (R. pp. 6-7). This Court should reverse this ruling.

As a means of protecting insureds who ordinarily possess no bargaining power when entering into an insurance contract, the Supreme Court recognized a 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). *Kleckley v. Northwestern Nat. Cas. Co.*, 338 S.C. 131, 134-135, 526 S.E.2d 218, 219 (2000).

The elements of an action for bad faith refusal to pay benefits under an insurance contract include: "(1) the existence of a mutually binding contract of insurance between the plaintiff and the defendant; (2) refusal by the insurer to pay benefits due under the contract; (3) resulting from the insurer's bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing arising on the contract; (4) causing damage to the insured." *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359-60, 415 S.E.2d 393, 396-97 (1992). "An insured may recover damages for a bad faith denial of coverage if he or she proves there was no reasonable basis to support the insurer's decision to deny benefits under a mutually binding insurance contract." *Dowling v. Home Buyers Warranty Corp.*, 303 S.C. 295, 297, 400 S.E.2d 143, 144 (1991) (citing *Varnadore v. Nationwide Mut. Ins. Co.*, 289 S.C. 155, 345 S.E.2d 711 (1986); *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616 (1983)).

Cock-N-Bull Steak House v. Generali Ins. Co., 321 S.C. 1, 6, 466 S.E.2d 727, 730 (1996).

Progressive's ground for contesting Ms. Jones's claim for full benefits under the

insurance contract must therefore be reasonable. *See, e.g., Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 357 S.C. 631, 645, 594 S.E.2d 455, 462 (2004) (“Under South Carolina law, an insurer acts in bad faith when there is no reasonable basis to support the insurer’s decision. But “[i]f there is a reasonable ground for contesting a claim, there is no bad faith.”) (quoting *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 360, 415 S.E.2d 393, 397 (1992))). The record demonstrates Progressive’s denial was not reasonable as a matter of law such that the trial court should have denied the motion to dismiss.

Progressive cited to a 1961 South Carolina Supreme Court case involving a soldier’s receipt of military medical care and a 2013 unpublished United States District Court case comparing payments under the Medicare program with payments due under a supplemental “limited benefit health coverage” policy. Neither of those cases related to Medicaid, neither case controlled this matter, and neither case was even persuasive on the issue of Progressive’s reasonableness for denying Ms. Jones the full MedPay benefits under the insurance agreement, in light of settled precedent from the Supreme Court of South Carolina.

The first case Progressive cited is *Gordon v. Fidelity & Cas. Co. of N.Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961). Mr. Gordon was a career soldier in the US Army. He obtained from F&G a liability insurance policy covering a motor scooter. The F&G policy required the company:

To pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical, x-ray and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing and funeral services * * *.

Gordon, at 441, 120 S.E.2d at 510. Mr. Gordon was injured while riding the scooter and was hospitalized at the government hospital at Fort Jackson for treatment of his injuries. He received

treatment at no charge due to his status as an Army soldier.

Mr. Gordon submitted claims to F&G for payment of the "reasonable cost" of his treatment based upon the appraisal of two physicians and the prevailing rates at a Columbia hospital. F&G refused to pay, asserting Mr. Gordon "incurred no expenses for the hospitalization and medical treatment received at the Fort Jackson hospital." *Id.*

The Court held "incur emphasizes the idea of liability." *Id.*, at 445, 120 S.E.2d at 512. The Court noted "the parties to this action stipulated that the respondent incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital...." *Id.*, at 446, 120 S.E.2d at 513. Because of the stipulation, the Court observed "the appellant was not liable to the respondent for the reasonable cost of his hospitalization, because the appellant had limited its liability to pay only 'all reasonable expenses incurred' by the respondent." *Id.* The Court concluded, "[t]here being no obligation on the part of the respondent to pay for the hospitalization he received at Fort Jackson hospital, he 'incurred' no expense within the meaning of the provision of the policy of insurance issued by the appellant." *Id.*, at 446, 120 S.E.2d at 513.

Gordon does not control here, nor is it persuasive on the issue. Unlike the plaintiff in *Gordon*, who stipulated he incurred no expense for treatment at the military hospital, Ms. Jones did incur liability for her medical care as well as expenses for her treatment. She was not a member of the Armed Forces eligible to receive treatment without expense at a military hospital. Furthermore, insofar as *Gordon* would permit Progressive to pay less than the ordinary charges for medical care, *Gordon* is inconsistent with much more recent Supreme Court precedent. See *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). The Court in *Covington* stated:

In *Haselden*, the Plaintiff submitted evidence that she *incurred* medical expenses in the amount of \$77,905.21. Medicaid paid \$24,109.04 to cover the services. The difference between the amounts billed and the amounts actually paid by Medicaid was \$51,620.59. Defendants entered a letter as a court exhibit, which showed the gross amount of the bills for Plaintiff's services and the corresponding Medicaid payments. The admissibility of the actual payment amount was not an appellate issue in *Haselden*, but rather the issue was Plaintiff's entitlement to recover the difference between the billed amount and the actual payment amount.

Covington, 597 S.E.2d at 143-144 (emphasis added)(citations omitted). Because of the collateral source rule, the Supreme Court found the tortfeasor could not take advantage of the contract between the injured party and a third person, “no matter whether the source of the funds is ‘an insurance company, an employer, a family member, or other source.’” *Id.* The Court noted the “actual payment amounts were made by a collateral source,” *i.e.*, reductions by each medical provider. *Id.*

The other case Progressive cited was *Barker v. Washington Nat. Ins. Co.*, C.A. No. 9:12-cv-1901-PMD (D.S.C. 2013), 2013 WL 1767620. The U.S. district court in *Barker* attempted to predict South Carolina law. Citing to *Gordon*, the district court concluded “as a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill...” The district court did not analyze the case under the collateral source rule as described in *Covington* or *Haselden*. Respectfully, Judge Duffy's unpublished order is wrong, and this Court should reject that analysis. Additionally, the order is not binding on this Court.

Both *Barker* and *Gordon*, therefore, are distinct from this case in meaningful ways.

Progressive's reliance on these two authorities was not reasonable as neither case dictated the result Progressive sought. Thus, there was evidence that there was no reasonable basis for Progressive to refuse to pay the amount the contract with Ms. Jones required Progressive to pay. Dismissal of Ms. Jones's bad faith claims as a matter of law was not proper. See *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616 (1983) (negligence on the issue of unreasonable refusal to pay benefits due under an insurance contract is for the finder of facts).

Accordingly, this Court should reverse the circuit court's order and remand the matter for proceedings consistent with this Court's ruling.

(2) Breach of Contract Accompanied by a Fraudulent Act

The circuit court initially denied Progressive's motion to dismiss this cause of action. However, the court dismissed this cause of action following Progressive's motion for reconsideration, holding Ms. Jones may not pursue the claim "under these circumstances." (R. p. 6). This Court should reverse.

In *Connor v. City of Forest Acres*, the Supreme Court stated:

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).

Here, Ms. Jones provided evidence that Progressive engaged in unfair dealing in the manner in which Progressive adjusted her claims for MedPay benefits. Progressive relied upon *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. Neither Progressive nor the district court analyzed relevant, applicable, and more recent precedent. Ms. Jones was therefore required to bring suit to force Progressive to honor its contractual commitments.

The circuit court should not have dismissed this cause of action under Progressive's motion to dismiss. This Court should reverse and remand for proceedings consistent with its mandate.

(3) Violation of South Carolina Code Ann. § 38-77-144 (2015)

The propriety of the circuit court's dismissal of this claim is discussed in the next section of this brief.

II. The Circuit Court Erred in Dismissing Ms. Jones's Claims for Violation of S.C. Code Ann. § 38-77-144 (2015) Because the Statute Permits a Private Cause of Action

A. Standard of Review

The circuit court ruled as a matter of law that S.C. Code Ann. § 38-77-144 (2015) does not provide a private right of action. Determining the proper interpretation of a statute is a question of law, and the appellate court reviews questions of law *de novo*. *State Farm Mut. Auto. Ins. Co. v. Windham*, 438 S.C. 156, 882 S.E.2d 754 (2022).

B. Discussion

In dismissing Ms. Jones's assertion of a violation of S.C. Code Ann. § 38-77-144 (2015), the circuit court held that Section 38-77-144 does not provide a private right of action. The Court should reverse that ruling and remand for further proceedings.

Section 38-77-144 provides:

There is no personal injury protection (PIP) coverage mandated under the automobile insurance laws of this State. Any reference to personal injury protection in Title 38 or 56 or elsewhere is deleted. If 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.

S.C. Code Ann. § 38-77-144 (2015). This statute removed the requirement that automobile insurers offer PIP or MedPay coverage, and provided that if an insurer did sell PIP, MedPay, or economic loss coverage, "the coverage shall not be assigned or subrogated and is not subject to setoff." Under this clause, the coverage may not be reduced by recovery from collateral sources.

The statute does not expressly create a private right of action for an insurer's refusal to pay MedPay or PIP benefits due under the insurance contract. Ms. Jones contended the statute

must provide a private right in order to permit an insured to require an insurer to comply with the statute. The circuit court disagreed and dismissed this claim. This was error.

The Supreme Court recently set forth the applicable rules for determining whether a statute provides a private right of action:

The main factor in determining whether a statute gives rise to a private cause of action is legislative intent, which is determined primarily from the language of the statute. *Kubic v. MERSCORP Holdings, Inc.*, 416 S.C. 161, 168, 785 S.E.2d 595, 599 (2016); *Georgetown Cnty. League of Women Voters v. Smith Land Co.*, 393 S.C. 350, 353, 713 S.E.2d 287, 289 (2011) (quoting *Doe v. Marion*, 373 S.C. 390, 396, 645 S.E.2d 245, 248 (2007)). Generally, when a statute does not expressly create civil liability, a duty will not be implied unless the statute was enacted for the special benefit of a private party. *Marion*, 373 S.C. at 397, 645 S.E.2d at 248; see also *16 Jade St., L.L.C. v. R. Design Constr. Co.*, 405 S.C. 384, 389–90, 747 S.E.2d 770, 773 (2013) (applying the rules for establishing a private cause of action in the context of determining whether a statute imposes a legal duty); *Citizens for Lee Cnty., Inc. v. Lee Cnty.*, 308 S.C. 23, 28, 416 S.E.2d 641, 645 (1992) (“The threshold consideration here is whether or not [plaintiffs] ... have an implied cause of action under the statute, since no private right of action is expressly provided.... [T]his Court held that assuring that legislation was enacted for the special benefit of the private party is a test for determining whether a right of private action is created by implication.” (citation omitted)). “In this respect, 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.” *Whitworth v. Fast Fare Mkts. of S.C., Inc.*, 289 S.C. 418, 420, 338 S.E.2d 155, 156 (1985) (quoting 73 Am. Jur. 2d *Statutes* § 432 (1974)); see also *Rayfield v. S.C. Dep’t of Corr.*, 297 S.C. 95, 103, 374 S.E.2d 910, 914 (Ct. App. 1988)] (“In 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).

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 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 seeks a set-off for reductions done due to a collateral course, Medicaid. The only way Ms. Jones, as the insured, can enforce the express provisions of Section 38-77-144 is by bringing a private lawsuit. *Cf. Nichols v. State Farm Mut. Ins. Co.*, 279 S.C. 336, 340, 306 S.E.2d 616, 619 (1983) ("Absent the threat of a tort action, the insurance company can, with complete impunity, deny any claim they wish, whether valid or not."). Her 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.

This Court should reverse the trial court's ruling and remand the matter with instructions to permit Ms. Jones to proceed with her claim under Section 38-77-144.

III. The Circuit Court Erred in Denying Ms. Jones's Claim for an Award of Attorney Fees Pursuant to S.C. Code Ann. § 38-59-40 (Supp. 2022)

A. Standard of Review

Regarding the circuit court's denial of statutory attorney fees, the factual finding of unreasonableness or bad faith is a condition precedent to an award of attorney's fees under S.C. Code Ann. § 38-59-40 (2015). *Flynn v. Nationwide Mut. Ins. Co.*, 281 S.C. 391, 315 S.E.2d 817 (Ct. App. 1984) (construing predecessor statute), citing *Brown v. State Farm Mutual Insurance Company*, 275 S.C. 276, 269 S.E.2d 769 (1980). The determination of whether attorney's fees should then be awarded is one in equity, made without the aid of a jury. *Flynn*. Thus, this Court is free to find facts in accordance with its view of the preponderance of the evidence. *Flynn*,

citing *Brown and Baker v. Pilot Life Insurance Company*, 268 S.C. 609, 235 S.E.2d 300 (1977).

In an action at equity, tried by a judge alone, this Court's standard of review is *de novo*. *Fountain v. Fred's, Inc.*, 436 S.C. 40, 47, 871 S.E.2d 166, 170 (2022); *Lewis v. Lewis*, 392 S.C. 381, 385–86, 709 S.E.2d 650, 651–52 (2011). In short, “[w]e have jurisdiction in appeals in equity to find the facts in accord with our view of the preponderance or greater weight of the evidence, in the absence of verdict by jury.” *Fountain*, at 47, 871 at 170, citing *Gilbert v. McLeod Infirmary*, 219 S.C. 174, 184, 64 S.E.2d 524, 528 (1951).

This factual determination should be made based on consideration of relevant evidence adduced at the trial of the case which resulted in judgment for the insured, as well as any other competent evidence of the lack of reasonable cause or bad faith of the insurer in refusing to pay the claim. *Flynn*, citing *Coker v. Pilot Life Insurance Company*, 265 S.C. 260, 217 S.E.2d 784 (1975).

B. Discussion

The circuit court held that because it found in a prior order that Progressive's denial of payment of the full amount was not in bad faith, “and made no finding at trial or in its review of the record that would suggest the refusal was made in bad faith or without reasonable cause,” (R. p. 11), Ms. Jones was not entitled to attorney fees pursuant to S.C. Code Ann. § 38-59-40 (Supp. 2022). Ms. Jones has challenged the dismissal of her bad faith claim. Further, she presented evidence Progressive's refusal to pay full MedPay benefits was without reasonable cause. The Court should reverse this ruling and remand the matter for the court to enter an order awarding reasonable attorney fees pursuant to Section 38-59-40.

An insurer is not required to pay attorney's fees in every case won by an insured. *Flynn v. Nationwide Mut. Ins. Co.*, 281 S.C. 391, 315 S.E.2d 817 (Ct. App. 1984), citing *Nelson v. United Fire Insurance Company of New York*, 275 S.C. 92, 267 S.E.2d 604 (1980) and *Madden v. Pilot Life Insurance Company*, 272 S.C. 264, 251 S.E.2d 196 (1979). However, Section 38-59-40 of the South Carolina Code 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 (Supp. 2022) (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: (1) refusal to pay the claim without reasonable cause, *or* (2) refusal to pay the claim due to bad faith. Here, 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 upon Progressive's erroneous argument that her contract of insurance permitted Progressive to limit payment to the medical expenses she "actually incurred," which Progressive arbitrarily deemed to be the reduced amount paid by a

collateral source, Medicaid. Settled precedent dictated that Progressive pay the full amount of the cost Ms. Jones incurred, not the reduced amount her medical provider agreed to accept from her health insurer. *See 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).

The circuit court correctly applied the collateral source rule in holding that Progressive could not benefit from the reduced amounts the medical providers accepted under Medicaid. However, the circuit court erred in refusing to award Ms. Jones her reasonable attorney fees for having to pursue this litigation to force Progressive to honor its agreement. This Court should reverse that ruling and remand the matter for further proceedings consistent with this Court's opinion.¹

¹ This would include an additional determination of attorney fees for having to pursue this appeal. See *Cook v. Government Emp. Ins. Co.*, 266 S.C. 309, 223 S.E.2d 33 (1976) (an award under the statute for having to prosecute the case would include an award for fees before the lower court as well as fees for the appeal).

CONCLUSION

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

Respectfully submitted,

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November 28, 2023

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Nov 29 2023

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

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TABLE OF CONTENTS

Table of Authorities	ii
Statement of Issues on Appeal	1
Statement of the Case	1
Factual and Procedural Background	2
A. The Progressive Policy.	2
B. The October 8, 2019 Accident and Jones Resulting Medical Payments Claim.	2
C. Motions and Circuit Court Orders.	4
Standard of Review	5
Argument	6
I. Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim was properly dismissed for two independent reasons.	6
A. This claim was properly dismissed because the "violation" alleged by Jones is not conduct prohibited by the statute.	6
B. This claim was also properly dismissed because the statute does not create a private cause of action.	8
II. The Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act, bad faith, breach of covenant of good faith and fair dealing, and breach of fiduciary duty claims because Progressive's alleged actions at issue were in accordance with the terms of the insurance policy and South Carolina law.	10
III. The Circuit Court properly dismissed Jones' bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims because such claims were duplicative, and Progressive had a reasonable basis to argue that payment of medical payments coverage should be at the Medicaid-adjusted rates.	13
A. Jones' "breach of the covenant of good faith and fair dealing" and "breach of fiduciary duty" claims were properly dismissed because they are duplicative of her bad faith claim.	13

B.	Jones' bad faith claim was properly dismissed because Progressive had a reasonable basis to dispute paying her medical payments claim at a higher rate than the Medicaid-adjusted rates.....	14
IV.	The Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act claim because she did not allege a separate fraudulent act and the only alleged acts were not fraudulent.....	16
V.	The Circuit Court properly denied Jones claim for attorney's fees.....	19
Conclusion		20

TABLE OF AUTHORITIES

Page Number

CASES

<i>Adkins v. South Carolina Dep't of Corr.</i> , 360 S.C. 413, 602 S.E.2d 51 (2004)	8
<i>Baker v. Pilot Life Ins. Co.</i> , 268 S.C. 609, 235 S.E.2d 300 (1977)	19
<i>Barker v. Washington Nat. Ins. Co.</i> , No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013).....	12, 15-17, 19
<i>BMW of N. Am., LLC v. Complete Auto Recon Servs., Inc.</i> , 399 S.C. 444, 7 31 S.E.2d 902 (Ct. App. 2012).....	14
<i>Boggs v. Aetna Cas. & Sur. Co.</i> , 272 S.C. 460, 252 S.E.2d 565 (1979).....	20
<i>Conner v. City of Forest Acres</i> , 348 S.C. 454, 560 S.E.2d 606 (2002)	10, 18
<i>Cothran v. State Farm Mut. Auto. Ins. Co.</i> , 427 S.C. 545, 831 S.E.2d 919 (2019).....	6-8
<i>Crossley v. State Farm Mut. Auto. Ins. Co.</i> , 307 S.C. 354, 415 S.E.2d 393 (1992).....	13-15
<i>Denson v. National Cas. Co.</i> , 439 S.C. 142, 886 S.E.2d 228 (2023).....	8-9
<i>Evans v. Liberty Nat. Life Ins. Co.</i> , No. 13-CV-0390-CVE-PJC, 2015 WL 1650192 (N.D. Okla. Apr. 14, 2015).....	12
<i>Greene v. Durham Life Ins. Co.</i> , 287 S.C. 197, 336 S.E.2d 478 (1985).....	20
<i>Gordon v. Fidelity & Cas. Co. of N. Y.</i> , 238 S.C. 438, 120 S.E.2d 509 (1961)	11, 15-18
<i>Helena Chem. Co. v. Allianz Underwriters Ins. Co.</i> , 357 S.C. 631, 594 S.E.2d 455 (2004)	15
<i>I'On, L.L.C. v. Town of Mt. Pleasant</i> , 338 S.C. 406, 526 S.E.2d 716 (2000).....	5
<i>Kay v. State Farm Mut. Auto. Ins. Co.</i> , 349 S.C. 446, 562 S.E.2d 676 (Ct. App. 2002).....	11
<i>Lister v. NationsBank of Delaware, N.A.</i> , 329 S.C. 133, 494 S.E.2d 449 (Ct. App. 1997).....	16-17
<i>Metz v. U.S. Life Ins. Co. in City of New York</i> , 662 F.3d 600 (2d Cir. 2011).....	12
<i>Minter v. GOCT, Inc.</i> , 322 S.C. 525, 473 S.E.2d 67 (Ct. App. 1996)	17
<i>Nakatsu v. Encompass Indem. Co.</i> , 390 S.C. 172, 700 S.E.2d 283 (Ct. App. 2010).....	9

<i>Nelson v. United Fire Ins. Co. of New York</i> , 275 S.C. 92, 267 S.E.2d 604 (1980)	19-20
<i>Ocean Winds Council of Co-Owners, Inc. v. Auto-Owners Ins. Co.</i> , 241 F. Supp. 2d 572 (D.S.C. 2002).....	13, 17
<i>RFT Mgmt. Co. v. Tinsley & Adams L.L.P.</i> , 399 S.C. 322, 732 S.E.2d 166 (2012).....	13, 18
<i>RoTec Servs., Inc. v. Encompass Servs., Inc.</i> , 359 S.C. 467, 597 S.E.2d 881 (Ct. App. 2004).....	16, 18
<i>Sentry Select Ins. Co. v. Guess Farm Equip., Inc.</i> , No. CIV.A. 5:12-03504-JM, 2013 WL 5797742 (D.S.C. Oct. 25, 2013).....	13-14, 18
<i>Smith v. Canal Ins. Co.</i> , 275 S.C. 256, 269 S.E.2d 348 (1980).....	17-18
<i>State Farm Mut. Auto. Ins. Co. v. Bowers</i> , 500 S.E.2d 212 (Va. 1998).....	12
<i>South Carolina Dep't of Soc. Servs. v. Tharp</i> , 312 S.C. 243, 439 S.E.2d 854 (1994).....	19
<i>South Carolina Ins. Co. v. White</i> , 301 S.C. 133, 390 S.E.2d 471 (Ct. App. 1990)	11
<i>State Farm Mut. Auto. Ins. Co. v. Richardson</i> , 313 S.C. 58, 437 S.E.2d 43 (1993).....	11
<i>Varnadore v. Nationwide Mut. Ins. Co.</i> , 289 S.C. 155, 345 S.E.2d 711 (1986).....	14
<i>Whitworth v. Fast Fare Markets of South Carolina, Inc.</i> , 289 S.C. 418, 338 S.E.2d 155 (1985)	8
<i>Wiggins v. Travelers Ins. Co.</i> , 498 F. Supp. 211 (D.S.C. 1979), <i>aff'd sub nom. Freddie Wiggins, Jr. v. Travelers Ins. Co.</i> , 636 F.2d 1215 (4th Cir. 1980).....	20
<i>Williams v. Gov't Emps. Ins. Co. (GEICO)</i> , 409 S.C. 586, 762 S.E.2d 705 (2014)	9
<i>Woodrich v. Farmers Ins. Co.</i> , 405 F.Supp.2d 1276 (N.D. Okla. 2004)	12

STATUTES

South Carolina Code Ann. § 38-77-144	4-9, 20
South Carolina Code Ann. § 38-59-40	19
42 C.F.R. § 447.15	12

STATEMENT OF ISSUES ON APPEAL¹

- I. Whether the Circuit Court properly dismissed Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim because the "violation" alleged by Jones is not the conduct prohibited by the statute and because the statute does not create a private cause of action.
- II. Whether the Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act, bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims because Progressive's alleged actions at issue were in accordance with the terms of the insurance contract and South Carolina law.
- III. Whether the Circuit Court properly dismissed Jones' "breach of the covenant of good faith and fair dealing" and "breach of fiduciary duty" claims because such claims are duplicative of her bad faith claim.
- IV. Whether the Circuit Court properly dismissed Jones' bad faith claim because she lacked standing to bring such claim and Progressive had a reasonable basis to dispute paying her medical payments claim at a higher rate than the Medicaid-adjusted rates.
- V. Whether the Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act claim because the acts alleged were not fraudulent acts.
- VI. Whether the Circuit Court properly denied Jones' claim for attorney's fees.

STATEMENT OF THE CASE

This action arises out of Progressive's payment of Alexis Jones' medical payments claim for an October 8, 2019 auto accident. The auto policy at issue includes a \$10,000 medical payments coverage limit for certain medical "expenses incurred" by an insured as a result of an accident. Alexis Jones ("Jones") is a Medicaid recipient. In South Carolina, Medicaid has agreements in place with medical service providers wherein the providers have agreed, prior to treating Medicaid recipients, to accept reduced rates as payment-in-full. Progressive reimbursed Jones under the medical payments

¹ Jones Complaint also alleges a "violation of the South Carolina Unfair Trade Practice Act" claim, which the Circuit Court dismissed. According to her Brief, Jones is not appealing that ruling. (Jones' Appellant Br., p. 7 ("The circuit court initially dismissed only the SCUPTA claim and Ms. Jones does not appeal that ruling.")).

coverage based on the Medicaid-adjusted rates charged and accepted by her medical providers rather than the total charges listed on the medical providers' initial bills. In her Complaint, Plaintiff bases her various causes of action on Progressive's payment of the Medicaid-adjusted provider rates rather than the providers' "sticker price." The policy only provides medical payments coverage for certain medical "expenses incurred" by Jones. Since Jones did not incur expenses beyond the Medicaid-adjusted rates, Progressive appropriately reimbursed her, pursuant to the medical payments coverage, at the Medicaid-adjusted rates.

FACTUAL AND PROCEDURAL BACKGROUND

A. The Progressive Policy

Progressive Northern Insurance Company ("Progressive") issued a personal auto policy, Policy No. 930693102, to Willie Brown with effective dates of June 21, 2019 to December 21, 2019 (the "Policy"). (Policy, R. p. 53). The Policy includes a medical payments coverage limit of \$10,000 each person. (Policy, R. p. 54). The Policy only provides medical payments coverage for certain medical expenses actually incurred by an insured person. The Policy provides in pertinent part:

PART II – MEDICAL PAYMENTS COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary **medical services** received within three years from the date of a **motor vehicle** accident because of **bodily injury**:

1. Sustained by an **insured person**; and
2. Caused by that **motor vehicle** accident.

(Policy, R. p. 66). Thus, the Policy only provides medical payments coverage for certain "expenses incurred for necessary medical services."

B. The October 8, 2019 Accident and Jones' Resulting Medical Payments Claim

On October 8, 2019, Jones was involved in an auto accident. (Compl., R. p. 22 ¶ 11). Jones made a claim for medical payments coverage under the Policy. (Compl., R. p. 23 ¶ 13). With her

claim, Jones submitted medical provider billing statements in excess of \$10,000. (Compl., R. pp. 22-23 ¶¶ 12-13). However, Jones is a Medicaid recipient. (Stipulation of Fact, R. p. 138 ¶ 4); (February 10, 2021 Circuit Court Order, R. p. 5). Prior to her ever receiving treatment, Medicaid had agreements in place with her medical service providers wherein the providers agreed to accept reduced rates as payment-in-full. (Stipulation of Fact, R. pp. 138-40); (February 10, 2021 Circuit Court Order, R. p. 5). Medicaid paid \$1,323.60 total for the medical treatment Jones received, and the medical providers accepted this amount as payment-in-full for the treatment rendered. *See* (April 6, 2023 Circuit Court Order, R. p. 14). Progressive paid medical payments coverage to Jones in the amount of \$1,323.60 – the same amount her medical providers accepted as payment in full for the treatment rendered. (*Id.*). Jones “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 ...” (Stipulation of Fact, R. p. 140 ¶ 17). At the bench trial, Jones testified as follows:

Q. Ms. Jones, as I understand it, Medicaid paid the hospital bill at MUSC and all the other doctors you went to from the accident on your behalf?

A. Yes.

Q. You’ve paid no money yourself?

A. No.

Q. Is that correct?

A. Correct.

Q. And you’re not legally obligated to pay any money to any of those by virtue of you being a Medicaid beneficiary. The hospital and doctors that you saw have agreed to accept what Medicaid paid them for a payment in full?

A. Yes.

Q. And you had no deductibles, out-of-pockets, nothing. Everything that you owed the doctors have been paid for by Medicaid?

A. Yes.

(R. p. 123, lines 4-24).

Despite the foregoing, Jones alleges she is owed the full \$10,000 medical payments coverage limit and that Progressive still owes her "\$8,676.40 in outstanding Medpay coverage." (Compl., R. pp. 23, 29-30 ¶¶ 14, 16, 25, Wherefore B.). Jones' Complaint asserted the following causes of action related to her medical payments coverage claim: (1) bad faith; (2) breach of contract; (3) breach of fiduciary duty; (4) breach of the covenant of good faith and fair dealing; (5) breach of contract accompanied by a fraudulent act; (6) violation of the South Carolina Unfair Trade Practice Act; and (7) violation of South Carolina Code § 38-77-144. (Compl., R. pp. 21-31).

C. Motions and Circuit Court Orders²

On May 11, 2020, Progressive filed a Motion to Dismiss the Complaint and a Memorandum of Law in support. (R. pp. 38-52). On August 10, 2020, the Circuit Court entered an Order granting the Motion in part and dismissing Jones' South Carolina Unfair Trade Practices Act claim. (R. pp. 2-4). On August 20, 2020, Progressive filed a Motion to Reconsider the August 10, 2020 Order. (R. pp. 107-08). On February 10, 2021, the Circuit Court entered an Order granting the Motion to Reconsider in part and denying it in part. (R. pp. 5-9). In this Order, the Circuit Court dismissed all the causes of action except for the breach of contract cause of action. The Order states:

[T]he Court finds that based on the allegations of the Complaint, and the legal positions of the parties, that 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. Therefore, those causes of action in the Plaintiff's Complaint, are hereby dismissed.

² When the case was originally filed, Willie Brown was a plaintiff. On September 3, 2020, the parties filed a Stipulation wherein it was acknowledged that he is not a real party in interest, and he was dismissed from the case.

(R. p. 7). The Order recognized that Progressive had submitted legal authority that the phrase “expenses incurred” meant the amount of money which an insured is legally obligated to pay for medical treatment and that South Carolina law allows an insurer to litigate a novel issue of law without fear of a bad faith or extra contractual claim. (R. p. 6). The Order also dismissed Jones’ “violation of South Carolina Code § 38-77-144” claim because the statute does not create a private cause of action. (R. p. 7).

The Circuit Court then held a bench trial on the only remaining cause of action for breach of contract. By Orders filed March 29, 2023 and April 6, 2023, the Circuit Court found for Jones on her breach of contract cause of action, awarding her \$8,676.40. (R. pp. 10-19). The Orders denied Jones’ request for attorney’s fees. (R. p. 17). Progressive’s appeal and Jones’ cross-appeal followed.

STANDARD OF REVIEW

“[A] respondent—the ‘winner’ in the lower court—may raise on appeal any additional reasons the appellate court should affirm the lower court’s ruling, regardless of whether those reasons have been presented to or ruled on by the lower court.” *Ion, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 419, 526 S.E.2d 716, 723 (2000). With respect to Jones’ (1) breach of contract accompanied by a fraudulent act claim; (2) bad faith claim; (3) breach of the covenant of good faith and fair dealing claim; (4) breach of fiduciary duty claim; (5) SCUTPA claim; (6) Section 38-77-144 claim; and (7) attorney’s fees claim, Progressive was the “winner” in the lower court. Therefore, as to these claims, the Court may affirm the Circuit Court’s ruling in favor of Progressive on any ground supported by the record on appeal. *See id.*

ARGUMENT

Alexis Jones appeals dismissal of one of her statutory claims – “violation of South Carolina Code of Laws Section 38-77-144.” (Compl., R. pp. 28-29 ¶¶ 24-25). This cause of action was properly dismissed because the statute is inapplicable to the conduct alleged and because the statute does not create a private cause of action. Her Complaint also asserts numerous common-law causes of action, all of which are premised on Progressive’s payment of Jones’ medical payments claim at the Medicaid-adjusted provider rates. Because the Progressive Policy only provides medical payments coverage for “expenses incurred,” such claims were properly dismissed. Under both federal and state Medicaid provisions, Jones never incurred expenses beyond her medical providers’ Medicaid-adjusted rates. Furthermore, the common law causes of action were properly dismissed for separate, additional reasons.

- I. **Jones’ “violation of South Carolina Code of Laws Section 38-77-144” claim was properly dismissed for two independent reasons.**
 - A. **This claim was properly dismissed because the “violation” alleged by Jones is not the conduct prohibited by the statute.**

South Carolina Code § 38-77-144 provides that “medical payments coverage...is not subject to a setoff.” S.C. Code § 38-77-144. Jones alleges that Progressive’s payment of medical payments coverage at the Medicaid-adjusted provider rates constitutes a setoff under § 38-77-144, but it does not. *See* (Compl., R. p. 29 ¶ 25). The South Carolina Supreme Court recently described what constitutes a “setoff” under South Carolina Code § 38-77-144. In *Cothran v. State Farm Mut. Auto. Ins. Co.*, a provision in the insurance policy purported to reduce the insurer’s obligation to pay PIP coverage to the insured by the amount the workers compensation carrier paid for the insured’s medical expenses. 427 S.C. 545, 550, 831 S.E.2d 919, 922 (2019) (“In this case, State Farm’s obligation to pay PIP coverage to Wadette is reduced—eliminated, in fact—by the amount her employer’s workers’

compensation carrier paid her for medical expenses.”). The Court held that this was a “setoff” in violation of § 38-77-144. *Id.*

As the Court explained, “The term ‘setoff’ is used universally to describe the reduction of PIP benefits by the amount of a third-party payment.” *Id.* at 550 n.3, 831 S.E.2d at 922 n.3. A setoff under the statute occurs when the insurer’s obligation to pay the insured is reduced by the amount of a third-party’s payment to the insured. The Court used a mathematical calculation to describe a setoff scenario:

Wadette incurred approximately \$40,000 in medical expenses. Her PIP benefits policy limit is \$5,000....If her workers’ compensation benefits were \$37,500, the “Coordination” provision would take effect and State Farm would owe her \$2,500. In this case, her workers’ compensation benefits equaled the total amount of her medical expenses, so the effect of the “Coordination” provision would be to eliminate State Farm’s obligation to pay any PIP benefits.

Id. at 550 n.2, 831 S.E.2d at 922 n.2. Given this example, a setoff occurs when the medical payments insurer takes the total medical expense amount the insured incurred and subtracts the benefits paid by a third-party to determine the amount of the policy limit it is required to pay (i.e., \$40,000 [incurred medical expenses] - \$40,000 [workers’ compensation benefits] = \$0 [medical payments coverage]).

Thus, a “setoff,” as that term has been defined by the South Carolina Supreme Court, would occur if Progressive attempted to reduce its medical payments coverage by the amounts paid by Medicaid – i.e., paid no medical payments coverage because Medicaid had already taken care of Jones’ treatment expenses. That is not what Progressive did or even what Jones alleges Progressive did. (Compl., R. p. 29 ¶ 25); (April 6, 2023 Circuit Court Order, R. p. 14 (recognizing that Progressive paid Jones the same “amount Medicaid paid to satisfy the medical bills”)). Her Complaint does not allege that Progressive reduced its medical payments benefits by the amount of the Medicaid payment. *See* (Compl., R. p. 29 ¶ 25). Rather, Jones alleges that Progressive “violated Section 38-77-144 by refusing to pay Plaintiff *any amount above* what Medicaid paid to Plaintiff Jones’s health care

providers.” (*Id.*) (emphasis added). Paying medical payments coverage at a Medicaid-adjusted provider rate does not constitute a “reduction of PIP benefits by the amount of a third-party payment.” *Cothran*, 427 S.C. at 550 n.3, 831 S.E.2d at 922 n.3. Because this does not constitute a “setoff” under South Carolina Code § 38-77-144, Jones’ “violation of South Carolina Code of Laws Section 38-77-144” claim was properly dismissed.

Moreover, nothing in South Carolina Code § 38-77-144 requires medical payments coverage for amounts greater than those actually incurred by the insured – i.e., amounts greater than the reduced rates negotiated between Medicaid and medical providers. As explained in Progressive’s Appellant Initial Brief and Reply Brief, such a requirement would be contrary to prior South Carolina Supreme Court precedent.

B. This claim was also properly dismissed because the statute does not create a private cause of action.

“‘[T]he 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.’” *Adkins v. South Carolina Dep’t of Corr.*, 360 S.C. 413, 418, 602 S.E.2d 51, 54 (2004) (quoting *Whitworth v. Fast Fare Markets of South Carolina, Inc.*, 289 S.C. 418, 420, 338 S.E.2d 155, 156 (1985)). “Where a statute does not specifically create a private cause of action, one can be implied **only if the legislation was enacted for the special benefit of a private party.**” *Id.* (emphasis in orig.). “A statute creates no liability to the person injured unless it discloses an intention, express or implied, that from disregard of the statutory command, a liability for resultant damage arises, which would not exist but for the statute.” *Denson v. National Cas. Co.*, 439 S.C. 142, 150, 886 S.E.2d 228, 233 (2023) (emphasis added).

South Carolina Code § 38-77-144, entitled “Personal injury protection (PIP) coverage not mandated,” does not purport to establish a civil liability. *See* S.C. Code § 38-77-144; *see also* (Jones’

Appellant Brief, p. 14 (“The statute does not expressly create a private right of action....”). It provides in full:

There is no personal injury protection (PIP) coverage mandated under the automobile insurance laws of this State. Any reference to personal injury protection in Title 38 or 56 or elsewhere is deleted. If 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.

S.C. Code § 38-77-144. Thus, the statute was enacted to make PIP/medical payments coverage non-mandatory. See (Jones’ Appellant Brief, p. 14 (“This statute removed the requirement that automobile insurers offer PIP of MedPay coverage....”). Furthermore, there is no need for this statutory provision to create a private cause of action “Statutory provisions relating to an insurance contract are part of the contract as a matter of law.” *Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 178, 700 S.E.2d 283, 287 (Ct. App. 2010); *Williams v. Gov’t Emps. Ins. Co. (GEICO)*, 409 S.C. 586, 598, 762 S.E.2d 705, 712 (2014) (same). Consequently, a violation of this statutory provision may constitute a breach of the insurance contract but would not give rise to its own independent cause of action. See *Denson*, 439 S.C. at 149–50, 886 S.E.2d at 232 (“[T]he duty or standard of care, statutory or otherwise, is merely an element of proof that comes into play *after* an action has been rightfully commenced *pursuant to the preexisting common-law cause of action.*”) (emphasis in orig.). Jones’ prior Respondent Brief on her breach of contract claim demonstrates this principle. It specifically incorporates her “setoff” argument into her breach of contract argument. (Jones’ Respondent Brief, pp. 3-5). Therefore, Jones’ “violation of South Carolina Code of Laws Section 38-77-144” claim was also properly dismissed because the statute creates no private cause of action, and such claim is duplicative of her breach of contract claim.

II. The Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act, bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims because Progressive's alleged actions at issue were in accordance with the terms of the insurance policy and South Carolina law.

The Circuit Court properly dismissed all of the above common-law claims. (February 10, 2021 Circuit Court Order, R. pp. 5-9). Each of these claims are premised on Progressive paying the reduced rates Medicaid previously negotiated with Jones' medical providers rather than the "sticker prices" on the providers' initial bills. *See* (Compl., R. pp. 22-30 ¶¶ 12-13, 20.c, 21.d.iii., 25.d., Wherefore B.); (Tr. Transcript, R. pp. 113-15) As more fully explained in Progressive's Appellant Initial Brief and Reply Brief, these actions were taken in accordance with the policy terms and allowed under South Carolina law.³ Therefore, those claims were properly dismissed.

In her Complaint, the "breach of contract accompanied by a fraudulent act" section does not set forth any alleged breach of the insurance contract, a required element of the claim. *See* (Compl., R. p. 27 ¶ 22); *Conner v. City of Forest Acres*, 348 S.C. 454, 465, 560 S.E.2d 606, 612 (2002) ("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....") From the remainder of the Complaint, the only potential breach Jones alleges is failure to pay medical payments coverage based on the total charges listed on the initial medical bills rather than the Medicaid-adjusted amounts actually accepted for services rendered. *See* (Compl., R. pp. 22-23, 29-30 ¶¶ 12-13, 25, Wherefore B.). This conduct is also the basis for Jones' other claims.⁴

³ Progressive's arguments set forth in its Appellant Initial Brief (filed August 14, 2023) and Reply Brief (filed November 3, 2023) are fully incorporated herein by reference.

⁴ In the Complaint, Jones' "breach of fiduciary duty" and "breach of the covenant of good faith and fair dealing" claim sections do not set forth any specific "breach" but merely state that Progressive breached its duties by its actions and conduct alleged elsewhere in the Complaint.

An insurer's obligation under an insurance policy is defined by the terms of the policy and cannot be enlarged by judicial construction. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137, 390 S.E.2d 471, 474 (Ct. App. 1990).⁵ "[I]f the intention of the parties is clear, courts have no authority to torture the meaning of policy language to extend or defeat coverage that was never intended by the parties." *Kay v. State Farm Mut. Auto. Ins. Co.*, 349 S.C. 446, 450, 562 S.E.2d 676, 679 (Ct. App. 2002). The Policy provides medical payments coverage for certain "reasonable expenses incurred for necessary medical services." (Policy, R. p. 66) (emphasis added). In the context of a medical payments coverage claim, the South Carolina Supreme Court in *Gordon v. Fidelity & Cas. Co. of N. Y.* clearly articulated that "expenses incurred" means there is an obligation on the part of the insured to pay that amount for the medical treatment or service received. 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961). It further explained that "a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'." *Id.* at 445, 120 S.E.2d at 512 (emphasis added).

Due to the way Medicaid works, Jones never became obligated to pay any amounts beyond the Medicaid-adjusted rates. Medicaid already has agreements in place with Medicaid providers before a Medicaid recipient ever receives any treatment. Pursuant to the South Carolina Medicaid provider agreement, the provider agrees before rendering treatment "that Medicaid reimbursement is payment in full...for care or services to a recipient/patient" and "that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient..." Medicaid

(Compl., R. pp. 25-27 ¶¶ 20-21). Jones' bad faith section alleges Progressive acted in bad faith by "offering substantially less than the amount due" under the policy. (Compl., R. p. 24 ¶ 17.g.).

⁵ Under South Carolina law, there is no statutorily mandated medical payments/personal injury protection coverage. S.C. Code § 38-77-144; *State Farm Mut. Auto. Ins. Co. v. Richardson*, 313 S.C. 58, 60, 437 S.E.2d 43, 45 (1993).

Participation and Payment Agreement, Form (07/17), available at <https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf> (emphasis added). Pursuant to the Code of Federal Regulations, a Medicaid provider is required to accept these previously-agreed-to amounts as "payment in full." 42 C.F.R. § 447.15 (requiring state Medicaid agency to "limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayments required by the plan to be paid by the individual"). Prior to the bench trial in this case, the parties stipulated that beyond the Medicaid-adjusted rates "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." (Stipulation of Fact, R. p. 140 ¶ 17) (emphasis added).

Therefore, under South Carolina law, Jones has not "incurred" expenses for medical services beyond the Medicaid-adjusted rates, which Progressive has already paid. *See also Barker v. Washington Nat. Ins. Co.*, No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013) (granting insurer summary judgment on insured's breach of contract and bad faith claims where insurer paid medical payments coverage based on Medicare-adjusted rates rather than "total charges" listed on providers initial bills).⁶ Consequently, the act of paying medical payments coverage based

⁶ *See also State Farm Mut. Auto. Ins. Co. v. Bowers*, 255 Va. 581, 585-586, 500 S.E.2d 212, 214 (1998) (holding insured did not "incur" expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015) (stating "[a] number of courts in other jurisdictions have found 'expenses incurred' to mean the amount actually paid, as opposed to the amount charged by the care provider" and holding "expenses incurred" meant amount insured actually paid to satisfy medical providers after "other insurance coverage...negotiated a lower rate of payment"); *Metz v. U.S. Life Ins. Co. in City of New York*, 662 F.3d 600, 602 (2d Cir. 2011) (holding "incurred" for insurance coverage meant

on medical providers' adjusted rates for a Medicaid patient rather than amounts listed on an initial bill is not a breach of the Progressive insurance contract. Therefore, Jones' breach of contract accompanied by a fraudulent act, bad faith, breach of the duty of good faith and fair dealing, and breach of fiduciary duty claims – all of which are premised on such act – were properly dismissed. See *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359, 415 S.E 2d 393, 396 (1992) (“The elements of a cause of action for bad faith refusal to pay first party benefits under a contract of insurance are... (2) refusal by the insurer to pay benefits due under the contract....”).

III. The Circuit Court properly dismissed Jones' bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims because such claims were duplicative, and Progressive had a reasonable basis to argue that payment of medical payments coverage should be at the Medicaid-adjusted rates.

A. Jones' “breach of the covenant of good faith and fair dealing” and “breach of fiduciary duty” claims were properly dismissed because they are duplicative of her bad faith claim.

Jones' bad faith, breach of the duty of good faith and fair dealing, and breach of fiduciary duty claims amount to a single bad faith claim. (February 10, 2021 Circuit Court Order, R. p. 7 (finding them to be “duplicative”). First, bad faith and breach of an implied duty of good faith and fair dealing are not separate causes of action. *Ocean Winds Council of Co-Owners, Inc. v. Auto-Owners Ins. Co.*, 241 F. Supp. 2d 572, 577 (D.S.C. 2002) (“[B]ad faith refusal to pay benefits and breach of implied warranty of good faith and fair dealing are not separate causes of action.”); *Sentry Select Ins. Co. v. Guess Farm Equip., Inc.*, No. CIV.A. 5:12-03504-JM, 2013 WL 5797742, at *10 (D.S.C. Oct. 25, 2013) (dismissing counterclaim for bad faith “because it is duplicative” of claim for breach of duty of good faith and fair dealing). Moreover, when a party's breach of

reduced rates negotiated by Medicare because insured “did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her”); *Woodrich v. Farmers Ins. Co.*, 405 F.Supp.2d 1276, 1279 (N.D.Okla.2004).

fiduciary duty claim is based on the same duty and arises out of the same factual allegations as another claim, it is duplicative and should be dismissed. *See RFT Mgmt. Co. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 336, 732 S.E.2d 166, 173 (2012) (dismissing breach of fiduciary duty claim because duplicative of legal malpractice claim based on same attorney-client relationship and factual allegations) In the Complaint, Jones' "breach of fiduciary duty" and "breach of the covenant of good faith and fair dealing" claim sections do not set forth any specific "breach" but merely state that Progressive breached its duties by conduct alleged elsewhere in the Complaint. (Compl., R. pp. 25-27 ¶¶ 20-21 ("Defendant's conduct as averred hereinabove was in breach of fiduciary duty")). Jones' own Appellant Brief demonstrates that these three claims are duplicative as she too lumps them together when discussing them and analyzes them all as a bad faith claim. (Jones' Appellant Brief, pp. 8-12 (calling these three (3) claims all "claims for bad faith")). Therefore, Jones' "breach of the covenant of good faith and fair dealing" and "breach of fiduciary duty" claims were properly dismissed because they are duplicative of her bad faith claim.

B. Jones' bad faith claim was properly dismissed because Progressive had a reasonable basis to dispute paying her medical payments claim at a higher rate than the Medicaid-adjusted rates.

"[I]f there is any reasonable ground for contesting the claim, there is no bad faith." *Varnadore v. Nationwide Mut. Ins. Co.*, 289 S.C. 155, 158, 345 S.E.2d 711, 714 (1986); *Crossley*, 307 S.C. at 360, 415 S.E.2d at 397 (same); *BMW of N. Am., LLC v. Complete Auto Recon Servs., Inc.*, 399 S.C. 444, 453, 731 S.E.2d 902, 907 (Ct. App. 2012) ("[W]here an insurer has a reasonable ground for contesting a claim, there is no bad faith."). Here, Progressive had a reasonable basis for contesting paying Jones' medical payments claim at a higher rate than the Medicaid-adjusted rates her providers accepted as payment in full for her treatment. The Policy only provides medical payments coverage for certain "reasonable *expenses incurred* for necessary medical services."

(Policy, R. p. 66) (emphasis added). As Jones admits, she is a Medicaid recipient, and she is not “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....” (Stipulation of Fact, R. pp. 138, 140 ¶¶ 4, 17). Moreover, as shown above and in Progressive’s Appellant Brief, numerous cases have held that “expenses incurred” for Medicaid and Medicare recipients are the adjusted rates their providers agreed to accept as payment in full prior to their treatment. Thus, as a matter of law, Progressive had a reasonable basis for contesting this claim, and Jones’ bad faith cause of action was properly dismissed.

As the Circuit Court correctly held and explained:

Under South Carolina law, an insurer who has a meritorious coverage defense is free to litigate the issue without fear of a bad faith or extra contractual claim. *Crossley v. State Farm Mut. Auto Ins. Co.*, 307 S.C. 354, 359, 415 S.E.2d 393, 396 (1992). Moreover, an insurer is not required to concede a novel issue of law in order to avoid a bad faith lawsuit. *Id.*; *Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 357 S.C. 631, 645, 594 S.E.2d 455, 462 (2004). In this case, Progressive Northern submitted legal authority that the term or the phrase “expenses incurred” meant the amount of money which an insured is legally obligated to pay for medical treatment. *Gordon v. Fidelity & Cas. Co. of N. Y.*, 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961); *Barker v. Washington Nat. Ins. Co.*, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013). Progressive Northern also submitted out of jurisdiction cases supporting this principle of law.... [T]he Court finds that based on the allegations of the Complaint, and the legal positions of the parties, that 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. Therefore, those causes of action in the Plaintiff’s Complaint, are hereby dismissed.

(February 10, 2021 Circuit Court Order, R. pp. 6-7).⁷ Therefore, the Circuit Court properly dismissed Jones’ bad faith claim.

⁷ Like in her Respondent Brief on the breach of contract claim, Jones’ Appellant Brief attempts to distinguish *Gordon* and *Barker* and inject the irrelevant issue of collateral source. (Jones’ Appellant Brief, pp. 9-12). For the reasons previously articulated in Progressive’s Reply Brief, *Gordon* is controlling and *Haselden* and its progeny are irrelevant.

IV. The Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act claim because she did not allege a separate fraudulent act and the only alleged acts were not fraudulent.

"To maintain an action for breach of contract accompanied by a fraudulent act, a plaintiff must prove 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." *RoTec Servs., Inc. v. Encompass Servs., Inc.*, 359 S.C. 467, 470, 597 S.E.2d 881, 883 (Ct. App. 2004). Under this claim in her Complaint, Jones does not set forth what the alleged breach of contract is or what the alleged fraudulent act is. (Compl., R. p. 27 ¶ 22). From the remainder of the Complaint, the only potential breach and fraudulent act Jones alleges is failure to pay medical payments coverage based on the total charges on the initial medical bills rather than the Medicaid-adjusted amounts for services rendered. *See* (Compl., R. pp. 22-23, 29-30 ¶¶ 12-13, 25, Wherefore B.).

Consequently, this claim was properly dismissed for three (3) separate reasons. Jones did not allege a fraudulent act separate from her alleged breach of contract. Additionally, as explained above and in Progressive's Appellant Brief, paying medical payments coverage at the Medicaid-adjusted

Furthermore, for Progressive the bad faith claim has a lower bar than the breach of contract claim. The question is whether Progressive had a reasonable basis for paying her medical payments claim at the Medicaid-adjusted rates. Although Progressive believes *Gordon* is controlling in this case, at a minimum *Gordon*, *Barker*, and the other cases cited by Progressive provide a reasonable basis for the belief that a Medicaid recipient does not incur expenses for amounts beyond the Medicaid-adjusted rates because there is no obligation to pay those amounts. *See Gordon*, 238 S.C. at 446, 120 S.E.2d at 513 ("[A] thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'."). In her Brief, Jones essentially admits that the Court would have to reject the analysis in *Barker* to reach her desired result in this case. (Jones' Appellant Brief, p. 11 ("Respectfully, Judge Duffy's unpublished order is wrong, and this Court should reject that analysis.")). This further demonstrates that Progressive had a reasonable basis under the *Barker* analysis for paying her claim at the Medicaid-adjusted rates.

rates is not a breach of the insurance policy. This is also not a fraudulent act, as required for this claim. Thus, for each of these separate reasons, this cause of action was properly dismissed.

The key element of this claim is a fraudulent act; "mere breach of a contract, even if willful or with fraudulent purpose, is not sufficient." *Lister v. NationsBank of Delaware, N.A.*, 329 S.C. 133, 142, 494 S.E.2d 449, 454 (Ct. App. 1997). The alleged fraudulent act must be "separate and distinct from the act(s) constituting the breach" *Smith v. Canal Ins. Co.*, 275 S.C. 256, 260, 269 S.E.2d 348, 350 (1980) (emphasis added); see also *Minter v. GOCT, Inc.*, 322 S.C. 525, 530, 473 S.E.2d 67, 70-71 (Ct. App. 1996) (requiring "evidence of an independent fraudulent act which accompanied the breach"). Where, as here, the alleged breach of contract and fraudulent act are one and the same, this claim is properly dismissed. See *Smith*, 275 S.C. at 260, 269 S.E.2d at 350 (holding this cause of action should have been struck where complaint merely restated manner in which defendant was alleged to have breached contract and the acts alleged "merely reaffirm [the insurer's] position on coverage and are not fraudulent in and of themselves"). Jones' Complaint does not articulate any separate allegedly fraudulent act.

Even now, Jones has failed to articulate a separate fraudulent act from her alleged breach of contract – i.e., paying the medical payments coverage at the Medicaid-adjusted rates. In her Appellant Brief, Jones argues that the "fraudulent act" underpinning her claim is actually "unfair dealing in the manner in which Progressive adjusted her claims for MedPay benefits" – i.e., "Progressive relied upon *Gordon...and Barker*" to pay her the Medicaid-adjusted rates. (Jones' Appellant Brief, pp. 12-13) (emphasis added). This conduct is not "separate and distinct from the act(s) constituting the [alleged] breach." See *Smith*, 275 S.C. at 260, 269 S.E.2d at 350. Therefore, the Circuit Court properly dismissed her "breach of contract accompanied by a fraudulent act" claim.

Additionally, to the extent this is her alleged "fraudulent act," this claim was properly dismissed because it is duplicative of her breach of the covenant of good faith and fair dealing claim, her breach of fiduciary duty claim, and her bad faith claim – all of which are premised on the same duty and acts. *See, e.g., Ocean Winds Council of Co-Owners, Inc.*, 241 F. Supp. 2d at 577; *Sentry Select Ins. Co.*, 2013 WL 5797742, at *10; *RFT Mgmt. Co.*, 399 S.C. at 336, 732 S.E.2d at 173.

This claim was also properly dismissed because paying medical payments coverage at the Medicaid-adjusted rates is not a fraudulent act. "Fraudulent act" is defined as "any act characterized by dishonesty in fact or unfair dealing." *RoTec Servs., Inc.*, 359 S.C. at 470, 597 S.E.2d at 883. "This fraudulent act, although separate and distinct from the act(s) constituting the breach, must accompany the breach and not be too remote in either time or character." *Smith*, 275 S.C. at 260, 269 S.E.2d at 350. The "facts and circumstances peculiar to each case [are] to bear heavily upon the conscience and judgment of the court or jury in determining its presence or absence." *Conner*, 348 S.C. at 466, 560 S.E.2d at 612.

Based on long-standing South Carolina Supreme Court precedent, Progressive understood and understands "expenses incurred" to mean expenses that the insured becomes obligated to pay. *See Gordon*, 238 S.C. at 446, 120 S.E.2d at 513. Jones is a Medicaid beneficiary, so she was never obligated to pay more than the Medicaid-adjusted rates. As a result, Progressive paid her medical payments claim at the Medicaid-adjusted rates rather than the "sticker prices" she was never obligated to pay. As a matter of law, this was not a fraudulent act. Jones failed to allege any facts which would tend to prove Progressive committed a fraudulent act accompanying its alleged breach of contract. Therefore, the Circuit Court also properly dismissed her breach of contract accompanied by a fraudulent act claim for this reason. *See RoTec Servs., Inc.*, 359 S.C. at 470, 597

S.E.2d at 883 (holding trial court's dismissal of this claim was proper where Encompass "failed to allege any facts which would tend to prove Rotec committed a fraudulent act accompanying its alleged breach of contract").

V. The Circuit Court properly denied Jones' claim for attorney's fees.

"Attorney's fees are not recoverable unless authorized by contract or by statute." *South Carolina Dep't of Soc. Servs. v. Tharp*, 312 S.C. 243, 245, 439 S.E.2d 854, 856 (1994). Nothing in the Progressive insurance contract allows for the recovery of attorney's fees in this case. *See* (Policy, R. pp. 53-93). Although attorney's fees may be awarded in a bad faith action pursuant to South Carolina Code § 38-59-40, there must be a trial judge's specific "finding of fact supported by the evidence" that the refusal to pay was without reasonable cause. *Baker v. Pilot Life Ins. Co.*, 268 S.C. 609, 613, 235 S.E.2d 300, 302 (1977); S.C. Code § 38-59-40(1) (requiring "a finding on suit of the contract made by the trial judge that the refusal was without reasonable cause or in bad faith").⁸ Here, there was no such finding of fact supported by the evidence. Rather, the Circuit Court properly dismissed Jones' bad faith claim, finding Progressive had a reasonable basis to refuse payment of Jones' medical payments claim at the "sticker prices" rather than the Medicaid-adjusted rates. (February 10, 2021 Circuit Court Order, R. pp. 6-7); (April 6, 2023 Circuit Court Order, R. p. 17). As shown above, Progressive had a reasonable basis for contesting this claim.⁹

⁸ In her Appellant Brief, Jones has limited her attorney's fees claim to this statute. (Jones' Appellant Brief, p. 16 (seeking attorney's fees "under S.C. Code Ann. § 38-59-40 (2015)").

⁹ In her own Brief, Jones acknowledges that the *Barker* court's analysis supports Progressive's position and that this Court would have to find its analysis to be in error to find for Jones. *See* (Jones' Appellant Brief, pp. 11, 13 (alleging Barker is "wrongly decided" and that "the district court wrongfully predicted the application of South Carolina law" and that the "order is wrong, and this Court should reject that analysis").

Moreover, the South Carolina Supreme Court has explicitly cautioned against awarding attorney's fees when an insurer is contesting "legal principles of novel impression in this State" because "[c]ertainly in a free society, one is entitled to properly litigate without the fear of unequal punishment." *Nelson v. United Fire Ins. Co. of New York*, 275 S.C. 92, 97, 267 S.E.2d 604, 607 (1980); *Greene v. Durham Life Ins. Co.*, 287 S.C. 197, 199, 336 S.E.2d 478, 480 (1985) (denying attorney's fees because insurer "should not be penalized for its decision to litigate a meritorious issue"); see also *Wiggins v. Travelers Ins. Co.*, 498 F. Supp. 211, 213 (D.S.C. 1979), *aff'd sub nom. Freddie Wiggins, Jr. v. Travelers Ins. Co.*, 636 F.2d 1215 (4th Cir. 1980). "The legislature did not intend, by enactment of [the attorney fee statute], that attorneys' fees should be paid in every contested case won by the insured." *Boggs v. Aetna Cas. & Sur. Co.*, 272 S.C. 460, 465, 252 S.E.2d 565, 568 (1979). Therefore, the Circuit Court properly denied Jones' claim for attorney's fees.

CONCLUSION

For the above-stated reasons, the Circuit Court's dismissal of Jones' bad faith, breach of fiduciary duty, breach of the covenant of good faith and fair dealing, breach of contract accompanied by a fraudulent act, and violation of South Carolina Code § 38-77-144 claims should be affirmed. With respect to the statutory cause of action, that statute is inapplicable to the conduct at issue and does not create a private cause of action.

With respect to the common law causes of action, many of which are duplicative, the alleged conduct at issue is permitted by the Policy terms and South Carolina law. The Policy only requires Progressive to pay for certain medical "expenses incurred" by the insured. The South Carolina Supreme Court previously held that the phrase "expenses incurred" requires an obligation on the part of the insured to pay such expense. Jones is a Medicaid recipient. Prior to treatment

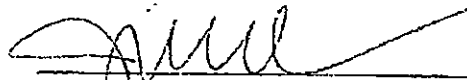
being rendered, Medicaid has agreements in place with its providers to accept certain rates as payment in full. As a result, Jones never became obligated to pay any medical expenses beyond the Medicaid-adjusted rates, which Progressive has already paid. Therefore, all of Jones' common law claims based on this conduct were properly dismissed.

In addition, the Circuit Court properly found that Progressive had a reasonable basis to contest reimbursement to Jones under the medical payments coverage at a higher rate rather than the Medicaid-adjusted rates. As a result, Jones' bad faith and statutory attorney's fees claims were also properly decided in Progressive's favor.

Progressive respectfully requests that the Court affirm the Circuit Court's rulings on these causes of action.

Respectfully submitted.

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Columbia, South Carolina
November 29, 2023

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S.C. SUPREME COURT

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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Nov 29 2023

SC Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company Appellant – Respondent.

CERTIFICATE OF COMPLIANCE

I, J.R. Murphy, attorney for Appellant-Respondent, certify that the Final Respondent Brief of Progressive Northern Insurance Company complies with the South Carolina Supreme Court Order of August 13, 2007 and Rule 211(b), SCACR.



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Nov 29 2023

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
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APPEAL FROM CHESTER COUNTY
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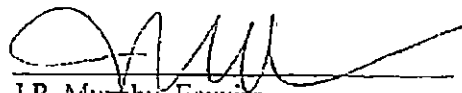
Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

PROOF OF SERVICE

I certify that I have served the Final Respondent Brief of Appellant-Respondent on Alexis Jones by depositing a copy of it in the United States Mail, postage prepaid, on November 29, 2023, addressed to her attorneys of record, J. Logan Cannon, Esquire, P.O. Drawer 36250, Rock Hill, South Carolina 29732 and by electronic mail at cannon@shawlawfirm.net and John S. Nichols, Esquire, Bluestein Thompson Sullivan, LLC, PO Box 7965, Columbia, SC 29202, and by electronic mail at john@bluesteinattorneys.com.



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**THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE
CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING
EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.**

**THE STATE OF SOUTH CAROLINA
In The Court of Appeals**

Alexis Jones, Respondent-Appellant,

v.

Progressive Northern Insurance Company, Appellant-
Respondent.

Appellate Case No. 2023-000654

Appeal From Chester County
Brian M. Gibbons, Circuit Court Judge

Unpublished Opinion No. 2025-UP-074
Heard December 3, 2024 – Filed February 24, 2025

AFFIRMED

Jeffery Logan Cannon, of Shaw And Cannon, LLC, of
Rock Hill; and John S. Nichols, of Bluestein Thompson
Sullivan LLC, of Columbia, both for Appellant.

John Robert Murphy and Megan Noelle Walker, both of
Murphy & Grantland, PA, of Columbia, for Respondent.

PER CURIAM: Alexis Jones, a Medicaid recipient, was involved in a car
accident and sustained injuries. Her medical expenses originally totaled

\$27,786.17 but were subsequently adjusted to \$1,323.60 and paid for by Medicaid. Jones was also covered by an automobile insurance policy (the Policy) from Progressive Northern Insurance Company (Progressive) which included a \$10,000 medical payments provision for "incurred" medical expenses. On appeal, Progressive argues the circuit court erred in finding it breached the insurance contract by paying Jones the reduced amount of expenses paid by Medicaid instead of the entire \$10,000 policy limit. It argues the term "incurred" means only the amount actually paid by Medicaid. On cross-appeal, Jones argues the circuit court erred in denying her claims that Progressive's refusal to pay the entire \$10,000 medical payment policy limit was (1) made in bad faith, (2) a breach of the covenant of good faith and fair dealing, (3) a breach of its fiduciary duty, (4) a breach of contract accompanied by a fraudulent act, and (5) a violation of S.C. Code Ann. § 38-77-144 (2015). She also asserts the circuit court erred in declining to award her attorney's fees pursuant to S.C. Code Ann. § 38-59-40 (2015). We affirm.

1. We hold the circuit court properly found Progressive breached the contract and awarded Jones the full policy limit; however, the circuit court erred in finding the term "expenses incurred" was ambiguous. See *Gibson v. Epting*, 426 S.C. 346, 351, 827 S.E.2d 178, 181 (Ct. App. 2019) ("Ambiguity of a contract is a question of law, which we review de novo."); *McCord v. Laurens Cnty. Health Care Sys.*, 429 S.C. 286, 292-93, 838 S.E.2d 220, 223 (Ct. App. 2020) ("To be ambiguous, contract language must be susceptible to two different but plausible meanings."). Our supreme court has held that the words "expenses incurred" in an automobile insurance policy are not ambiguous and should be taken in the plain and ordinary sense of the words. See *Gordon v. Fid. & Cas. Co. of N.Y.*, 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961) (finding there was "no uncertainty or ambiguity in the language of the policy" in regards to the phrase "expense incurred," and the words "must be taken in the plain and ordinary sense in which they are generally used and understood"); *id.* ("[I]n cases where there is no ambiguity, contracts of insurance, like other contracts, must be construed according to the terms which the parties have used, to be taken and understood in their plain, ordinary and popular sense."). Black's Law Dictionary defines "incur" as "[t]o be liable or subject to." *Black's Law Dictionary* 768 (6th Ed. 1990). Additionally, our supreme court in *Gordon* stated, "South Carolina law defines 'expense incurred' for insurance purposes as 'a thing for which there exists [an] obligation to pay, either express or implied.'" See *Gordon*, 238 S.C. at 445, 120 S.E.2d at 512.

However, we find the circuit court properly determined that Jones incurred medical expenses in excess of what Progressive paid. Once Jones was treated by the

medical providers, she became liable for or subject to the costs of the care— regardless of her insurance coverage. Progressive relies heavily on the *Gordon* case. In *Gordon*, however, the plaintiff received *free* medical care from a military hospital. See *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. Further, his claim was based on an appraisal from two doctors and utilizing the prevailing rates in the area since he was not billed for the services he received. *Id.* Gordon's medical services were free so he was not obligated to pay for the services rendered. *Id.* Therefore, he did not "incur" an expense. *Id.* In this case, Jones did not receive free medical care. She was charged for the services rendered, and she was billed for the same. When Jones went for treatment, she had no way to know what treatment she needed, how much it would cost, or how much would be covered by Medicaid. Once she received the treatment, she was billed the full amount. While the bills were adjusted for Medicaid at some point, most of the bills in the record show the full amount charged with no adjustment for Medicaid. Therefore, while we acknowledge that her costs were eventually adjusted and paid by Medicaid, Jones still incurred the full amount charged and was responsible for ensuring the bills were paid.

The Policy must be construed in favor of Jones. See *id.* at 444, 120 S.E.2d at 512 (explaining "the terms of an insurance policy must be construed most liberally in favor of the insured"). First, the Policy does not provide a definition of "incurred" that differs from what case law has established. Furthermore, there is no provision in the Policy providing for a different (or lesser) payment amount when the insured is covered by Medicaid.¹ Accordingly, we believe the circuit court properly found Progressive breached the contract because Jones incurred \$27,786.17 in medical expenses and, therefore, Progressive was obligated to pay her the entire \$10,000 medical payment under the Policy.

2. We hold the circuit court properly dismissed Jones's bad faith claim. See *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 631, 699 S.E.2d 699, 703 (Ct. App. 2010) ("In reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRCF, the appellate court applies the same standard of review as the [circuit] court."); *id.* at 632, 699 S.E.2d at 703 ("[T]he [circuit] court must base its ruling solely on allegations set forth in the complaint."). Jones originally asserted three

¹ Progressive relies heavily on an unpublished order from *Barker v. Washington National Insurance Company*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013). However, the insurance contract in *Barker* contained a provision which provided the insurer would only pay the Medicare adjusted amount. We do not have such a provision in this case.

closely related claims against Progressive: bad faith, breach of duty of good faith and fair dealing, and breach of fiduciary duty. As the circuit court pointed out in its order and Jones acknowledged in her brief, we believe these three causes of action are redundant and are best analyzed together under a bad faith claim.

Neither party disputes that the first, second, or fourth elements required for a bad faith claim are met in this case. See *Cock-N-Bull Steak House, Inc. v. Generali Ins. Co.*, 321 S.C. 1, 6, 466 S.E.2d 727, 730 (1996) (explaining the elements of an action for bad faith include (1) a "mutually binding contract of insurance between the plaintiff and the defendant," (2) the insurer's refusal to pay benefits due under the contract, (3) the refusal is a result of insurer's bad faith or unreasonable action, and (4) which causes damage to the insured (quoting *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359-60, 415 S.E.2d 393, 396-97 (1992))). As to the third element, we believe there is no evidence that Progressive acted in bad faith. See *Dowling v. Home Buyers Warranty Corp.*, 303 S.C. 295, 297, 400 S.E.2d 143, 144 (1991) ("An insured may recover damages for a bad faith denial of coverage if he or she proves there was no reasonable basis to support the insurer's decision to deny benefits under a mutually binding insurance contract."). Progressive denied Jones the full policy limits based upon its misapplication of *Gordon and Barker*. Although we disagree with Progressive's interpretation of those cases, we do not find Progressive acted in bad faith. Additionally, because we hold the circuit court properly dismissed the bad faith claim, we do not reach the issue of attorney's fees.

3. We hold the circuit court properly dismissed Jones's claim for breach of contract accompanied by a fraudulent act. See *HHHunt Corp.*, 389 S.C. at 631, 699 S.E.2d at 703 ("In reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRCP, the appellate court applies the same standard of review as the [circuit] court."); *Conner v. City of Forest Acres*, 348 S.C. 454, 465-66, 560 S.E.2d 606, 612 (2002) ("[T]o 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."); *id.* at 466, 500 S.E.2d at 612 ("The fraudulent act is any act characterized by dishonesty in fact or unfair dealing."). 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's claim was *part of* the breach. See *Minter v. GOCT, Inc.*, 322 S.C. 525, 530, 473 S.E.2d 67, 70 (Ct. App. 1996) (explaining there must be "evidence of an independent fraudulent act which accompanied the breach").

4. We hold the circuit court correctly found section 38-77-144 does not provide a private cause of action. See *HHHunt Corp.*, 389 S.C. at 631, 699 S.E.2d at 703 ("In reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRCP, the appellate court applies the same standard of review as the [circuit] court."). We find the Legislature did not intend to provide insureds a private cause of action under section 38-77-144. See § 38-77-144 ("If an insurer sells no-fault insurance coverage which provides [PIP], medical payment coverage, or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a setoff."). 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. See *Denson v. Nat'l Cas. Co.*, 439 S.C. 142, 151, 886 S.E.2d 228, 233 (2023) ("The main factor in determining whether a statute gives rise to a private cause of action is legislative intent, which is determined primarily from the language of the statute."); *id.* at 151-52, 886 S.E.2d at 233 ("Generally, when a statute does not expressly create civil liability, a duty will not be implied unless the statute was enacted for the special benefit of a private party."). 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.

AFFIRMED.

WILLIAMS, C.J., and MCDONALD and TURNER, JJ., concur.

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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

Appellate Case No. 2023-000654

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

PETITION FOR REHEARING

Pursuant to Rule 221 of the South Carolina Appellate Court Rules, Appellant-Respondent Progressive Northern Insurance Company (“Progressive”), by and through its undersigned counsel, hereby respectfully submits this Petition for Rehearing.

ARGUMENT

This appeal concerns what “expenses incurred” means in the context of medical payments coverage for a Medicaid recipient. The Progressive policy only provides Medical Payments coverage for certain medical “expenses incurred” by an insured as a result of an accident. The Court’s February 24, 2025 Opinion held that Ms. Jones incurred \$27,786.17 in medical expenses even though she readily admits that she never became obligated to pay this amount. Progressive respectfully asserts that the Court’s decision warrants reconsideration because it fails to take into account the realities of how Medicaid works and makes no

meaningful distinction between this case and the Supreme Court's prior Opinion in *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961). As Medicaid providers, Ms. Jones' providers entered into provider contracts with the South Carolina Department of Health and Human Services before ever rendering any treatment to Medicaid beneficiaries. Under those provider agreements, they agreed to accept set fees as payment-in-full for services rendered. In this case, those previously-agreed-to set fees totaled \$1,323.60. As a result, there was never any obligation on the part of Ms. Jones to pay \$27,786.17 for her medical treatment. Consequently, this amount cannot be an expense she "incurred."

I. The Court's Opinion fails to take into account the realities of how Medicaid works.

The Court's Opinion states: "[W]hile we acknowledge that her costs *were eventually adjusted and paid by Medicaid*, Jones still incurred the full amount charged...." (February 24, 2025 Opinion, p. 3) (emphasis added). This statement demonstrates a fundamental misunderstanding of how Medicaid works.

"A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency...." 42 C.F.R. § 447.15.¹ Before rendering treatment to Medicaid recipients, "healthcare providers must first enter into a contract with the South Carolina Department of Health and Human Services ("SCDHHS"), the state agency responsible for the administration of the Medicaid program in South Carolina." *Pee Dee Health Care, P A. v. Sanford*, 509 F.3d 204, 206 (4th Cir. 2007). "Healthcare providers in South Carolina are not required to accept Medicaid

¹ In this case, it is undisputed that Ms. Jones was not responsible for "any deductible, coinsurance, or copayment" under Medicaid. See 42 C.F.R. § 447.15. Thus, the amount paid by the Medicaid agency was the amount the Medicaid providers had agreed to accept "as payment in full." *Id.*

patients. However, if a healthcare provider elects to treat Medicaid patients..., it does so by entering into a contract ("provider contract" or "contract") with SCDHHS." *Id.* at 207. "The contract provides for the method and amounts of payment." *Id.*; see also *Anco, Inc. v. State Health & Hum. Servs. Fin. Comm'n*, 300 S.C. 432, 436, 388 S.E.2d 780, 783 (1989) ("The Finance Commission implements the Medicaid program by contracting with qualified providers."). Pursuant to the South Carolina Medicaid provider contract, the provider agrees before rendering treatment "that Medicaid reimbursement is payment in full...for care or services to a recipient/patient" and "*that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient....*" Medicaid Participation and Payment Agreement, Form (07/17), available at <https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf> (emphasis added). Thus, a Medicaid patient never incurs costs beyond the Medicaid-adjusted rates. His or her providers have already agreed before treatment to accept those rates as "payment in full." See *id.*

As Justice Burnett succinctly explained:

The Medicaid program provides individuals with medical treatment by doctors who agree to accept such patients in exchange for payment at a predetermined rate schedule. The patient not only receives medical care, but also incurs no liability for the cost of the care once the doctor accepts payment. *The difference between the amount billed and the amount paid, the amount in issue in this case, is "phantom" money in that no one has paid the amount and no one will incur a debt for the amount.*

Haselden v. Davis, 353 S.C. 481, 487, 579 S.E.2d 293, 296 (2003) (J. Burnett dissenting and J. Pleicones concurring in dissent) (emphasis added).² "[T]he plaintiff has never paid nor will ever

² See also *McAmis v. Wallace*, 980 F. Supp. 181, 184 (W.D. Va. 1997) (recognizing that in a Medicaid situation no one pays the written-off amount and the patient "has not incurred this fee"); *Sheeks v. Farmers Ins. Exch.*, 146 Mich. App. 361, 365, 379 N.W.2d 493, 495 (Mich. Ct.

be liable for the written-off difference between the billed and paid amount..." *Id.* Consequently, "it is unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person" and then allow that person to pocket an insurance windfall, raising future insurance rates for all South Carolinians. *See id.*

II. The South Carolina Supreme Court's decision in *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961) requires this Court to find that Ms. Jones did not "incur" the "phantom" expenses billed by her medical providers in violation of their provider contracts with Medicaid.

As this Court's Opinion correctly recognizes, the phrase "expenses incurred" is not ambiguous, and the South Carolina Supreme Court has already defined it in this context. (February 24, 2025 Opinion, p. 2). In *Gordon*, the insurer "agreed 'to pay all reasonable expense incurred' for necessary medical and surgical service." 238 S.C. at 444, 120 S.E.2d at 512. The South Carolina Supreme Court stated: "There is no uncertainty or ambiguity in the language of the policy. It is too plain to call for judicial construction." *Id.*

However, this Court's Opinion fails to take into account the entirety of the definition the South Carolina Supreme Court gave to the phrase "expense incurred" in this context. This Court's Opinion states:

[O]ur supreme court in *Gordon* stated, "South Carolina law defines 'expense incurred' for insurance purposes as 'a thing for which there exists [an] obligation to pay, either express or implied.'" *See Gordon*, 238 S.C. at 445, 120 S.E.2d at 512.

App. 1985) ("[I]n the instant case, plaintiff's health care providers must accept as payment in full the Medicaid payments from the state. M.C.L. § 400.111b(11); M.S.A. § 16.490(21b)(11). Accordingly, the amount charged to and reimbursed by Medicaid is the reasonable charge incurred by plaintiff...."); *Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019); *Metz v. U.S. Life Ins. Co. in City of New York*, 662 F.3d 600, 602 (2d Cir. 2011); *State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va.1998); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *5 (N.D. Okla. Apr. 14, 2015).

(February 24, 2025 Opinion, p. 2). With respect to the language in the above parentheticals, there is no such quote in *Gordon*.

What the South Carolina Supreme Court in *Gordon* actually said was:

"Incur emphasizes the idea of liability * * *. Webster's New International Dictionary. 1. Bouv. Law Dict., Rawle's Third Revision, p. 1531 similarly points to this inherency in its definition of the term incur: 'To have liabilities thrust upon one by act or operation of law * * *'. Also, there are examples in specific legal situations, where it has been held that *a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'*. See e. g. *Stern-Slegman-Prins Co. v. Commissioner*, 8 Cir., 79 F.(2d) 289; *Bauer Bros. Co. v. Commissioner*, 6 Cir., 46 F.(2d) 874.'

There being no obligation on the part of the respondent to pay for the hospitalization he received at Fort Jackson hospital, he 'incurred' no expense within the meaning of the provision of the policy of insurance issued by the appellant.

Gordon, 238 S.C. at 444, 120 S.E.2d at 512 (emphasis added). In its Opinion, the Court states that the distinguishing factor between the South Carolina Supreme Court's case of *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961) and this case is that *Gordon* "received free medical care from a military hospital." (February 24, 2025 Opinion, p. 3) (emphasis in orig.). However, *Gordon* did not receive free medical care at a military hospital. His medical care was paid for by taxpayers. He just received free-to-him medical care. Likewise, Ms. Jones' medical care was paid for by taxpayers. She also received free-to-her medical care. Thus, the difference between medical expenses being paid by a taxpayer-funded Veterans' Administration or a taxpayer-funded Medicaid program is not a meaningful distinction.

As the South Carolina Supreme Court stated: "[A] thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'." *Gordon*, 238 S.C. at 445, 120 S.E.2d at 512. Based on the way Medicaid works, those "phantom" charges from Ms. Jones' medical providers – which they issued in violation of their

provider agreements – were “a thing for which there exists no obligation to pay.” *See id.* Consequently, those “phantom” charges cannot be an “expense incurred.” *See id.* at 446, 120 S.E.2d at 513 (“There being no obligation on the part of the respondent to pay for the hospitalization he received at Fort Jackson hospital, he ‘incurred’ no expense within the meaning of the provision of the policy of insurance issued by the appellant.”). Like the claimant in *Gordon*, Ms. Jones stipulated that she is not legally obligated to pay any money to any of her medical providers for the medical treatment she received. (R. p. 123, lines 4-24); (Stipulation of Fact, R. p. 140 ¶ 17). Thus, the *Gordon* decision requires this Court to find that Ms. Jones has “incurred” no expense within the meaning of the policy provision.³

Additionally, the insured being sent a bill for “phantom” charges she was never required to pay is also not a meaningful distinction from the *Gordon* case. The South Carolina Supreme Court in *Gordon* specifically referenced and relied upon a case where an insured had been billed

³ The Court’s Opinion also purports to distinguish the *Barker* case based on policy language:

Progressive relies heavily on an unpublished order from *Barker v. Washington National Insurance Company*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013). However, the insurance contract in *Barker* contained a provision which provided the insurer would only pay the Medicare adjusted amount. We do not have such a provision in this case.

(February 24, 2025 Opinion, p. 3 n.1). However, the fight in *Barker* was over the “expenses incurred” language in the policy. *Id.* at *4 (“*Barker* emphasizes the ‘100% in full’ language, while WNIC emphasizes ‘expenses incurred.’”). The *Barker* court did not address the Medicare limitation until after determining that the insured never “incurred” expenses above the Medicare-adjusted rates. *Id.* at *6 (“The Second Circuit Court of Appeals affirmed, concluding that under New York law, the Medicare recipient ‘did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her.’ *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir.2011). Similarly, this Court concludes that under South Carolina law, *Barker* was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare, which amount appears to be about \$15,929.29.”). The District Court based its opinion on the “expenses incurred” policy language and the way Medicare works, which is identical to Medicaid in that physicians contract ahead of time with a government agency to accept set fees for a given service. *Id.* at *4-6.

for an amount he was never required to pay, and that court held there were no expenses incurred. See *Gordon*, 238 S.C. at 444-45, 120 S.E.2d at 512 ("In the case of *Drearr v. Connecticut General Life Ins. Co.*, La.App., 119 So.2d 149, 151, the plaintiff was a war veteran and was confined in a government hospital for treatment of and surgery for a duodenal ulcer. He had an insurance policy which contracted to pay him for the expense incurred for hospital charges and services. He brought an action to recover the amount of an alleged bill rendered by the Veterans' Administration for his hospital charges and services."). Thus, the Court made no meaningful distinction between this case and the *Gordon* case, which requires a finding that Ms. Jones never incurred expenses beyond the Medicaid-adjusted rates.

CONCLUSION

For the above-stated reasons, Progressive respectfully requests that the Court reconsider its February 24, 2025 Opinion. The Opinion fails to take into account the realities of how Medicaid works. Specifically, the providers have previously entered into contracts wherein they agreed to accept set amounts as payment in full and to not bill patients for any additional amounts. Furthermore, the Opinion fails to make any meaningful distinctions between this case and the *Gordon* case. Therefore, Progressive respectfully requests that the Court grant it summary judgment on Jones' breach of contract claim.

Respectfully submitted,

MURPHY & GRANTLAND, P.A.

s/J.R. Murphy

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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

Appellate Case No. 2023-000654

Alexis Jones Respondent – Appellant,

v.

Progressive Northern Insurance Company.....Appellant – Respondent.

PROOF OF SERVICE

I certify that I have served the Petition for Rehearing of Appellant-Respondent on Alexis Jones by depositing a copy of it in the United States Mail, postage prepaid, on March 11, 2025, addressed to her attorneys of record, J. Logan Cannon, Esquire, P.O. Drawer 36250, Rock Hill, South Carolina 29732 and by electronic mail at cannon@shawcannon.com and John S. Nichols, Esquire, Bluestein Thompson Sullivan, LLC, PO Box 7965, Columbia, SC 29202, and by electronic mail at john@bluesteinattorneys.com.

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March 11, 2025

Jenny A. Kitchings
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Columbia, SC 29211

Re: Alexis Jones vs. Progressive Northern Insurance Company
Civil Action No.: 2020-CP-12-00207
Appeal No.: 2023-000654
Claim No.: 19-4070335
Insured: Willie Brown
Date of Loss: 10-8-2019
Our File No.: 1115-3581

Dear Ms. Kitching:

Enclosed for filing Appellant-Respondent's Petition for Rehearing. Please return a clocked copy to me via email.

By copy of this email, I am advising opposing counsel of my communication with the court and providing a copy of same.

My firm's check in the amount of \$50.00 for the filing of the Petition for Rehearing will be sent to the court via U.S. Mail today.

With warm personal regards, I am

Sincerely yours,

s/J. R. Murphy

J. R. Murphy

JRM/sb
Enclosures

cc: J. Logan Cannon, Esquire (via email)
John S. Nichols, Esquire (via email)

RECEIVED

Mar 12 2025

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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,.....Respondent-Appellant,

v.

Progressive Northern Insurance Company.....Appellant-Respondent.

**RESPONDENT-APPELLANT'S
PETITION FOR REHEARING**

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TABLE OF CONTENTS

Table of Authorities	ii
Arguments	1
The Court Should Grant Rehearing Regarding the Following Issues:	
1. Plaintiff's Bad Faith Claim	1
2. Plaintiff's Claim for Attorneys' Fees	3
3. Plaintiff's Claim for Breach of Contract Accompanied by a Fraudulent Act	5
4. Right of Action Under Section 38-77-144	7
Conclusion	9

TABLE OF AUTHORITIES

CASES South Carolina

<i>Connor v. City of Forest Acres</i> , 348 S.C. 454, 560 S.E.2d 606 (2002)	5, 7
<i>Cothran v. State Farm Mut. Auto. Ins. Co.</i> , 427 S.C. 545, 831 S.E.2d 919 (2019)	2
<i>Doe v. State</i> , 421 S.C. 490, 808 S.E.2d 807 (2017)	4
<i>Duncan v. Provident Mut. Life Ins. Co.</i> , 310 S.C. 465, 427 S.E.2d 657 (1993)	3
<i>Gordon v. Fidelity & Cas. Co. of N.Y.</i> , 238 S.C. 438, 120 S.E.2d 509 (1961)	1, 2, 5, 6
<i>Harper v. Ethridge</i> , 290 S.C. 112, 348 S.E.2d 374 (Ct. App. 1986)	6
<i>Hood v. United Services Auto Association</i> , 445 S.C. 1, 910 S.E.2d 767 (2025)	1, 3
<i>Jones v. Progressive North. Ins. Co.</i> , 2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025) ..	<i>passim</i>
<i>Mixson, Inc. v. Am. Loyalty Ins. Co.</i> , 349 S.C. 394, 562 S.E.2d 659 (Ct. App. 2002)	1
<i>Nichols v. State Farm Mut. Auto. Ins. Co.</i> , 279 S.C. 336, 306 S.E.2d 616 (1983)	3, 7
<i>Portrait Homes v. Penn. Nat. Mut. Cas. Ins. Co.</i> , 442 S.C. 515, 900 S.E.2d 245 (Ct. App. 2023) ..	1
<i>Rayfield v. S.C. Dep't of Corr.</i> , 297 S.C. 95, 374 S.E.2d 910 (Ct. App. 1988)	8
<i>Shelley Constr. Co. v. Sea Garden Homes, Inc.</i> , 287 S.C. 24, 336 S.E.2d 488 (Ct. App. 1985) ..	4
<i>Sullivan v. Calhoun</i> , 117 S.C. 137, 108 S.E. 189 (1921)	6

Other Jurisdictions

<i>Barker v. Washington Nat. Ins. Co.</i> , 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013) ..	1, 2, 5, 6

STATUTES

S.C. Code Ann. § 38-59-40 (2015)	4, 5
S.C. Code Ann. § 38-77-144 (2015)	3, 7, 8, 9

RULES

Rule 221, SCACR	1
Rule 240, SCACR	1

ARGUMENTS

Pursuant to Rules 221 and 240, SCACR, Respondent-Appellant Alexsis Jones petitions this Court to rehear and reconsider the opinion in *Jones v. Progressive Northern Ins. Co.*, 2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025). Ms. Jones asserts the Court overlooked or misapprehended the following points in affirming Ms. Jones' cross-appeal:

1. Plaintiff's Bad Faith Claim

The Court 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* and *Barker*. 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 to the contrary and the lack of ambiguity in the contract, the insurer can defeat a bad faith claim in South Carolina. The Court's 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 *Mixson'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 clear precedent that does not support or is contrary to its position.

Otherwise, all an insurer who denies coverage due under the policy will need to do to defeat a bad faith claim is to misstate a case’s holding based upon a “misinterpretation,” that is, “misapplication” of a case. This cannot be the law.

In this matter, as this Court observed, neither of the two cases Progressive relied upon, *Gordon v. Fid. & Cas. Co. of N.Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961) and the unpublished federal court order from *Barker v. Washington National Insurance Company*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013), supported the position Progressive took in denying payment to Ms. Jones of benefits she was due under her policy. The Court 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 veteran 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 case¹, is wrongly decided and, being an unpublished

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

order by a Federal District Court, is not binding on this Court; it is not good precedent for Progressive's position.

As Ms. Jones argued in her brief, as a means of protecting insureds who ordinarily possess no bargaining power when entering into an insurance contract, the Supreme 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 two months ago, the Supreme 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 the Supreme Court's jurisprudence under *Nichols* and its progeny.

Ms. Jones respectfully requests that this Court reconsider its holding and grant this Petition for Rehearing, withdraw its opinion, and reverse the circuit court's dismissal of Ms. Jones' bad faith claim.

2. Plaintiff's Claim for Attorneys' Fees

The Court 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

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.

² Westlaw flags *Nichols* as overruled. This is a misstatement. The case Westlaw referenced, *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 reaffirmed in *Hood*.

dismissal of Ms. Jones' bad faith claim, the Court should reconsider its holding dismissing Ms. Jones' claim for attorneys' fees.

Furthermore, the Court overlooked or misapprehended that Ms. Jones sought fees under S.C. Code Ann. § 38-59-40 (Supp. 2022), which 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: (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, both the circuit court and this Court essentially amend the statute's use of the word "or" into "and." Amending this statute, however, is for the General Assembly, not this 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.”)

This Court overlooked 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 even *Barker* so as to support Progressive’s unsupported argument that her contract of insurance permitted Progressive to limit payment to the medical expenses she “actually incurred,” which Progressive arbitrarily deemed to be the reduced amount paid by a collateral source, Medicaid. This was not “reasonable cause” to deny payment to her.

The Court should grant this Petition, withdraw its opinion, rehear this matter, and reverse the circuit court’s order denying Ms. Jones the right to seek attorney fees under Section 38-59-40.

3. 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’s claim was *part of the* breach.” (emphasis by the Court).

Although the Court cited to the Supreme Court’s holding in *Connor v. City of Forest Acres*, the Court failed to properly apply the case. The Supreme 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 (Cl. 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 overlooked 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 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 position amounted to unfair dealing with her, which was apart from its breach of its contract of insurance by its arbitrary reduction in payments due.

The Court should grant this Petition, withdraw its opinion, rehear this matter, and reverse

the circuit court's order denying Ms. Jones claims for breach of contract accompanied by a fraudulent act as described in *Connor*.

4. Right of Action Under Section 38-77-144

The Court affirmed the circuit court's ruling that S.C. Code Ann. § 38-77-144 (2015) does not provide a private right of action. 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 overlooked or misapprehended Ms. Jones' specific arguments in making this ruling.

Ms. Jones pointed out 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 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."). Her 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 also failed to consider Supreme Court precedent holding "In 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). The essential purpose of the statute is 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 insured can enforce that protection is through a lawsuit. 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 reverse the trial court's ruling and remand the matter with instructions to permit Ms. Jones to proceed with her claim under Section 38-77-144.

CONCLUSION

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

Respectfully submitted,

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March 12, 2025

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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
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APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Appellate Case No. 2023-000654
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Alexis Jones,.....Respondent-Appellant,

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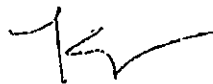
CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the date indicated below, she served counsel for the Appellant-Respondent with a copy of the Respondent-Appellant's *Petition for Rehearing* by email only to the following:

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Megan Walker, Esq.
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March 12, 2025
Columbia, South Carolina



Kalen Reed, Paralegal

Kalen Reed

From: Kalen Reed
Sent: Wednesday, March 12, 2025 4:13 PM
To: J. Murphy; mwalker@murphygrantland.com
Cc: John Nichols; Meredith Brown; cannon@shawcannon.com
Subject: Alexis Jones v. Progressive Northern Insurance Company/Appellate Case #2023-000654
Attachments: Petition for Rehearing.pdf

Good afternoon,

Attached please find Respondent-Appellant's Petition for Rehearing which is being served upon you in the above matter.

Thank you,



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March 12, 2025

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SC Court of Appeals

VIA ELECTRONIC FILING

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RE: Alexis Jones v. Progressive Northern Insurance Company
Appellate Case No.: 2023-000654

Dear Ms. Kitchings:

Please find enclosed for filing the Respondent-Appellant's *Petition for Rehearing* in reference to the above matter. I have also enclosed a certificate of service upon counsel for Appellant-Respondent. Please let me know if you need anything further.

With kind regards,

John S. Nichols

JSN/knr
Enclosures

cc: J. Logan Cannon, Esq.
J.R. Murphy, Esq.
Megan Walker, Esq.

The South Carolina Court of Appeals

Alexis Jones, Respondent-Appellant,

v.

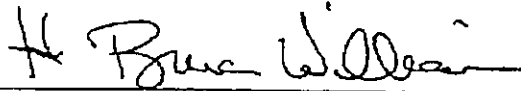
Progressive Northern Insurance Company, Appellant-
Respondent.

Appellate Case No. 2023-000654

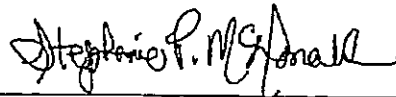
ORDER

After careful consideration of the petitions for rehearing, the court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petitions for rehearing are denied. The attached opinion is substituted for the previous opinion, which is withdrawn.

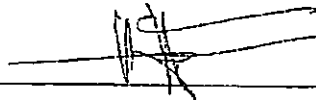
Additionally, after thorough review, it has been determined that there was an error regarding the filing date of the Opinion, which has since been corrected. Therefore, Alexis Jones's petition for rehearing was timely filed and the motion to strike is also denied.



C.J.



J.



J.

Columbia, South Carolina

FILED
Apr 16 2025

cc:

John Robert Murphy, Esquire

Jeffery Logan Cannon, Esquire

John S. Nichols, Esquire

Megan Noelle Walker, Esquire

Betty Jo Lawson

The Honorable Brian M. Gibbons

**THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE
CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING
EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.**

**THE STATE OF SOUTH CAROLINA
In The Court of Appeals**

Alexis Jones, Respondent-Appellant,

v.

Progressive Northern Insurance Company, Appellant-
Respondent.

Appellate Case No. 2023-000654

Appeal From Chester County
Brian M. Gibbons, Circuit Court Judge

Unpublished Opinion No. 2025-UP-074
Heard December 3, 2024 – Filed February 26, 2025
Withdrawn, Substituted, and Refiled April 16, 2025

AFFIRMED

Jeffery Logan Cannon, of Shaw And Cannon, LLC, of
Rock Hill; and John S. Nichols, of Bluestein Thompson
Sullivan LLC, of Columbia, both for Appellant.

John Robert Murphy and Megan Noelle Walker, both of
Murphy & Grantland, PA, of Columbia, for Respondent.

PER CURIAM: Alexis Jones, a Medicaid recipient, was involved in a car accident and sustained injuries. Her medical expenses originally totaled \$27,786.17 but were subsequently adjusted to \$1,323.60 and paid for by Medicaid. Jones was also covered by an automobile insurance policy (the Policy) from Progressive Northern Insurance Company (Progressive) which included a \$10,000 medical payments provision for "incurred" medical expenses. On appeal, Progressive argues the circuit court erred in finding it breached the insurance contract by paying Jones the reduced amount of expenses paid by Medicaid instead of the entire \$10,000 policy limit. It argues the term "incurred" means only the amount actually paid by Medicaid. On cross-appeal, Jones argues the circuit court erred in denying her claims that Progressive's refusal to pay the entire \$10,000 medical payment policy limit was (1) made in bad faith, (2) a breach of the covenant of good faith and fair dealing, (3) a breach of its fiduciary duty, (4) a breach of contract accompanied by a fraudulent act, and (5) a violation of S.C. Code Ann. § 38-77-144 (2015). She also asserts the circuit court erred in declining to award her attorney's fees pursuant to S.C. Code Ann. § 38-59-40 (2015). We affirm.

1. We hold the circuit court properly found Progressive breached the contract and awarded Jones the full policy limit; however, the circuit court erred in finding the term "expenses incurred" was ambiguous. *See Gibson v. Epting*, 426 S.C. 346, 351, 827 S.E.2d 178, 181 (Ct. App. 2019) ("Ambiguity of a contract is a question of law, which we review de novo."); *McCord v. Laurens Cnty. Health Care Sys.*, 429 S.C. 286, 292-93, 838 S.E.2d 220, 223 (Ct. App. 2020) ("To be ambiguous, contract language must be susceptible to two different but plausible meanings."). Our supreme court has held that the words "expenses incurred" in an automobile insurance policy are not ambiguous and should be taken in the plain and ordinary sense of the words. *See Gordon v. Fid. & Cas. Co. of N.Y.*, 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961) (finding there was "no uncertainty or ambiguity in the language of the policy" in regards to the phrase "expense incurred," and the words "must be taken in the plain and ordinary sense in which they are generally used and understood"); *id.* ("[I]n cases where there is no ambiguity, contracts of insurance, like other contracts, must be construed according to the terms which the parties have used, to be taken and understood in their plain, ordinary and popular sense."). Black's Law Dictionary defines "incur" as "[t]o be liable or subject to." *Black's Law Dictionary* 768 (6th Ed. 1990). "South Carolina law defines 'expense incurred' for insurance purposes as 'a thing for which there exists [an] obligation to pay, either express or implied.'" *See Barker v. Washington National Insurance Company*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013) (quoting *Gordon*, 238 S.C. at 445, 120 S.E.2d at 512).

However, we find the circuit court properly determined that Jones incurred medical expenses in excess of what Progressive paid. Once Jones was treated by the medical providers, she became liable for or subject to the costs of the care—regardless of her insurance coverage. Progressive relies heavily on the *Gordon* case. In *Gordon*, however, the plaintiff received *free* medical care from a military hospital. See *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. Further, his claim was based on an appraisal from two doctors and utilizing the prevailing rates in the area since he was not billed for the services he received. *Id.* Gordon's medical services were free so he was not obligated to pay for the services rendered. *Id.* Therefore, he did not "incur" an expense. *Id.* In this case, Jones did not receive free medical care. She was charged for the services rendered, and she was billed for the same. When Jones went for treatment, she had no way to know what treatment she needed, how much it would cost, or how much would be covered by Medicaid. Once she received the treatment, she was billed the full amount. While the bills were adjusted for Medicaid at some point, most of the bills in the record show the full amount charged with no adjustment for Medicaid. Therefore, while we acknowledge that her costs were eventually adjusted and paid by Medicaid, Jones still incurred the full amount charged and was responsible for ensuring the bills were paid.

The Policy must be construed in favor of Jones. See *id.* at 444, 120 S.E.2d at 512 (explaining "the terms of an insurance policy must be construed most liberally in favor of the insured"). First, the Policy does not provide a definition of "incurred" that differs from what case law has established. Furthermore, there is no provision in the Policy providing for a different (or lesser) payment amount when the insured is covered by Medicaid.¹ Accordingly, we believe the circuit court properly found Progressive breached the contract because Jones incurred \$27,786.17 in medical expenses and, therefore, Progressive was obligated to pay her the entire \$10,000 medical payment under the Policy.

2. We hold the circuit court properly dismissed Jones's bad faith claim. See *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 631, 699 S.E.2d 699, 703 (Ct. App. 2010) ("In reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRCF, the appellate court applies the same standard of review as the [circuit] court."); *id.* at 632, 699 S.E.2d at 703 ("[T]he [circuit] court must base its ruling

¹ Progressive relies heavily on an unpublished order from *Barker*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *5. However, the insurance contract in *Barker* contained a provision which provided the insurer would only pay the Medicare adjusted amount. We do not have such a provision in this case.

solely on allegations set forth in the complaint."). Jones originally asserted three closely related claims against Progressive: bad faith, breach of duty of good faith and fair dealing, and breach of fiduciary duty. As the circuit court pointed out in its order and Jones acknowledged in her brief, we believe these three causes of action are redundant and are best analyzed together under a bad faith claim.

Neither party disputes that the first, second, or fourth elements required for a bad faith claim are met in this case. See *Cock-N-Bull Steak House, Inc. v. Generali Ins. Co.*, 321 S.C. 1, 6, 466 S.E.2d 727, 730 (1996) (explaining the elements of an action for bad faith include (1) a "mutually binding contract of insurance between the plaintiff and the defendant," (2) the insurer's refusal to pay benefits due under the contract, (3) the refusal is a result of insurer's bad faith or unreasonable action, and (4) which causes damage to the insured (quoting *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359-60, 415 S.E.2d 393, 396-97 (1992))). As to the third element, we believe there is no evidence that Progressive acted in bad faith. See *Dowling v. Home Buyers Warranty Corp.*, 303 S.C. 295, 297, 400 S.E.2d 143, 144 (1991) ("An insured may recover damages for a bad faith denial of coverage if he or she proves there was no reasonable basis to support the insurer's decision to deny benefits under a mutually binding insurance contract."). Progressive denied Jones the full policy limits based upon its misapplication of *Gordon and Barker*. Although we disagree with Progressive's interpretation of those cases, we do not find Progressive acted in bad faith. Additionally, because we hold the circuit court properly dismissed the bad faith claim and made no finding that the denial was without reasonable cause, we do not reach the issue of attorney's fees.

3. We hold the circuit court properly dismissed Jones's claim for breach of contract accompanied by a fraudulent act. See *HFH Hunt Corp.*, 389 S.C. at 631, 699 S.E.2d at 703 ("In reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRCP, the appellate court applies the same standard of review as the [circuit] court."); *Conner v. City of Forest Acres*, 348 S.C. 454, 465-66, 560 S.E.2d 606, 612 (2002) ("[T]o 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."); *id.* at 466, 500 S.E.2d at 612 ("The fraudulent act is any act characterized by dishonesty in fact or unfair dealing."). 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's claim was *part of* the breach. See *Minter v. GOCT, Inc.*, 322 S.C. 525, 530, 473 S.E.2d 67, 70 (Ct. App. 1996)

(explaining there must be "evidence of an independent fraudulent act which accompanied the breach").

4. We hold the circuit court correctly found section 38-77-144 does not provide a private cause of action. *See HHHunt Corp.*, 389 S.C. at 631, 699 S.E.2d at 703 ("In reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRCP, the appellate court applies the same standard of review as the [circuit] court."). We find the Legislature did not intend to provide insureds a private cause of action under section 38-77-144. *See* § 38-77-144 ("If an insurer sells no-fault insurance coverage which provides [PIP], medical payment coverage, or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a setoff."). 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. *See Denson v. Nat'l Cas. Co.*, 439 S.C. 142, 151, 886 S.E.2d 228, 233 (2023) ("The main factor in determining whether a statute gives rise to a private cause of action is legislative intent, which is determined primarily from the language of the statute."); *id.* at 151-52, 886 S.E.2d at 233 ("Generally, when a statute does not expressly create civil liability, a duty will not be implied unless the statute was enacted for the special benefit of a private party."). 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.

AFFIRMED.

WILLIAMS, C.J., and MCDONALD and TURNER, JJ., concur.