

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No. 2016-CP-26-0166
Appellate Case No. 2016-001499

RECEIVED

MAR 31 2017

SC Court of Appeals

Jeanne Beverly, Individually Appellant
and on behalf of others
similarly situated

v.

Grand Strand Regional, ... Respondents.
Medical Center, LLC

RECORD ON APPEAL (VOLUME 1)

John G. Felder, Jr.
McGowan, Hood & Felder
1517 Hampton Street
Columbia, SC 29201
Telephone: (803) 779-0100
Facsimile: (803) 256-0702
jfelder@mcgowanhood.com

Chad A. McGowan
Jordan C. Calloway
1539 Health Care Drive
Rock Hill, South Carolina 29732
Telephone: (803) 327-7800
Facsimile: (803) 328-5656
cmcgowan@mcgowanhood.com
jcalloway@mcgowanhood.com

Roy Harmon
Harmon & Major, P.A.
PO Box 8954

James Lynn Werner
William R. Thomas
Katon E. Dawson, Jr.
Parker Poe Adams & Bernstein LLP
1201 Main Street, Suite 1450
Post Office Box 1509 (29202)
Columbia, SC 29201
Telephone: (803) 255-8000
jwerner@parkerpoe.com
willthomas@parkerpoe.com

Attorneys for Respondent

Greenville, SC 29604
Telephone: (864) 467-1712
harmonmajor@gmail.com

Sidney L. Major, Jr.
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
sidmajor@bellsouth.net

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29577
Telephone: (843)448-4357
jeffcchandler@aol.com

Attorneys for Appellant

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FORM 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2016-CP-26-0166

Jeanne Beverly, individually and
on behalf of others similarly situated
PLAINTIFF(S)

Grand Strand Regional Medical Center, LLC
DEFENDANT(S)

Submitted by: Benjamin H. Culbertson, Presiding Judge

Attorney for : ☐ Plaintiff ☐ Defendant
or
☐ Self-Represented Litigant

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. ☐ See Page 2 for additional information.
- ☐ **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
- ☐ **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:

Defendant's Motion to Dismiss is GRANTED.
Attorney James Lynn Werner is to prepare a formal order.

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk : _____

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
N/A	N/A	\$ N/A

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Benjamin H. Culbertson

Benjamin H. Culbertson, Circuit Court Judge

2148

Judge Code

April 27, 2016

Date

For Clerk of Court Office Use Only

This judgment was entered on the _____ day of _____, 20____ and a copy mailed first class or placed in the appropriate attorney's box on this _____ day of _____, 20____ to attorneys of record or to parties (when appearing pro se) as follows:

John G. Felder

Jordan Christopher Calloway

ATTORNEY(S) FOR THE PLAINTIFF(S)

James Lynn Werner

William R. Thomas

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Court Reporter: Grace Hurley

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	FIFTEENTH JUDICIAL CIRCUIT
	)	
Jeanne Beverly, individually and on behalf of	)	C.A. No. 2016-CP-26-0166
others similarly situated,	)	
	)	
Plaintiffs,	)	
	)	ORDER GRANTING DEFENDANT'S
vs.	)	MOTION TO DISMISS
	)	
Grand Strand Regional Medical Center, LLC,	)	
	)	
Defendant.	)	
	)	

THIS MATTER CAME BEFORE THIS COURT for hearing on April 26, 2016, on a Motion to Dismiss by Defendant Grand Strand Regional Medical Center, LLC ("Defendant") pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure. Defendant moved the Court to dismiss the claims of Plaintiff Jeanne Beverly ("Plaintiff") arguing (1) Plaintiff's claim for breach of contract fails because she is not a third-party beneficiary to the contract between Defendant and Blue Cross Blue Shield of South Carolina ("BCBS-SC"); (2) Plaintiff's claim for bad faith breach of contract fails because she is not a party entitled to enforce the subject contract and South Carolina law does not recognize the failure of a medical provider to file an insurance claim as a breach of a fiduciary duty; and (3) Plaintiff's claim for unjust enrichment fails because the Complaint does not allege Defendant charged or collected more than its regular rates. This Court held oral argument, considered the arguments of counsel, and finds Defendant's Motion to Dismiss is well-grounded and Plaintiff's Complaint is dismissed for the reasons set forth below.

FACTS AND PROCEDURAL HISTORY

According to the allegations in Plaintiff's Complaint:

1. Plaintiff was involved in a motor vehicle accident on September 6, 2012, and received treatment for her injuries on that date in Defendant's hospital.

2. At the time of the collision and her treatment, Plaintiff was covered under a health insurance policy issued by BCBS-SC.

3. Prior to the events in question, Defendant and BCBS-SC entered into a contract (the "Institutional Agreement") by which Defendant became a BCBS-SC Preferred Provider Organization.

4. Plaintiff asserts she is a third-party beneficiary under the contract (the Institutional Agreement) between Defendant and BCBS-SC.

5. According to Plaintiff, at the time she was treated, her insurance information was provided to Defendant; however, Defendant failed to submit her bills to BCBS-SC for payment.

6. Plaintiff further alleges that Defendant disregarded the reimbursement rates agreed upon with BCBS-SC in the Institutional Agreement and billed her the full price for the medical services provided.

7. Based on these allegations, on January 11, 2016, Plaintiff filed this action for breach of contract, bad faith/breach of fiduciary duty, and unjust enrichment, arguing she is a third-party beneficiary entitled to enforce the Institutional Agreement.

8. On March 7, 2016, Defendant filed a Motion to Dismiss.

STANDARD OF REVIEW

A motion to dismiss must be granted if the facts alleged in the complaint, and inferences reasonably deducible therefrom, do not entitle plaintiff to the relief sought. *Chewning v. Ford Motor Co.*, 346 S.C. 28, 32-33, 550 S.E.2d 584, 586 (Ct. App. 2001) (citing *Jarrell v. Petoseed Co.*, 331 S.C. 207, 209, 500 S.E.2d 793, 794 (Ct. App. 1998)).

Ordinarily, "in considering a motion to dismiss pursuant to Rule 12(b)(6), SCRPC, the circuit court must base its ruling solely upon the allegations set forth on the face of the complaint." *Charleston Cty. Sch. Dist. v. Harrell*, 393 S.C. 552, 557, 713 S.E.2d 604, 607

(2011) (citing *Doe v. Greenville Cty. Sch. Dist.*, 375 S.C. 63, 66-67, 651 S.E.2d 305, 307 (2007)). However, it is also proper that “a court may consider documents outside of the complaint if the complaint incorporates the documents by reference.” *Carolina First Corp. v. Whittle*, 343 S.C. 176, 190 n.7, 539 S.E.2d 402, 410 n.7 (Ct. App. 2000); see *Brazell v. Windsor*, 384 S.C. 512, 516, 682 S.E.2d 824, 826 (2009) (finding a court may consider documents that are incorporated by reference in the complaint but not attached to the complaint without converting a motion to dismiss into a motion for summary judgment); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 629-30, 699 S.E.2d 699, 701-02 (Ct. App. 2010) (assuming a plaintiff incorporated a document by attaching it to the complaint, thereby, allowing the court to consider the document in granting a motion to dismiss). ~~This conclusion by the South Carolina Court of Appeals regarding the legitimate scope of review under a Rule 12 motion is consistent with a long line of authority arising under Rule 12 of the Federal Rules of Civil Procedure.¹ In applying Rule 12, federal courts have recognized that where “collateral documents are inherent to the allegations in the complaint . . .” it is appropriate for the court to consider the referenced documents in deciding a motion to dismiss (i.e., without converting the motion to one for summary judgment). See *In re: DataStream Sys., Inc. Securities Litigation*, No. 6:99-0088-13, 2000 WL 33176025, at *1 (D.S.C. July 27, 2000); see also *Darcangelo v. Verizon Communications, Inc.*, 292 F.3d 181, 195 n.5 (4th Cir. 2002); *Abadian v. Lee*, 117 F.Supp.2d 481, 485 (D.Md. 2000).~~

¹ ~~“Since [the South Carolina] Rules of Procedure are based on the Federal Rules, where there is no South Carolina law, [South Carolina courts] look to the construction placed on the Federal Rules of Civil Procedure.” *Gardner v. Newsome Chevrolet-Buick, Inc.*, 304 S.C. 328, 330, 404 S.E.2d 200, 201 (1991).~~

LAW AND ANALYSIS

The cornerstone of Plaintiff's entire Complaint is her allegation that she is a third-party beneficiary under the contract (Institutional Agreement) between Defendant and BCBS-SC. Plaintiff expressly asserts she has the right to enforce the contract (Institutional Agreement) between Defendant and BCBS-SC. Thus, Plaintiff has placed in issue the terms of the Institutional Agreement between Defendant and BCBS-SC and that Agreement is undoubtedly inherent to the allegations of the Complaint. It is appropriate, therefore, for this Court to consider the terms of that Agreement in deciding Defendant's Motion to Dismiss.

I. Plaintiff is not a third-party beneficiary to the Institutional Agreement and does not have standing to maintain her claim for breach of contract.

South Carolina law is clear, "one not in privity of contract with another cannot maintain an action against him in breach of contract, and any damage resulting from the breach of a contract between the defendant and a third-party is not, as such, recoverable by the plaintiff." *Fabian v. Lindsay*, 410 S.C. 475, 488, 765 S.E.2d 132, 139 (2014) (quoting *Windsor Green Owners Ass'n v. Allied Signal, Inc.*, 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004)); see *Bob Hammond Constr. Co. v. Banks Constr. Co.*, 312 S.C. 422, 424, 440 S.E.2d 890, 891 (Ct. App. 1994) (holding a third party not in contractual privity with the contracting parties had no right to enforce a contract unless the contracting parties intended to create a third-party beneficiary to the agreement); *Kleckley v. Northwestern Nat'l Cas. Co.*, 338 S.C. 131, 136, 526 S.E.2d 218, 220 (2000) (holding an injured third party could not assert a bad faith claim against a tortfeasor's insurance company because the injured party was not a party to the contract).

It is a long standing principle that parties contract for their own benefit, and not for the benefit of third parties. *Ancrum v. Camden Water, Light & Ice Co.*, 82 S.C. 284, 295, 64 S.E. 151, 155 (1909). The presumption is that a contract to which a plaintiff is not a party is not enforceable by the plaintiff and that presumption may only be overcome by the showing that the

plaintiff was intended to be the direct beneficiary of the contract. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005). To determine whether the parties to a contract intended a plaintiff to be a third-party beneficiary, a court must look to and give legal effect to the intentions of the parties as expressed in the language of their contract. *Gilbert v. Miller*, 356 S.C. 25, 30, 586 S.E.2d 861, 864 (Ct. App. 2003) (citing *United Dominion Realty Trust, Inc. v. Wal-Mart Stores, Inc.*, 307 S.C. 102, 413 S.E.2d 866 (Ct. App. 1992)). A court's function is to look at the clear language of the contract and to give that language its lawful meaning and to determine the intent of the parties as found in the clear language of their agreement. *Trancik v. USAA Ins. Co.*, 354 S.C. 549, 555, 581 S.E.2d 858, 861 (Ct. App. 2003) (citing *Smith-Cooper v. Cooper*, 344 S.C. 289, 543 S.E.2d 271 (Ct. App. 2001)). A court does not have the "authority to alter a contract by construction or make new contracts for the parties, and words cannot be read into a contract which impart an intent wholly unexpressed when the contract was executed." *Gilstrap v. Culpepper*, 283 S.C. 83, 86, 320 S.E.2d 445, 447 (1984).

Section 16.16 of the Institutional Agreement – the contract from which Plaintiff purports to derive her rights and claims – states the following:

This Agreement is not intended to, and shall not be construed to, make any person or entity a third party beneficiary. Notwithstanding the preceding, nothing in this section shall affect Plans rights under Article XV, or a Member's right to receive Covered Services pursuant to the terms of this Agreement.

The language of the Institutional Agreement is clear, explicit, and unambiguous. The intent of Defendant and BCBS-SC (the parties to the Agreement) is undeniably clear from this provision: they did not intend for anyone to have third-party beneficiary rights under the Agreement. Therefore, the language of the Institutional Agreement determines its force and effect and the Court construes its terms according to their plain, ordinary, and popular meaning. See *ERIE Ins. Co. v. Winter Const. Co.*, 393 S.C. 455, 461, 713 S.E.2d 318, 321 (Ct. App. 2011) ("Basic

contract law provides that when a contract is clear and unambiguous, the language alone determines the contract's force and effect." (citing *C.A.N. Enters., Inc. v. S.C. Health & Human Servs. Fin. Comm'n*, 296 S.C. 373, 377, 373 S.E.2d 584, 586 (1988)). The Court finds Section 16.16 plainly evidences BCBS-SC and Defendant's intent to exclude third-party beneficiaries from enforcing the Institutional Agreement.

~~Furthermore, the Court notes that under similar circumstances, courts in other jurisdictions have applied similar reasoning and reached identical conclusions. See *RPC Liquidation v. Iowa Dept. of Transp.*, 717 N.W.2d 317, 321-322 (Iowa 2006) (considering a similar third party liability provision and holding a third party could not recover under the terms of the contract); *Richmond Shopping Center, Inc. v. Wiley N. Jackson Co.*, 220 Va. 135, 142 (Va. 1979) (finding that despite a conflict in the contract's terms, a provision specifically stating third parties may not recover under the contract governs and, therefore, third parties were not entitled to recover under the contract); *SynchroPile, Inc. v. Traylor Bros. Inc.*, No. CIV.A. 10-1896, 2011 WL 3419630, at *5-6 (E.D. La. Aug. 3, 2011), *aff'd*, 470 F. App'x 349 (5th Cir. 2012) (holding that the four corners of the contract manifested a clear intent of the parties not to directly benefit third parties and finding third parties were barred from recovering under the plain language of the contract). The Court also notes that in an unpublished opinion addressing similar facts the Court of Appeals found a contract's explicit language stating it did not apply to third parties was clear evidence the contracting parties did not intend for third parties to benefit from the contract and, therefore, the court held third parties were not intended beneficiaries of the contract and could not file claims as such. *Atherton v. Tenet Healthcare Corp.*, No. 2005-UP-362, 2005 WL 7084013, at *4 (Ct. App. May 25, 2005).²~~

² ~~While an unpublished opinion may not hold precedential value, the Court finds the reasoning applied by the Court of Appeals in *Atherton* provides clear and directly applicable guidance in the present matter. Rule 268(d)(2), SCACR.~~

Although the Institutional Agreement contains plain, unambiguous language stating it is not for the benefit of third parties, Plaintiff argues the Institutional Agreement carves out an exclusion for a BCBS-SC member seeking to ensure receipt of "covered services." Section 2.6 of the Institutional Agreement defines "covered services" as "those . . . services, supplies, equipment and/or items to be delivered by or through [the defendant] to [the plaintiff] *that are reimbursable* [under the plaintiff's insurance plan with BCBS-SC]." (emphasis added). Nothing indicates that BCBS-SC reimburses for costs, if any, incurred in filing an insurance claim. Therefore, filing for insurance benefits is not a "reimbursable service," and Defendant does not have any obligation to file for insurance benefits on Plaintiff's behalf.

The Court finds the plain, unambiguous language of Section 16.16 excludes third-party beneficiaries and the Institutional Agreement, does not contain any exceptions to this provision. Accordingly, Plaintiff's claim for breach of contract is dismissed as a matter of law because under the plain language of the Institutional Agreement Plaintiff cannot be a third-party beneficiary with standing to bring a claim for breach of contract.

II. Plaintiff's claim for bad faith breach of the Institutional Agreement fails because Defendant does not owe Plaintiff a fiduciary duty to file her insurance claims.

Plaintiff alleges that a special, or fiduciary, relationship was created between Defendant and Plaintiff by virtue of the contract between Defendant and BCBS-SC and Plaintiff's alleged status as a third-party beneficiary to that contract. [Complaint ¶ 39]. Plaintiff further argues a special relationship was created with Defendant by virtue of her status as a third-party beneficiary to the Institutional Agreement and her choice to seek medical care from Defendant. [Complaint ¶ 45]. Based on these allegations, Plaintiff asserts that Defendant breached a fiduciary duty to submit her insurance claims to BCBS-SC. [Complaint ¶ 40].

The Court finds Plaintiff's claim for breach of a fiduciary duty fails, because Plaintiff is not a third-party beneficiary to the Institutional Agreement and, furthermore, South Carolina law

does not recognize the failure of a medical provider to file an insurance claim as a breach of a fiduciary duty.

“To establish a claim for breach of fiduciary duty, the plaintiff must prove (1) the existence of a fiduciary duty, (2) a breach of that duty, and (3) damages proximately resulting from the wrongful conduct of the defendant.” *Turpin v. Lowther*, 404 S.C. 581, 589, 745 S.E.2d 397, 401 (Ct. App. 2013) (citing *RFT Mgmt. Co. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 335-36, 732 S.E.2d 166, 173 (2012)). “The existence of a fiduciary duty is a question of law for the court.” *Id.*

“To establish the existence of a fiduciary relationship, the facts and circumstances must indicate the party reposing trust in another has some foundation for believing the one so entrusted will act not in his own behalf but in the interest of the party so reposing.” *Moore v. Moore*, 360 S.C. 241, 251, 599 S.E.2d 467, 472 (Ct. App. 2004) (citing *Burwell v. S.C. Nat'l Bank*, 288 S.C. 34, 41, 340 S.E.2d 786, 790 (1986)). “[A] fiduciary relationship cannot be created by the unilateral action of one party.” *Id.* (citing *Regions Bank v. Schmauch*, 354 S.C. 648, 670, 582 S.E.2d 432, 444 (Ct. App. 2003)). The other party to the purported relationship must have actually accepted or induced the confidence allegedly placed in him. *Id.* (citation omitted); see *Cowburn v. Leventis*, 366 S.C. 20, 37, 619 S.E.2d 437, 447 (Ct. App. 2005); *Ellis v. Davidson*, 358 S.C. 509, 519-20, 595 S.E.2d 817, 822 (Ct. App. 2004); *Steele v. Victory Sav. Bank*, 295 S.C. 290, 295, 368 S.E.2d 91, 94 (Ct. App. 1988).

Plaintiff alleges a fiduciary relationship was created by her reliance on the Institutional Agreement—to which she is not a party, and which she is not entitled to enforce—and from her decision to seek medical treatment from the Defendant's hospital. These are both unilateral actions by Plaintiff, and a fiduciary relationship cannot be created by unilateral action. See *Moore*, 360 S.C. at 251, 599 S.E.2d at 472. Moreover, Plaintiff cannot assert a successful claim

for breach of a fiduciary duty by merely alleging she placed a level of trust in Defendant by choosing to seek medical care and treatment at Defendant's hospital and then claiming a fiduciary duty was breached when Defendant refused to submit her insurance claims. The duty and the breach must relate to the same thing. *See Turpin*, 404 S.C. at 589, 745 S.E.2d at 401 (noting that to establish a claim for breach of a fiduciary duty a plaintiff must prove: (1) the existence of a fiduciary duty; (2) a breach of *that* duty; and (3) damages resulting from the breach). A duty relating to providing medical care and treatment is not the same as a duty to file insurance claims.

South Carolina Courts have not found a fiduciary duty is breached when a doctor fails to offer assistance in filing an insurance claim. *See Wogan v. Kunze*, 366 S.C. 583, 605, 623 S.E.2d 107, 119 (Ct. App. 2005), *aff'd as modified*, 379 S.C. 581, 666 S.E.2d 901 (2008). Moreover, as discussed in the previous section, Plaintiff does not have the right to enforce the Institutional Agreement and—even if she could—nothing in the Institutional Agreement creates a fiduciary duty between Defendant and Plaintiff for Defendant to file an insurance claim for Plaintiff.

Accordingly, the Court finds Plaintiff failed to allege facts sufficient to state a claim for breach of a fiduciary duty. A fiduciary relationship was not created between Defendant and Plaintiff and South Carolina does not recognize the failure to file an insurance claim as a basis for a claim for breach of a fiduciary duty.

III. Plaintiff's claim for unjust enrichment fails, because Defendant's collection of full payment of its bill for services rendered does not constitute unjust enrichment.

Plaintiff alleges that Defendant was unjustly enriched by collecting payments from Plaintiff for medical services provided by Defendant, but at a higher value than the discounted rates established in the Institutional Agreement between Defendant and BCBS-SC. However, Plaintiff does not allege that she conferred any benefit upon Defendant except that she paid a non-discounted rate for the medial services which Defendant provided to her.

Unjust enrichment is an equitable concept based on the same principles as *quantum meruit*, quasi-contract, and implied by law contracts. See *Myrtle Beach Hospital, Inc. v. City of Myrtle Beach*, 341 S.C. 1, 8, 532 S.E.2d 868, 872 (2000). To state a cause of action for unjust enrichment, a plaintiff must allege the defendant unjustly retained benefits or money which in justice and equity belong to another. See *Dema v. Tenet Physician Servs.-Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009). "To recover restitution in the context of unjust enrichment, the plaintiff must show: (1) he conferred a non-gratuitous benefit on the defendant; (2) the defendant realized some value from the benefit; and (3) it would be inequitable for the defendant to retain the benefit without paying the plaintiff for its value." 56 *Leinbach Inv'rs, LLC v. Magnolia Paradigm, Inc.*, 411 S.C. 466, 479, 769 S.E.2d 242, 249 (Cl. App. 2014) (quoting *Inglese v. Beal*, 403 S.C. 290, 297, 742 S.E.2d 687, 691 (Cl. App. 2013)).

Plaintiff has failed to allege Defendant received an inequitable benefit. Plaintiff's claims are based upon Defendant charging her the non-discounted rate for the medical services it provided to her, rather than the discounted rate reflected in the Institutional Agreement between Defendant and BCBS-SC. Plaintiff is neither a party, nor a third-party beneficiary of the Institutional Agreement, and she does not have the right to enforce its terms. The existence of discounted rates does not establish that the standard rates are unjust, inequitable, or excessive. There is no allegation in the Complaint that Defendant charged more than its regular rates for the medical services which were admittedly rendered. Defendant was not unjustly enriched by collecting from Plaintiff its regular rates, rather than discounted rates for the services which it provided.

The South Carolina Court of Appeals' decision in *Pitts v. Jackson National Life Insurance Company*, illustrates the fallacy of Plaintiff's alleged unjust enrichment claim. 352 S.C. 319, 574 S.E.2d 502. In that case, the plaintiff sued the insurance company asserting a

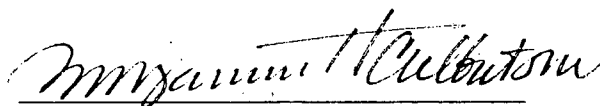
claim for unjust enrichment based on the allegation that the company failed to issue a preferred policy instead of a standard policy for his daughter, while the preferred policy would have charged lower premiums than the standard policy of equal face value. After reciting the same essential elements of any claim for unjust enrichment, the Court of Appeals found there was no benefit conferred upon the insurance company that would be unjust for it to retain. In the present case, Plaintiff sought and was provided medical services by Defendant and, according to the Complaint, was charged regular rates in exchange for those services rendered to her. As in *Pitts*, Plaintiff's claim is that Defendant was unjustly enriched merely by failing to apply a discounted rate for its services. Such an allegation is insufficient under South Carolina law to sustain a claim for unjust enrichment. Therefore, Plaintiff's claim for unjust enrichment is improper and is dismissed as a matter of law.

CONCLUSION

WHEREFORE, Defendant Grand Strand Regional Medical Center, LLC's Motion to Dismiss Plaintiff's Complaint for failure to state a claim under Rule 12(b)(6) of the South Carolina Rules of is hereby GRANTED, and Plaintiff's Complaint is hereby DISMISSED WITH PREJUDICE in its entirety.

AND IT IS SO ORDERED.

May 25, 2016
Conway, South Carolina


The Honorable Benjamin H. Culbertson
Circuit Court Judge

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

FORM 4

JUDGMENT IN A CIVIL CASE

CASE NO: 2016-CP-26-0166

Jeanne Beverly, individually and on
behalf of others similarly situated
PLAINTIFF(S)

Grand Strand Regional Medical Center, LLC
DEFENDANT(S)

Submitted by: Benjamin H. Culbertson, Presiding Judge

Attorney for : ☐ Plaintiff ☐ Defendant
or
☐ Self-Represented Litigant

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. ☐ See Page 2 for additional information.
- ☐ **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
- ☐ **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:

Plaintiff's Motion to Alter or Amend Judgment is DENIED.
(This motion is decided without oral arguments.)

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.
Additional Information for the Clerk :

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
N/A	N/A	\$ N/A

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Benjamin H. Culbertson
Benjamin H. Culbertson, Circuit Court Judge
SCRPC Form 4C (03/2013)

2148
Judge Code

June 22, 2016
Date

Page 1

For Clerk of Court Office Use Only

This judgment was entered on the _____ day of _____, 20____ and a copy mailed first class or placed in the appropriate attorney's box on this _____ day of _____, 20____ to attorneys of record or to parties (when appearing pro se) as follows:

John G. Felder, Jr.

Chad A. McGowan

Roy Harmon

Sidney L. Major, Jr.

Jeff C. Chandler

ATTORNEY(S) FOR THE PLAINTIFF(S)

James Lynn Werner

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Court Reporter: None

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

Jeanne Beverly, individually and on behalf of
others similarly situated,

Plaintiff,

vs.

Grand Strand Regional Medical Center, LLC,

Defendant.

IN THE COURT OF COMMON PLEAS

FIFTEENTH JUDICIAL CIRCUIT

Civil Action No.: 2016-CP-26-

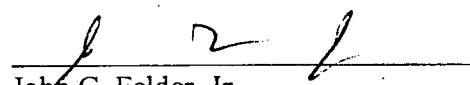
SUMMONS

2016 JUN 11 PM 2:40
HORRY COUNTY

TO: THE DEFENDANT ABOVE NAMED:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your answer to the said Complaint on the subscriber at his office at 1517 Hampton Street, Columbia, South Carolina 29201 within thirty (30) days after the service hereof, exclusive of the day of such service; and, if you fail to appear and defend by filing an Answer to the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.

Respectfully submitted,


John G. Felder, Jr.
McGowan, Hood & Felder, LLC
1517 Hampton Street
Columbia, SC 29201
Telephone: (803) 779-0100
Facsimile: (803) 256-0702
jfelder@mcgowanhood.com

Chad A. McGowan
McGowan, Hood & Felder, LLC
1539 Healthcare Drive
Rock Hill, South Carolina 29732
Telephone: (803) 327-7800
Facsimile: (803) 328-5656
cmcgowan@mcgowanhood.com

Roy Harmon
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
harmonmajor@gmail.com

Sidney L. Major, Jr.
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
sidmajor@bellsouth.net

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, SC 29577
Telephone: (843)448-4357
jeffcchandler@aol.com

Dated: January 8, 2016

Columbia, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FOR THE FIFTEENTH JUDICIAL CIRCUIT
Civil Action No. 2016-CP-26-

Jeanne Beverly, individually and on behalf
of others similarly situated,

Plaintiff,

v.

Grand Strand Regional Medical Center,
LLC,

Defendant.

**CLASS ACTION COMPLAINT
JURY TRIAL DEMANDED**

2016 JUN 11 PM 2:40
Horry County
Clerk of Court

Plaintiff Jeanne Beverly, individually and on behalf of others similarly situated, alleges and states the following claims for relief against Defendant Grand Strand Regional Medical Center, LLC.

NATURE OF THE ACTION

1. Plaintiff Jeanne Beverly and those similarly situated were patients at Defendant's hospital who sought medical treatment arising from motor vehicle accidents. At the time of treatment, Defendant refused to process or submit bills to Plaintiff's health insurance provider and required Plaintiff and similarly situated patients to pay medical bills out of pocket.
2. Ms. Beverly and the class she seeks to represent were named "insureds" under existing insurance policies with Blue Cross Blue Shield Insurance Company ("BCBS").
3. Defendant is a preferred provider in the BCBS network and previously agreed, pursuant to a contract, to scheduled rates of payment for BCBS's insureds as a condition of being a preferred provider.

4. Ms. Beverly and the class she seeks to represent are third party beneficiaries to the contract between Defendant and BCBS, and have a right to enforce the contract between Defendant and BCBS.
5. Defendant's decision to not submit claims was based on monetary gain. By not submitting claims through BCBS, Defendant was able to increase its cash flow by charging insureds the full price of services instead of at the reduced price previously negotiated with BCBS for BCBS's insureds. Defendant's actions ignored its contractual obligations to both BCBS, Plaintiff, and other class members.
6. Defendant's conduct deprived Ms. Beverly and other class members of the benefit of their insurance coverage.

PARTIES

Plaintiff:

7. Plaintiff Jeanne Beverly is a citizen and resident of Myrtle Beach, South Carolina. Plaintiff was a patient of Defendant Grand Strand Regional Medical Center who, like the class members she seeks to represent, was denied the right to have her claims processed and submitted to her insurance carrier by Defendant.

Defendant:

8. Defendant Grand Strand Regional Medical Center, LLC is a limited liability company organized under the laws of the state of Delaware that provides medical services in South Carolina, maintains a registered agent in Richland County, South Carolina, and transacts significant business in South Carolina.

JURISDICTION AND VENUE

9. The jurisdiction of this Court is founded upon S.C. Const. art. V § 11, which grants the circuit court general jurisdiction over civil actions.
10. This Court has personal jurisdiction over Defendant because Defendant conducts business in South Carolina and/or has the requisite minimum contacts with South Carolina necessary to constitutionally permit the Court to exercise jurisdiction, with such jurisdiction also being within the contemplation of the South Carolina “long arm” statute, S.C. Code Ann. § 36-2-803 (2003).
11. Venue in this Court is proper pursuant to the Rules of the South Carolina Supreme Court and the South Carolina Code.

GENERAL FACTUAL ALLEGATIONS APPLICABLE TO ALL CLAIMS

12. Upon information and belief, Ms. Beverly was involved in a motor vehicle collision on September 6, 2012, in which she sustained serious injuries.
13. Ms. Beverly received treatment at Defendant’s hospital for those injuries.
14. At the time of the collision and treatment, Ms. Beverly was covered by a health insurance policy issued by BCBS. Ms. Beverly obtained this health insurance coverage for the purpose of defraying medical expenses.
15. Ms. Beverly’s insurance information was provided to Defendant at the time of her admission and treatment.
16. At all relevant times, Defendant was a preferred provider in the BCBS network.
17. As a preferred provider, Defendant agreed to accept BCBS insurance and provide services for BCBS’s insureds at reduced cost.

18. Despite these contractual relationships and Ms. Beverly's presentment of her insurance coverage, Defendant and its representatives refused to submit Ms. Beverly's bills related to the vehicle collision to BCBS for payment.
19. Medical claims of motor vehicle victims in a hospital's emergency room represent the worst performing revenue streams for a hospital.
20. By refusing to accept insurance coverage for motor vehicle accidents, Defendant can generate a significant increase in cash flow by receiving payment immediately and in an amount that far exceeds the negotiated rate with BCBS.
21. Defendant demanded payment in full from Ms. Beverly despite her insurance coverage.
22. Defendant claimed an amount due of \$7,031.25 for initial medical treatment and an additional \$ 968.75 for the removal of staples.
23. Ms. Beverly was not aware at the time of treatment of Defendant's systematic refusal to honor its contractual obligations regarding emergency room bills for insured patients and did not learn of this information until a later date.
24. Defendant ignored its contractual arrangement with BCBS in an attempt to avoid the discounts it voluntarily negotiated and agreed to in order to become a preferred provider for BCBS. By not submitting Ms. Beverly's bills, BCBS unfairly profited from Ms. Beverly and others similarly situated.
25. Ms. Beverly is a third party beneficiary of the agreements between Defendant and BCBS.

CLASS ACTION ALLEGATIONS

26. Plaintiffs reallege and incorporate by reference the allegations set forth above.
27. Pursuant to Rule 23, SCRCP, Plaintiffs bring this action on behalf of herself and all other similarly situated persons. Plaintiffs seek to represent the class defined as follows:

All persons (or estates of persons) in South Carolina or persons (or estates of person) who have jurisdiction with a South Carolina Court under the Door Closing Statute) insured by BCBS receiving services in Defendant's emergency department from September 6, 2009 to present for whom Defendant failed to submit the bill for medical services to BCBS and instead obtained recovery from the person.

28. On information and belief, the class includes a substantial number of Defendant's patients and is so numerous that joinder of all members is impractical.
29. There are questions of fact or law common to the class predominating over questions affecting only individual class members, including without limitation:
 - a. Whether Defendant's contract with BCBS requires submission of emergency room claims for payment by the insurer rather than the patient;
 - b. Whether Defendant's pursuit of payment from class members rather than from class members' insurer was permitted by law;
 - c. Whether Defendant acted in good faith by pursuing medical expenses from class members despite Defendant's contractual obligations; and
 - d. Whether Defendant's retention of money for medical expenses paid by class members is just.
30. Plaintiffs' claims are typical of the absent class members in that all allege financial losses and other damages attributable to Defendant's process of charging and collecting medical expenses from insured emergency room patients.
31. Plaintiffs will fairly and adequately protect the interests of the other class members. Plaintiffs' counsel is experienced in handling class action claims. Neither Plaintiff nor Plaintiffs' counsel has any interests adverse to or in conflict with the absent class members.
32. The amount in controversy for all class members exceeds one hundred dollars.

COUNT I
BREACH OF CONTRACT

33. Plaintiff and the other class members entered into a contractual agreement with BCBS, whereby Plaintiff and the other class members agreed to pay monthly premiums to BCBS for the benefit of health insurance.
34. BCBS as a part of its service to Plaintiff and other class members, contracted with Defendant to provide payments for their insureds' services. Specifically, Defendant bargained and contracted with BCBS for discounted payments as satisfaction of patient's accounts. This arrangement entitled Defendant to a preferred provider status within the BCBS network and generated business for Defendant.
35. Defendant breached its contract with BCBS, Plaintiff, and the other class members, as third party beneficiaries, by refusing to submit claims to BCBS. Defendant deprived Ms. Beverly of the benefits of the discounts and other provisions negotiated between BCBS and Defendant.
36. As a direct and proximate result of Defendant's breach, Plaintiff and the other class members have suffered damages, which include all payments collected by Defendant from Plaintiff and the other class members together with prejudgment interest.

COUNT II
BAD FAITH

37. The aforementioned paragraphs are hereby incorporated by reference as if fully set forth herein.
38. Plaintiff and other class members were patients at Defendant's hospital from 2012 until present.

39. Defendant created a special relationship with Plaintiff and the other similarly situated class members by contracting with BCBS, thereby making Plaintiff and the other class members third party beneficiaries to its contract with BCBS.
40. Defendant breached the fiduciary duties owed to Plaintiff and the other class members by refusing to submit her insurance claims.
41. Defendant held itself out to be a BCBS preferred provider, with a guaranteed acceptance of BCBS insurance.
42. Defendant actively sought patients' trust for providing medical treatment and care, both as a corporate entity and as a medical facility.
43. Defendant represented to both BCBS and BCBS's insureds that it would provide treatment and care as a preferred provider, which was memorialized in the contract signed by Defendant and BCBS.
44. Defendant actively sought BCBS's insureds as patients, not to ensure that they were provided appropriate medical care, but rather so they could profit off its mischaracterization of its relationship with BCBS.
45. Plaintiff and other similarly situated class members reasonably placed a level of trust in Defendant by choosing to seek medical care and treatment from Defendant based on Defendant's status as a preferred provider.
46. Defendant breached its fiduciary duty to Plaintiff and other class members by choosing to prioritize its revenue stream over the fiduciary relationship it created with BCBS and its insureds.
47. Defendant's goal to maximize its revenue stream was achieved at the monetary expense of patients, like Plaintiff and other class member involved in motor vehicle accidents.

48. Defendant failed to act with fairness and good faith in its dealings with Plaintiff and other class members, and instead used its position to the detriment of BCBS's insureds involved in motor vehicle accidents.
49. The breach of fiduciary duty is believed to be outrageous, willful, wanton, and with reckless disregard of Plaintiff and other similarly situated class members.
50. By the above-referenced conduct, breaches, violations, and failures, it is believed that Defendant failed to discharge its professional and fiduciary duties with the care, skill, prudence, and diligence under the circumstances as required by a prudent person or entity, acting in a like capacity and familiar with such matters.

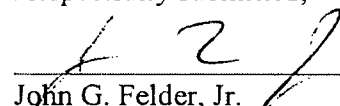
COUNT III
UNJUST ENRICHMENT

51. The aforementioned paragraphs are hereby incorporated by reference as if they were set forth fully herein.
52. Defendant was unjustly enriched through the collection of additional payments from Plaintiff and the other class members for payment of services at a higher value than contracted for with BCBS.
53. This conduct constitutes an unjust retention of a benefit to the detriment of Plaintiff and class members, and Defendant's retention of money is against the fundamental principles of justice and good conscience and is patently unfair.
54. It would be unconscionable for Defendant to retain the payments made by Plaintiff and other class members because those funds were received with complete disregard of available insurance coverage and in contradiction to the agreed upon price for services bargained for between Defendant and BCBS.
55. Equity demands that Defendant be compelled to return its ill-gotten gains.

56. As a direct and proximate result of Defendant's conduct, Plaintiff and other class members have suffered damages, and request an order be entered creating a constructive trust for any sums illegally collected by Defendant, for counsel fees and costs of suit, and any other relief this Court deems necessary or proper.

WHEREFORE, having fully stated her claims against the Defendant, Plaintiff respectfully prays that the Court certify a South Carolina class, award the relief as set forth above for actual damages, special and consequential damages, punitive damages, attorney's fees and costs, and for such other and further relief as the Court deems necessary and proper. Plaintiff demands a jury trial on all actions so triable.

Respectfully submitted,



John G. Felder, Jr.
McGowan, Hood & Felder
1517 Hampton Street
Columbia, SC 29201
Telephone: (803) 779-0100
Facsimile: (803) 256-0702
jfelder@mcgowanhood.com

Chad A. McGowan
1539 Healthcare Drive
Rock Hill, South Carolina 29732
Telephone: (803) 327-7800
Facsimile: (803) 328-5656
cmcgowan@mcgowanhood.com

Roy Harmon
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
harmonmajor@gmail.com

Sidney L. Major, Jr.
Harmon & Major, P.A.

PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
sidmajor@bellsouth.net

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29577
Telephone: (843)448-4357
jeffcchandler@aol.com

January 6, 2016.
Columbia, South Carolina.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	FIFTEENTH JUDICIAL CIRCUIT
	)	
Jeanne Beverly, individually and on behalf of others similarly situated,	)	C.A. No. 2016-CP-26-0166
	)	
Plaintiffs,	)	
	)	MOTION TO DISMISS
vs.	)	
	)	
Grand Strand Regional Medical Center, LLC,	)	
	)	
Defendants.	)	
	)	

Defendant moves, pursuant to Rule 12(b)(6), for an Order dismissing Plaintiff's Complaint on the grounds it fails to state facts sufficient to constitute a cause of action. Specifically:

1. Plaintiff asserts a claim for breach of a contract to which she is not a party and which expressly provides that the parties thereto do not intend to make any person or entity a third-party beneficiary thereof. As a matter of law, Plaintiff's First Cause of Action for breach of contract based on a third-party beneficiary right fails.
2. Plaintiff asserts a claim for bad faith breach of the same contract, or for breach of fiduciary duty arising from said contract. Plaintiff alleges she placed a level of trust in Defendant to provide medical care and treatment; however, South Carolina does not recognize the failure of a medical care provider to file an insurance claim as a breach of a fiduciary duty.
3. Plaintiff asserts a claim for unjust enrichment based upon Defendant collecting payment for services rendered. However, there is no allegation that Defendant

charged or collected more than its regular rates and Defendant cannot be unjustly enriched by charging or collecting its regular rates.

Alternatively, Plaintiff asserts all of its rights and claims as flowing from and through the agreement between Defendant and BCBS-SC; however, that agreement expressly provides that any problems or disputes arising out of the agreement are to be resolved by arbitration. Therefore, Plaintiff cannot pursue the claims in this forum and must be compelled to arbitrate such claims as may exist. This action must be dismissed, or stayed, while any arbitration proceeds.

This Motion is based upon the Complaint, the documents referenced therein, the applicable authorities and upon such arguments and memoranda of law as may be submitted in support hereof.

Respectfully submitted,



James Lynn Werner
William R. Thomas
Katon E. Dawson Jr.
Parker Poe Adams & Bernstein LLP
1201 Main Street, Suite 1450
Post Office Box 1509 (29202)
Columbia, South Carolina 29201
Telephone: (803) 255-8000
Facsimile: (803) 255-8017
jimwerner@parkerpoe.com
willthomas@parkerpoe.com
katondawson@parkerpoe.com

*Attorneys for Defendant
Grand Strand Regional Medical Center, LLC*

March 3, 2016
Columbia, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	FIFTEENTH JUDICIAL CIRCUIT
	)	
Jeanne Beverly, individually and on behalf of	)	C.A. No. 2016-CP-26-0166
others similarly situated,	)	
	)	
Plaintiffs,	)	
	)	MEMORANDUM OF LAW
vs.	)	IN SUPPORT
	)	OF DEFENDANT'S
Grand Strand Regional Medical Center, LLC,	)	MOTION TO DISMISS
	)	
Defendant.	)	
	)	

Defendant Grand Strand Regional Medical Center ("GSRMC" or "Defendant") submits this memorandum of law in support of its Motion to Dismiss Plaintiff's Complaint.

FACTS AND ALLEGATIONS

Plaintiff has sued Defendant on purported causes of action for (1) breach of contract, (2) bad faith or breach of fiduciary duty, and (3) unjust enrichment. The entire Complaint arises out of the following simple facts or allegations:

- a. Plaintiff was involved in a motor vehicle collision on September 6, 2012, and received treatment for her injuries on that date in the emergency room of Defendant hospital. [Complaint, ¶¶ 12 and 13]
- b. At the time of the collision and her treatment, Plaintiff alleges she was covered under a health insurance policy issued by Blue Cross/Blue Shield (BCBS). [Complaint ¶ 14]
- c. Defendant was party to a contract with BCBS under which Defendant was a preferred provider in the BCBS network and agreed to accept payment from BCBS for services provided to insureds pursuant to a payment rate schedule in the contract. [Complaint ¶¶ 3, 16 and 17]

- d. Plaintiff asserts that she is a third-party beneficiary to the contract between Defendant and BCBS, with rights to enforce that contract. [Complaint ¶¶ 4 and 25]
- e. Plaintiff alleges that at the time she was treated at Defendant hospital her insurance information was provided to Defendant. [Complaint ¶ 15]
- f. Plaintiff alleges that Defendant refused to submit her bills to BCBS for payment, in breach of Defendant's contract with BCBS. [Complaint ¶¶ 18 and 35]
- g. Plaintiff alleges that Defendant demanded payment in full from her for the medical treatment provided. [Complaint ¶¶ 21 and 22]
- h. Plaintiff alleges that Defendant created a "special relationship" with her by contracting with BCBS. [Complaint ¶ 39]
- i. Plaintiff alleges that she placed a level of trust in Defendant "by choosing to seek medical care and treatment from Defendant." [Complaint ¶ 45]
- j. Plaintiff alleges that Defendant breached its fiduciary duty "by refusing to submit her insurance claims." [Complaint ¶ 40]
- k. Plaintiff alleges that Defendant was unjustly enriched by collection of payment for the medical services rendered at a higher value than contracted for with BCBS. [Complaint ¶ 52]

STANDARD OF REVIEW

A motion to dismiss must be granted if the facts alleged in the complaint, and inferences reasonably deducible therefrom, do not entitle plaintiff to the relief sought. *Chewning v. Ford Motor Co.*, 346 S.C. 28, 32-33, 550 S.E.2d 584, 586 (Ct. App. 2001) (citing *Jarrell v. Petoseed Co.*, 331 S.C. 207, 209, 500 S.E.2d 793, 794 (Ct. App. 1998)).

Ordinarily, “in considering a motion to dismiss pursuant to Rule 12(b)(6), SCRPC, the circuit court must base its ruling solely upon the allegations set forth on the face of the complaint.” *Charleston Cty. Sch. Dist. v. Harrell*, 393 S.C. 552, 557, 713 S.E.2d 604, 607 (2011) (citing *Doe v. Greenville Cty. Sch. Dist.*, 375 S.C. 63, 66-67, 651 S.E.2d 305, 307 (2007)). However, it is also proper that “a court may consider documents outside of the complaint if the complaint incorporates the documents by reference.” *Carolina First Corp. v. Whittle*, 343 S.C. 176, 190 n.7, 539 S.E.2d 402, 410 n.7 (Ct. App. 2000); see *Brazell v. Windsor*, 384 S.C. 512, 516, 682 S.E.2d 824, 826 (2009) (finding a court may consider documents that are incorporated by reference in the complaint but not attached to the complaint without converting a motion to dismiss into a motion for summary judgment); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 629-30, 699 S.E.2d 699, 701-02 (Ct. App. 2010) (assuming a plaintiff incorporated a document by attaching it to the complaint, thereby, allowing the court to consider the document in granting a motion to dismiss). This conclusion by the South Carolina Court of Appeals regarding the legitimate scope of review under a Rule 12 motion is consistent with a long line of authority arising under Rule 12 of the Federal Rules of Civil Procedure.¹ In applying Rule 12, federal courts have recognized that where “collateral documents are inherent to the allegations in the complaint. . .” it is appropriate for the court to consider the referenced documents in deciding a motion to dismiss (*i.e.*, without converting the motion to one for summary judgment). See *In re: DataStream Sys., Inc. Securities Litigation*, No. 6.99-0088-13, 2000 WL 33176025, at *1 (D.S.C. July 27, 2000); see also *Darcangelo v. Verizon Communications, Inc.*, 292 F.3d 181, 195 n.5 (4th Cir. 2002); *Abadian v. Lee*, 117 F.Supp.2d 481, 485 (D.Md. 2000).

¹ “Since [the South Carolina] Rules of Procedure are based on the Federal Rules, where there is no South Carolina law, [South Carolina courts] look to the construction placed on the Federal Rules of Civil Procedure.” *Gardner v. Newsome Chevrolet-Buick, Inc.*, 304 S.C. 328, 330, 404 S.E.2d 200, 201 (1991).

7

ARGUMENT

1. Plaintiff's Claim for Breach of Contract Fails Because Plaintiff Lacks Standing to Enforce the Subject Agreement.

The Complaint does not allege a contract between Plaintiff and Defendant. Rather, Plaintiff alleges the existence of a contract between Defendant and BCBS and asserts she is a third-party beneficiary of that contract with the right to enforce it.² Further, Plaintiff alleges that Defendant breached its contract with BCBS and she sues for damages based on that breach.

South Carolina law is clear, "one not in privity of contract with another cannot maintain an action against him in breach of contract, and any damage resulting from the breach of a contract between the defendant and a third-party is not, as such, recoverable by the plaintiff." *Fabian v. Lindsay*, 410 S.C. 475, 488, 765 S.E.2d 132, 139 (2014) (quoting *Windsor Green Owners Ass'n v. Allied Signal, Inc.*, 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004)); see *Bob Hammond Constr. Co. v. Banks Constr. Co.*, 312 S.C. 422, 424, 440 S.E.2d 890, 891 (Ct. App. 1994) (holding a third party not in contractual privity with the contracting parties had no right to enforce a contract unless the contracting parties intended to create a third party beneficiary to the agreement); *Kleckley v. Northwestern Nat'l Cas. Co.*, 338 S.C. 131, 136, 526 S.E.2d 218, 220 (2000) (holding an injured third party could not assert a bad faith claim against a tortfeasor's insurance company because the injured party was not a party to the contract).

² In fact, there is an "Institutional Agreement" between Blue Cross Blue Shield of South Carolina (BCBS-SC) and Grand Strand Regional Medical Center. That Agreement relates to BCBS-SC Preferred Provider Organization and Defendant's participation therein. That Agreement is expressly covered by a confidentiality provision, and the Agreement will not be otherwise disclosed until such time as an appropriate Confidentiality Order can be resolved and entered. However, two directly applicable and relevant provisions will be referenced or recited in connection with this Motion.

Defendant refers to and relies upon the aforementioned Institutional Agreement in this Motion because Plaintiff has based her claims on such an agreement. However, Defendant does not acknowledge that said Institutional Agreement applies to Plaintiff in this case.

In this case, Plaintiff attempts to avoid dismissal by asserting she is a third-party beneficiary of the Contract between Defendant and BCBS. In that sense, it is true that, if a contract is made for the benefit of a third person, that person may enforce the contract if the contracting parties intended to create a direct, rather than an incidental or consequential, benefit to such third person. *Id.* (citation omitted). However, one can only be a third-party beneficiary if “the contracting parties intend to directly benefit” that party. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005) (citing *Touchberry v. City of Florence*, 295 S.C. 47, 48-49, 367 S.E.2d 149, 150 (1988)).

The presumption is that a contract to which the plaintiff is not a party is not enforceable by that person and that presumption may only be overcome by the showing that the plaintiff was intended to be the direct beneficiary of the contract. *Id.* To determine whether the parties to the contract intended the plaintiff to be a third-party beneficiary, the Court must look to and give legal effect to the intentions of the parties as expressed in the language of their contract. *Gilbert v. Miller*, 356 S.C. 25, 30, 586 S.E.2d 861, 864 (Ct. App. 2003) (citing *United Dominion Realty Trust, Inc. v. Wal-Mart Stores, Inc.*, 307 S.C. 102, 413 S.E.2d 866 (Ct. App. 1992)). The Court’s function is to look at the clear language of the contract and to give that language its lawful meaning and to determine the intent of the parties as found in that clear language of their agreement. *Trancik v. USAA Ins. Co.*, 354 S.C. 549, 555, 581 S.E.2d 858, 861 (Ct. App. 2003) (citing *Smith-Cooper v. Cooper*, 344 S.C. 289, 543 S.E.2d 271 (Ct. App. 2001)).

It is clear that a party claiming to be a third-party beneficiary may not sustain an action for breach of contract when the contract explicitly states that it is not intended to apply to or be for the benefit of third parties.³ In this case, the contract between Defendant and BCBS, upon

³ In an unpublished opinion, the Court of Appeals found a contract’s explicit language stating it did not apply to third parties was clear evidence the contracting parties did not intend for third parties to benefit from the contract and, therefore, the court held third parties were not intended beneficiaries of the contract and could not file claims as

which Plaintiff purports to derive her rights and claims for breach, contains the express provision in Article 16.16 that, “this agreement is not intended to, and shall not be construed to, make any person or entity a third-party beneficiary.” Such explicit language in the very agreement allegedly giving rise to the claim for breach of contract, defeats Plaintiff’s claim. Plaintiff is not, and cannot be an intended beneficiary of the Contract upon which she sues, and she cannot bring this suit. Plaintiff’s claim for breach of contract must be dismissed, as a matter of law.

2. Plaintiff’s Bad Faith Claim Fails Because Defendant Was Not a Fiduciary.

In her second alleged cause of action entitled “Bad Faith” – Plaintiff asserts that a special relationship was created with Defendant by virtue of Defendant having contracted with BCBS and, allegedly, having made Plaintiff a third-party beneficiary of that contract. She further alleges that she placed a level of trust in Defendant by choosing to seek medical care and treatment from Defendant. From these limited allegations, Plaintiff argues that Defendant owed her a fiduciary duty to submit her insurance claims. [Complaint ¶40]. Plaintiff is wrong. As a matter of law, these allegations cannot sustain a cause of action for breach of fiduciary duty or bad faith.

As discussed in the previous section, Plaintiff cannot maintain legitimate status as an intended third-party beneficiary of the Contract between Defendant and BCBS. The express provisions of that Contract absolutely negate any such intention or status. Since Plaintiff cannot enjoy third-party beneficiary status under that contract, neither can she claim that a breach of that Contract constitutes a breach of a fiduciary duty or an act of bad faith actionable by her. This conclusion is axiomatic.

such. *Atherton v. Tenet Healthcare Corp.*, No. 2005-UP-362, 2005 WL 7084013, at *4 (Ct. App. May 25, 2005). While an unpublished opinion may not hold precedential value, the reasoning applied by the Court of Appeals in *Atherton* provides clear and directly applicable guidance in the present matter. Rule 268(d)(2), SCACR.

Under South Carolina law, it is also clear that Plaintiff cannot assert a fiduciary relationship with Defendant merely by alleging that she placed a level of trust in the Defendant by choosing to seek medical care and treatment at Defendant's hospital. "[A] fiduciary relationship cannot be created by the unilateral action of one party." *Moore v. Moore*, 360 S.C. 241, 251, 599 S.E.2d 467, 472 (Ct. App. 2004) (citing *Regions Bank v. Schmauch*, 354 S.C. 648, 670, 582 S.E.2d 432, 444 (Ct. App. 2003)). The other party to the purported relationship must have actually accepted or induced the confidence allegedly placed in him. *Id.* (citation omitted); see *Cowburn v. Leventis*, 366 S.C. 20, 37, 619 S.E.2d 437, 447 (Ct. App. 2005); *Ellis v. Davidson*, 358 S.C. 509, 519-20, 595 S.E.2d 817, 822 (Ct. App. 2004); *Steele v. Victory Sav. Bank*, 295 S.C. 290, 295, 368 S.E.2d 91, 94 (Ct. App. 1988).

In this case, Plaintiff alleges that she placed trust in Defendant by seeking medical care and treatment from Defendant. In contrast, the alleged breach of fiduciary duty was in Defendant's "refusing to submit her insurance claims." Thus the allegations of the Complaint do not align the alleged duty with the alleged breach. This alone would be fatal to Plaintiff's claim.

The courts of South Carolina have also rejected this argument. *Wogan v. Kunze*, 366 S.C. 583, 605, 623 S.E.2d 107, 119 (Ct. App. 2005), *aff'd as modified*, 379 S.C. 581, 666 S.E.2d 901 (2008) (rejecting breach of fiduciary duty claim and observing that the South Carolina courts have not found the failure of a medical care provider to offer assistance in filing claims to be a breach of fiduciary duty). Here, the Defendant hospital acted as Plaintiff's health care provider, not her insurance agent or financial fiduciary. There is simply no legal or factual basis to Plaintiff's bald and conclusory allegation that Defendant was her fiduciary for insurance purposes. Plaintiff's Second Count fails as a matter of law and must be dismissed.

3. Defendant's Collection of Full Payment of Its Bill for Services Rendered Does Not Constitute Unjust Enrichment.

Unjust enrichment is an equitable concept based on the same principles as *quantum meruit*, quasi-contract, and implied by law contracts. See *Myrtle Beach Hospital, Inc. v. City of Myrtle Beach*, 341 S.C. 1, 8, 532 S.E.2d 868, 872 (2000). These quasi-contract principles have no application to Plaintiff's overpayment theory, and Plaintiff fails to establish any cause of action that would entitle her to recover for unjust enrichment. See *Pitts v. Jackson Nat'l Life Ins. Co.*, 352 S.C. 319, 339, 574 S.E.2d 502, 512 (Ct. App. 2002).

Here, Plaintiff does not assert a *quantum meruit*, quasi-contract, or implied by law theory of contract – she alleges an actual contract and claims it was breached. As a matter of law, whenever a plaintiff seeks to recover on an unjust enrichment theory while also claiming that the rights are encompassed within the terms of an express contract, the unjust enrichment claim must fail. *Swanson v. Stratos*, 350 S.C. 116, 122, 564 S.E.2d 117, 120 (Ct. App. 2002) (citing with approval 66 Am. Jur. 2d *Restitution and Implied Contracts* § 81 (2001) (“[I]t is a defense to an action in *quantum meruit* that there is an express contract covering the issue of compensation for services or materials furnished”). Thus, if Plaintiff's breach of contract claim is allowed to proceed, her unjust enrichment claims must be dismissed.

In this case, Plaintiff cannot succeed on her unjust enrichment claim in any event. There is no allegation in the Complaint that Defendant charged more than its regular rates for the medical services which were admittedly rendered. Defendant cannot be unjustly enriched by collecting from Plaintiff its regular rates for the services which it provided. Furthermore, Plaintiff never even alleges that she paid higher or inequitable amounts.

The South Carolina Court of Appeals decision in *Pitts v. Jackson National Life Insurance Company*, illustrates the fallacy of Plaintiff's alleged unjust enrichment claim. 352 S.C. 319, 574 S.E.2d 502. In that case, the plaintiff sued the insurance company asserting a claim for

PPAB 3138274v2 8

unjust enrichment based on the assertion that the company failed to issue a preferred policy instead of a standard policy for his daughter, while the preferred policy would have charged lower premiums than the standard policy of equal face value. After reciting the same essential elements of any claim for unjust enrichment, the Court of Appeals found there was no benefit conferred upon the insurance company that would be unjust for it to retain. In the present case, Plaintiff sought and was provided medical services by Defendant and, according to the Complaint, was charged regular rates in exchange for those services rendered to her. As in *Pitts*, Plaintiff's claim is that Defendant was unjustly enriched merely by failing to apply a discounted rate for its services. Such an allegation is insufficient under South Carolina law to sustain a claim for unjust enrichment. Therefore, Plaintiff's claim for unjust enrichment is improper and should be dismissed as a matter of law.

4. If Plaintiff Is Allowed To Pursue Any Claim Arising Out of The Institutional Agreement Between Defendant and BCBS-SC, Then This Action Must Be Stayed or Dismissed and She Must Be Compelled To Pursue Her Claim In Arbitration As Expressly Required Under Article XII of Said Agreement.

Although Plaintiff's claims should be dismissed as a matter of law for the reasons stated above, if she is allowed to pursue any claim arising out of or related to the Institutional Agreement between Defendant and BCBS-SC, as she seeks to do, then she must pursue those claims in arbitration in accordance with the express requirements of Article XII of such Agreement. The express Institutional Agreement between Defendant and BCBS-SC provides that "any problem or dispute" is subject to the agreement of the parties to arbitrate such problem or dispute.

The agreement to arbitrate set forth in the very contract which Plaintiff seeks to enforce, and upon which she asserts her rights in this case, must be enforced. Both federal and state policy favor arbitration of disputes. *Towles v. United HealthCare Corp.* 338 S.C. 29, 34, 524 S.E.2d 839, 842 (Ct. App 1999); *Toler's Cove Homeowners Ass'n, Inc. v. Trident Const. Co.*, PPAB 3138274v2

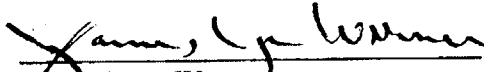
Inc., 355 S.C. 605, 612, 586 S.E.2d 581, 585 (2003) (stating it is the policy in South Carolina to favor arbitration in disputes). In fact, the courts of South Carolina will resolve any doubts concerning the scope of arbitral issues in favor of arbitration. *Landers v. Fed. Deposit Ins. Corp.*, 402 S.C. 100, 109, 739 S.E.2d 209, 213 (2013). A Motion to Compel Arbitration, when there is an arbitration clause in the written contract, should be granted unless the arbitration clause in question is not susceptible to any interpretation which would apply to the asserted dispute. *Tritech Elc., Inc. v. Frank M. Hall & Co.*, 343 S.C. 396, 399, 540 S.E.2d 864, 865 (Ct. App. 2000).

Thus, since Plaintiff seeks to derive her rights, and base her claims, on the Institutional Agreement between Defendant and BCBS-SC, she must arbitrate her disputes in accordance with the expressed provisions of that Agreement. Any claims which survive this Motion to Dismiss, must be compelled to arbitration, and this litigation must be dismissed, or stayed, in the meantime.

CONCLUSION

For the reasons stated above, Plaintiff's Complaint should be dismissed as a matter of law. Alternatively, if any claim survives this Motion to Dismiss, that claim must be compelled to arbitration and this litigation dismissed, or stayed, pending completion of that arbitration.

Respectfully submitted,



James Lynn Werner

William R. Thomas

Katon E. Dawson Jr.

Parker Poe Adams & Bernstein LLP

1201 Main Street, Suite 1450

Post Office Box 1509 (29202)

Columbia, South Carolina 29201

Telephone: (803) 255-8000

Facsimile: (803) 255-8017

jimwerner@parkerpoe.com

willthomas@parkerpoe.com

katondawson@parkerpoe.com

Attorneys for Defendant

Grand Strand Regional Medical Center, LLC

March 3, 2016

Columbia, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

Jeanne Beverly, individually and on behalf
of others similarly situated,

Plaintiff,

v.

Grand Strand Regional Medical Center,
LLC,

Defendant.

IN THE COURT OF COMMON PLEAS

FOR THE FIFTEENTH JUDICIAL CIRCUIT

Civil Action No. 2016-CP-26-0166

**PLAINTIFF'S MEMORANDUM OF
LAW IN OPPOSITION TO
DEFENDANTS' MOTION TO DISMISS**

FILED
HORRY COUNTY
2016 APR 13 PM 2:05
MELANIE HUGGINS, M.D.
CLERK OF COURT

Plaintiff Jeanne Beverly, individually and on behalf of others similarly situated respectfully submits Plaintiff's Memorandum of Law in Opposition to Defendant Grand Strand Regional Medical Center, LLC's ("GSRMC") Motion to Dismiss.

FACTS

Plaintiff Jeanne Beverly was injured in a car accident on September 6, 2012 and was treated at GSRMC the same day. (Compl. ¶¶ 12-13). Plaintiff had health insurance through Blue Cross Blue Shield of South Carolina ("BCBS"). She sought treatment at GSRMC because it is a BCBS Preferred Provider Organization ("PPO") provider. (Compl. ¶ 16). To become a BCBS PPO provider, GSRMC entered a contract with BCBS known as an "Institutional Agreement," which imposes several requirements on prospective PPO providers "for the benefit of [BCBS] members" like Plaintiff. Institutional Agreement § 1.1. GSRMC agreed to (1) submit all BCBS members' bills to BCBS as soon as practicable¹; (2) seek payment for those services "solely

¹ Institutional Agreement § 6.3

copy

from” BCBS²; (3) accept the discounted reimbursement rate outlined in the Agreement³; and (4) refrain from charging BCBS members directly except for coinsurance, copays, and deductibles⁴.

Even though Plaintiff is a BCBS member and the services GSRMC provided her are covered by the Institutional Agreement, GSRMC charged the full amount for those services and sought payment from Plaintiff rather than BCBS. (Compl. ¶ 21). GSRMC disregarded the agreed upon reimbursement rate and sent Plaintiff a \$7,031.25 bill for emergency room services and an additional \$968.75 bill for staple removal. (Compl. ¶ 22). Upon information and belief, GSRMC routinely chooses to disregard the reimbursement rate to which it agreed and routinely charges BCBS members directly for medical service costs that grossly exceed the reimbursement rate. See (Compl. ¶¶ 27-32). Accordingly, Plaintiff, individually and on behalf of similarly situated BCBS members, filed a Class Action Complaint against GSRMC alleging claims for (1) breach of contract; (2) bad faith; and (3) unjust enrichment. GSRMC filed the current Motion to Dismiss on March 3, 2016.

LEGAL STANDARD

A defending party may assert in its answer or in a pre-answer motion a defense alleging the complaint against the defending party fails to state facts sufficient to constitute a cause of action. Rule 12(b)(6), SCRCF. When reviewing a 12(b)(6) motion, a court must view a complaint in the light most favorable to the plaintiff and every doubt must be resolved in the plaintiff's favor. Plyler v. Burns, 373 S.C. 637, 645, 647 S.E.2d 188, 192 (2007). If the “facts alleged and inferences reasonably deducible therefrom would entitle the plaintiff to any relief on any theory of the case,” then the court may not grant a 12(b)(6) motion. Sloan Constr. Co. v. Southco Grassing Co., 377 S.C. 108, 113, 659 S.E.2d 158, 161 (2008). A court may not dismiss

² Institutional Agreement § 6.1

³ Institutional Agreement § 6.4

⁴ Institutional Agreement § 6.1 (a)-(d)

a complaint merely because the court doubts the plaintiff will prevail. Plyler, 373 S.C. at 645, 647 S.E.2d at 192.

ARGUMENT

1. Plaintiff may allege a breach of contract claim as a third-party beneficiary.

The Institutional Agreement expressly acknowledges its terms are intended to benefit not just the parties (i.e. GSRMC and BCBS) but also BCBS members. Even in the provision purporting to exclude third-party beneficiaries, the Institutional Agreement acknowledges benefits the contract confers on BCBS members like Plaintiff. By choosing to enter the Institutional Agreement, GSRMC chose to forgo the full cost of Covered Services and the right to look to patients directly for payment in exchange for access to BCBS's members and the guaranteed payment the Institutional Agreement provides. In both its structure and terms, the Institutional Agreement intended to directly benefit Plaintiff and she is entitled to enforce it.

Generally, a contract may be enforced only by those who objectively manifest assent to its terms and enter the contract as parties. Hardaway Concrete Co. v. Hall Contracting Co., 374 S.C. 216, 225, 647 S.E.2d 488, 492 (Ct. App. 2007). As an exception to this rule, a person that contract parties "intended to directly benefit" may be a third-party beneficiary who may then assert a breach of contract claim. Helms Realty, Inc. v. Gibson-Wall Co., 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005). A contract's language is the first point of reference for determining the parties' intent. Wallace v. Day, 390 S.C. 69, 74-75 700 S.E.2d 446, 449 (Ct. App. 2010) (citing C.A.N. Enters., Inc. v. S.C. Health & Human Servs. Fin. Comm'n, 296 S.C. 373, 377, 373 S.E.2d 584, 586 (1988)). When the contract language is capable of two or more meanings, the contract is ambiguous, creating a question of fact on the parties' intent. Id.

The Institutional Agreement clearly intended to provide direct benefits to BCBS members like Plaintiff. The contract's express purpose was for GSRMC to become a provider for a PPO created "for the benefit of [BCBS] members." Institutional Agreement at §§ 1.1-1.2; Cf. M & M Group Inc. v. Holmes, 379 S.C. 468, 476-77, 666 S.E.2d 262, 266 (Ct. App. 2008) (using recital provision to determine parties' intent). Benefitting BCBS members inheres to the PPO concept, which the Institutional Agreement defines as a "network of providers" that "contain[s] financial incentives for Members." Institutional Agreement § 2.16. Plaintiffs contracted with BCBS to become PPO members so they could reap the financial and medical benefits of the PPO network outlined in the Institutional Agreements between BCBS and each PPO provider. Given the PPO structure GSRMC signed on to and the clearly expressed language in the Institutional Agreement, it is not reasonable for GSRMC to argue the Institutional Agreement was not intended to benefit Plaintiff.

GSRMC contends the Institutional Agreement expressly excluded the possibility of third-party beneficiaries. Def.'s Mem. in Supp. of Mot. to Dismiss at 5-6 (citing Institutional Agreement § 16.16). GSRMC's memorandum provided the Court only a portion of this provision. Section 16.16 reads in full:

This Agreement is not intended to, and shall not be construed to, make any person or entity a third party beneficiary. Notwithstanding the preceding, nothing in this section shall affect Plans rights under Article XV, or **a Member's right to receive Covered Services pursuant to the terms of this Agreement.**

(Emphasis added).

The highlighted language is crucial for two reasons. First, it provides further proof the Institutional Agreement contemplated Plaintiff and intended to directly benefit her. The provision acknowledges a "Member's rights" under the Institutional Agreement. Second, even if this section is construed as a general exclusion of third-party beneficiary rights, it clearly

includes carve outs for certain scenarios including a BCBS member seeking to ensure receipt of Covered Services. Plaintiff's breach of contract claim is simply an attempt to enforce the Institutional Agreement's terms on the provision of Covered Services.

As alleged in the Complaint, Plaintiff's did not "receive Covered Services pursuant to the terms of the Agreement." The Institutional Agreement required GSRMC to provide Plaintiff's the Covered Services their medical conditions required. Institutional Agreement § 4.1. Except for Plaintiff's coinsurance, copayment, and deductible obligations, GSRMC was then required to seek payment for Covered Services "solely from" BCBS. Institutional Agreement § 6.1. To provide Covered Services "pursuant to the terms of the Agreement," GSRMC was required to "bill [BCBS] in a manner acceptable to and as prescribed by [BCBS]" and to "exercise reasonable efforts to submit all bills" to BCBS "as soon as practicable after Covered Services are rendered." Institutional Agreement §§ 6.2-6.3. Finally, the Institutional Agreement provides that GSRMC "shall accept the reimbursement terms and rates for Covered Services" stated in the Agreement and its attachments. Institutional Agreement § 6.4.

This is not how GSRMC provided Covered Services to Plaintiff. Plaintiff was treated in GSRMC's emergency department (Compl. ¶¶ 13, 27) but almost nothing related to the submission or payment of bills for her treatments was consistent with GSRMC's contractual obligations. The bills were not submitted to BCBS (Compl. ¶ 18) even though GSRMC was required to do so. Institutional Agreement § 6.2. GSRMC sought payment from Plaintiff (Compl. ¶ 21) rather than BCBS even though the Agreement expressly prohibits this practice. Institutional Agreement § 6.1. GSRMC then sought and obtained for Covered Services more than the contractually-established reimbursement rate. (Compl. ¶ 24); Institutional Agreement § 6.4. Thus, even if Section 16.16 generally excludes third-party beneficiaries, Plaintiff falls

within the provision's exception because her claim relates to her "right to receive Covered Services pursuant to the terms of this Agreement."

Plus, GSRMC's argument has been rejected by other jurisdictions considering a nearly identical Institutional Agreement. In Benton v. Vanderbilt Univ., 118 F. Supp. 2d 877 (M.D. Tenn. 2000), a patient injured in an auto accident and treated at the defendant hospital sued the hospital for breach of contract when the hospital refused to submit bills to BCBS of Tennessee and instead asserted a lien against the victim's potential tort recovery. The patient alleged a breach of contract claim and argued he was a third party beneficiary to the hospital's Institutional Agreement with BCBS of Tennessee. Id. at 879; see also Benton v. Vanderbilt Univ., 137 S.W.3d 614 (Tenn. 2004) (holding on remand that patient is third-party beneficiary to her insurer's contract with hospital). The Tennessee Supreme Court reaffirmed this holding in 2014 in another case construing a BCBS of Tennessee-hospital Institutional Agreement. West v. Shelby County Healthcare Corp., 459 S.W.3d 33, 45 (Tenn. 2014) ("We have already held that persons insured by an insurance company are intended third-party beneficiaries of the contract between their insurance company and a hospital" (citing Benton, 137 S.W.3d at 620)).⁵

Thus, under South Carolina law, Plaintiff is a third-party beneficiary to the Institutional Agreement between BCBS and GSRMC and is entitled to enforce its provisions. Defendants' motion to dismiss Plaintiff's breach of contract claim should be denied.

2. Plaintiff properly alleges a breach of fiduciary duty claim.

The Complaint properly states a cause of action for breach of fiduciary duty. This claim requires proof of (1) the existence of a fiduciary duty; (2) breach of that duty owed to the

⁵ See also Cates v. Integris Health, Inc., No. CIV-12-0763-F, 2013 WL 3923512 (W.D. Okla. July 29, 2013); Dorr v. Sacred Heart Hosp., 597 N.W.2d 462, 475 (Wis. Ct. App. 1999) (finding insured was third-party beneficiary to hospital-insurer contract despite contract provision purporting to exclude third-party beneficiaries).

plaintiff by the defendant; and (3) damages proximate resulting from the wrongful conduct of the defendant; Turpin v. Lowther, 404 S.C. 581, 589, 745 S.E.2d 397, 401 (Ct. App. 2013) (citing RFT Mgmt. Co. v. Tinsley & Adams, L.L.P., 399 S.C. 322, 335-36, 732 S.E.2d 166, 173 (2012)). A fiduciary relationship is formed when one party places a “special confidence” in another so that the other must “act in good faith and with due regard to the interests of the one imposing the confidence.” Hendricks v. Clemson Univ., 353 S.C. 449, 458, 578 S.E.2d 711, 715 (2003). To demonstrate a fiduciary relationship, Plaintiff must only show the facts and circumstances surrounding her claim provided a foundation for believing GSRMC would act in Plaintiff’s interest and that GSRMC either accepted or induced the confidence Plaintiff placed in it. Moore v. Moore, 360 S.C. 241, 251, 599 S.E.2d 467, 472 (Ct. App. 2004) (citing Burwell v. S.C. Nat’l Bank, 288 S.C. 34, 41, 340 S.E.2d 786, 790 (1986); Regions Bank v. Schmauch, 354 S.C. 648, 671, 582 S.E.2d 432, 444 (Ct. App. 2003)).

Through the facts and circumstances surrounding Plaintiff’s treatment at GSRMC, including the Institutional Agreement’s terms, Plaintiffs have properly pled the existence and breach of a fiduciary duty. As a BCBS insured in need of emergency room services, Plaintiff sought out GSRMC, an entity that entered the Institutional Agreement to become a BCBS PPO provider. (Compl. ¶¶ 39, 45); Institutional Agreement § 1.2. Plaintiff “placed a level of trust” that GSRMC would function as a BCBS PPO provided by offering emergency room services to BCBS members, submitting bills for those services to BCBS as soon as practicable after the services were provided, accepting the established reimbursement rate for those services, and never looking to Plaintiff for payment except for coinsurance, copayments, and deductibles. (Compl. ¶ 45); Institutional Agreement § 6.1-6.4. GSRMC “held itself out” as a BCBS PPO provider and “actively sought” patients to trust GSRMC would act as a BCBS PPO provider

(Compl. ¶¶ 42, 44). Plaintiff further alleges GSRMC breached this trust by choosing not to submit bills to BCBS as it had agreed and by seeking payment at levels above the reimbursement rate and from someone other than BCBS. (Compl. ¶¶ 46-48).

GSRMC argues Plaintiff's claim fails because (1) Plaintiff was not a third-party beneficiary to the Institutional Agreement; (2) GSRMC owed Plaintiff no fiduciary duty; and (3) even if GSRMC owed a fiduciary duty, claim submission is not a part of the duty. None of these arguments are consistent with South Carolina law or the Institutional Agreement GSRMC entered. As discussed above, Plaintiff was an intended third-party beneficiary of the Institutional Agreement. GSRMC is also wrong to conclude it owed Plaintiff no fiduciary duty. It is true that a fiduciary duty may not be created by unilateral action. Def. Mem. in Supp. of Mot. to Dismiss at 7 (Moore, 360 S.C. at 251, 599 S.E.2d at 472). However, Plaintiff's fiduciary claim is based on both Plaintiff placing trust in GSRMC (Compl. ¶ 45) and GSRMC's actions to induce and accept that trust. (Compl. ¶¶ 41-44).

Finally, Plaintiff's fiduciary duty claim is not precluded by Wogan v. Kunze, 366 S.C. 585, 605, 623 S.E.2d 107, 119 (Ct. App. 2005). In fact, the medical provider-patient relationship is recognized as a confidential relationship in South Carolina. Id. (citing McCormick v. England, 328 S.C. 627, 639, 494 S.E.2d 431, 437 (Ct. App. 1997)). Wogan affirmed summary judgment on a breach of fiduciary duty claim related to Medicare claim submission because the claim was essentially a repackaged medical malpractice claim and because the Medicare Act does not permit a statutory claim for relief. 366 S.C. at 606, 623 S.E.2d at 606. Plaintiffs' claim is significantly different. Plaintiff's claim is not dependent on the Medicare Act and does not conflict in any way with federal law. Plus, the Institutional Agreement is substantially different than the contract considered in Wogan where the Court of Appeals specifically noted that the

contract did not specify a claim submission requirement. 366 S.C. at 604, 623 S.E.2d at 119. Here, however, the Institutional Agreement expressly states GSRMC "shall bill" BCBS and "shall exercise reasonable efforts to submit all bills as soon as practicable." Institutional Agreement at §§ 6.2, 6.3.

In short, GSRMC wanted to be a BCBS PPO provider to gain access to BCBS's extensive membership and guaranteed revenue sources from BCBS. (Compl. ¶¶ 43-44). To do so, GSRMC agreed to abide by the PPO's rules explicitly intended to benefit BCBS members like Plaintiff. Those rules include a limited reimbursement rate, claim submission mandate, and a requirement that GSRMC look only to BCBS for payment. By agreeing to these terms, GSRMC was able to hold itself out as a BCBS preferred provider which induced Plaintiff to trust that GSRMC would follow the rules. GSRMC breached that trust causing Plaintiff to incur medical expenses and other damages. (Compl. ¶¶ 46-49). These allegations properly state a claim for breach of fiduciary duty and Defendant's motion should be denied.

3. Plaintiff may allege an unjust enrichment claim based on GSRMC's collection of medical expenses beyond the reimbursement rate established in the Institutional Agreement.

GSRMC only became a PPO provider by agreeing to accept the established reimbursement rate for Covered Services provided to BCBS members like Plaintiff. Institutional Agreement § 6.4 (GSRMC "shall accept the reimbursement terms and rates for Covered Services"). In complete disregard of that duty, GSRMC unjustly charged Plaintiff and collected from her significantly more than the reimbursement rate. (Compl. ¶¶ 21-22; 52). Under these circumstances it is proper for Plaintiff to allege a claim for unjust enrichment or *quantum meruit*. These claims are one and the same and require proof that (1) Plaintiff conferred on GSRMC a benefit; (2) GSRMC realized that benefit; and (3) it would be inequitable for GSRMC to retain

the benefit under these circumstances without paying Plaintiff for its value. Gignilliat v. Gignilliat, Savitz & Bettis, 385 S.C. 452, 684 S.E.2d 756 (2009); Clyde v. Johnson, 402 S.C. 458, 466, 742 S.E.2d 6, 10 (Ct. App. 2013) (“*quantum meruit* is a remedy for unjust enrichment”).

Unjust enrichment is similar to restitution and both terms are simply “modern designations for the older doctrine of quasi-contracts.” JASDIP Props. SC, LLC v. Estate of Richardson, 395 S.C. 633, 640, 720 S.E.2d 485, 489 (Ct. App. 2011) (quoting Ellis v. Smith Grading & Paving, Inc., 294 S.C. 470, 473, 366 S.E.2d 12, 14 (Ct. App. 1988)). Contrary to GSRMC’s argument (Def.’s Mem. at 8), it is proper for Plaintiff to allege both an unjust enrichment/*quantum meruit* and a breach of contract claim. While a plaintiff may not be able to recover for both claims in some circumstances, the claims are not mutually exclusive and Plaintiff may plead both. See Williams Carpet Contractors, Inc. v. Skelly, 400 S.C. 320, 734 S.E.2d 177, 181 (Ct. App. 2012) (“A breach of contract claim and *quantum meruit* claim can be alternative rather than inconsistent remedies”).

As to the merits of Plaintiff’s unjust enrichment claim, GSRMC argues only that the claim is foreclosed by Pitts v. Jackson National Life Insurance Co., 352 S.C. 319, 574 S.E.2d 502 (Ct. App. 2002). Pitts held that it was not inequitable for an insurer to retain the price of an insurance policy even though the insurer could have offered a policy with similar coverage at a lesser price. 352 S.C. at 339, 574 S.E.2d at 512. Plaintiff’s claim is substantially different. While the Pitts defendant was permitted to refuse to offer a gratuitous discount, GSRMC is not permitted to collect for its services a much higher payment rate than it had agreed to accept. GSRMC did far more than just refuse to offer a discount. Instead, it agreed to one and then maneuvered to charge a higher rate anyway. All funds GSRMC collected from Plaintiff above

the reimbursement rate is a benefit that GSRMC came by inequitably. It is unjust for GSRMC to retain these funds, and Plaintiff's unjust enrichment/*quantum meruit* claim is a proper claim to seek a remedy for this wrong.

4. Plaintiff is not bound to arbitrate her claims against GSRMC.

Even though it has moved under Rule 12(b)(6), SCRC⁶, GSRMC asks the Court to compel Plaintiff to arbitrate her claims based on a provision in the Institutional Agreement. However, "a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit." Landers v. Fed. Deposit Ins. Corp., 402 S.C. 100, 108, 739 S.E.2d 209, 213 (2013) (quoting United Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574, 582 (1960)). GSRMC has not pointed to any document where Plaintiffs agreed to arbitrate her claims.

The Institutional Agreement's arbitration provision specifically excludes Plaintiffs' claims from its reach. GSRMC argues the provision requires arbitration for "any problem or dispute." Def.'s Mem. in Supp. of Mot. to Dismiss at 9 (citing Institutional Agreement § 12.2). Yet again, GSRMC does not provide all of the crucial language. Section 12.2's states:

In the event that **the parties** through mutual negotiation are not able to satisfactorily resolve any problem or dispute (other than a Utilization Management Program decision, which shall be governed by the terms of Article VII), **Plan and Institution agree to arbitrate** such problem or dispute using a single arbitrator.

(Emphasis added). Thus, while the Institutional Agreement recognizes BCBS members' rights and the PPO to which GSRMC gained access was created for the benefit of BCBS members, the Agreement specifically limits arbitration to "the parties." The arbitration provision goes a step

⁶ Rule 12(b)(6), SCRC⁶ allows a defending party to move for dismissal for "failure to state facts sufficient to constitute a cause of action." A 12(b)(6) motion tests only "the factual and legal sufficiency of the complaint." Woodell v. Marion School Dist. One, 307 S.C. 297, 298, 414 S.E.2d 794, 794 (Ct. App. 1992).

further by stating arbitration applies only to claims between "Plan and Institution," i.e. BCBS and GSRMC. When an insurer-health care provider contract specifically limits arbitration to its parties, a third-party beneficiary's claims are not subject to arbitration. For example, in Rath v. Managed Health Network, Inc., 844 P.2d 12 (Idaho 1992), the court refused to submit a third-party beneficiary's claim to arbitration when the contract specifically limited arbitration to disputes "between the parties to this Agreement." GSRMC is bound by the contract language it chose. Since language clearly does not include Plaintiffs' claims within its arbitration provision, GSRMC cannot compel Plaintiff to arbitrate.

5. Forcing Arbitration in this case would be unconscionable.

The Institutional Agreement contemplates the marketing of the PPO advantages to members and the member communications state charges will be at network rate. This is one of the major advantages to a consumer of purchasing this particular plan. Accordingly, the PPO network is published to consumers and plan members as advantages of doing business with the health care providers "in the network".

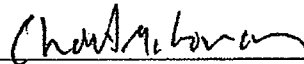
It would be unconscionable and unforeseeable by the consumer that an undisclosed, confidential provision in the agreement would foreclose suit when A hospital violates the published facts of agreement to consumers and then bills patients in excess of the rate agreed upon by member's insurance plan (BCBS). It would be unconscionable to entice consumers to use the medical providers in the network, based on promises of the network price discounts, and then then, in a secret provision, remove the consumer's ability to do anything about it. See, Aiken v. World Fin. Corp. of S.C., 373 S.C. 144, 644 S.E.2d 705 (2007); Simpson v. World Fin. Corp. of S.C., 373 S.C. 178, 644 S.E.2d 723 (2007); Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663 (2007); Chassereau v. Global-Sun Pools, Inc., 373 S.C. 168, 644 S.E.2d

718 (2007). South Carolina Supreme Court has raised issue of whether an arbitration agreement is unconscionable and narrows the applicability of arbitration provisions to claims for "outrageous torts that are unforeseeable to a reasonable consumer in the context of normal business dealings." Aiken v. World Fin. Corp. of S.C., 373 S.C. 144, 151, 644 S.E.2d 705, 709 (2007).

CONCLUSION

Based on the arguments stated above, Plaintiff respectfully requests an order denying GSRMC's motion to dismiss. Plaintiff is a third-party beneficiary to the Institutional Agreement and may allege a breach of contract claim to enforce its terms. Plus, the Complaint properly alleges all elements of a breach of fiduciary duty claim. Finally, the Institutional Agreement specifically excludes Plaintiff's claims from its arbitration provision, and GSRMC may not compel arbitration.

Respectfully submitted,



John G. Felder, Jr.
McGowan, Hood & Felder
1517 Hampton Street
Columbia, SC 29201
Telephone: (803)779-0100
Facsimile: (803) 256-0702
jfelder@mcgowanhood.com

Chad A. McGowan
1539 Healthcare Drive
Rock Hill, South Carolina 29732
Telephone: (803) 327-7800
Facsimile: (803) 328-5656
cmcgowan@mcgowanhood.com

Roy Harmon

Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
harmonmajor@gmail.com

Sidney L. Major, Jr.
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
sidmajor@bellsouth.net

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29577
Telephone: (843)448-4357
jeffcchandler@aol.com

April 14, 2016.
Columbia, South Carolina.

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

Jeanne Beverly, individually and on behalf
of others similarly situated,

Plaintiff,

v.

Grand Strand Regional Medical Center,
LLC,

Defendant.

IN THE COURT OF COMMON PLEAS

FOR THE FIFTEENTH JUDICIAL CIRCUIT

Civil Action No. 2016-CP-26-0166

**PLAINTIFF'S MOTION TO
ALTER OR AMEND JUDGMENT**

FILED 13 PM 2:17

Pursuant to Rule 59, SCRCP, Plaintiff Jeanne Beverly, individually and on behalf of others similarly situated, hereby moves to alter or amend the Court's judgment granting Defendant Grand Strand Regional Medical Center, LLC's ("GSRMC") Motion to dismiss. Plaintiff received written notice of entry of the Court's order on May 2, 2016. Plaintiff's motion is based on the following grounds:

First, the Court's finding that Plaintiff is not a third-party beneficiary to GSRMC's Institutional Agreement with Blue Cross Blue Shield of South Carolina ("BCBSSC") is based on an improper application of South Carolina contract law. The Court failed to give effect to the plain language of Institutional Agreement § 16.16 which, while generally excluding third-party beneficiaries, protects Plaintiff's "right to receive Covered Services pursuant to the terms of this Agreement." The Complaint properly alleges Plaintiff received "Covered Services" following a motor vehicle accident. (Compl. ¶¶ 12-14). Thus, determining § 16.16's application depends not on the meaning on "Covered Services" but rather on whether Plaintiff's claims allege the Covered Services she received were not provided "pursuant to the terms of" the Institutional Agreement.

Copy

Since Defendant chose not to define “pursuant to,” the phrase must be given its plain and ordinary meaning. Bardsley v. Gov’t Employees Ins. Co., 405 S.C. 68, 76, 747 S.E.2d 436 (2013). “Pursuant to” means “in compliance with” or “in accordance with.” Black’s Law Dictionary 1272 (8th ed. 1999). To comply with the Institutional Agreement, Defendant was required to submit a claim to BCBSSC for Plaintiff’s medical care. Institutional Agreement § 6.3. In accordance with the Institutional Agreement’s terms, Defendant had a duty to accept the reimbursement rate to which it agreed and to seek reimbursement from BSBSSC alone. Institutional Agreement §§ 6.1, 6.4. Plaintiff’s Complaint alleges Defendant failed to submit a claim for her medical care to BCBSSC (Compl. ¶ 18), pursued reimbursement directly from her (Compl. ¶ 21), and sought reimbursement at rates that exceed the one to which it agreed by contract. (Compl. ¶¶ 21-22). Accordingly, Plaintiff alleges GSRMC’s conduct denied Plaintiff the “right to receive Covered Services pursuant to the terms of this Agreement.” The plain language of the purported third-party beneficiary exclusion does not apply to Plaintiff’s claims, and GSRMC’s motion should be denied.

The Court was also required to interpret the Institutional Agreement in its entirety when determining whether Plaintiff qualifies as a third party beneficiary. Gaffney v. Gaffney, 401 S.C. 216, 222, 736 S.E.2d 683, 687 (Ct. App. 2012) (“the court must examine the entire contract not merely whether certain phrases taken in isolation could be interpreted in more than one way”). The Court failed to comply with this rule by overlooking numerous Institutional Agreement provisions describing its intended benefits to BCBSSC members including Plaintiff. The Institutional Agreement’s express purpose was to add GSRMC to a PPO network “for the benefit of [BCBSSC] members.” Institutional Agreement §§ 1.1-1.2. The PPO was specifically intended to “contain financial incentives for Members.” Institutional Agreement § 2.16. Later, the

Institutional Agreement articulates those benefits including guaranteed coverage for Covered Services, cost controls, and relief from the administrative burden of submitting claims. Institutional Agreement §§ 6.1-6.4.

Taken as a whole, the Institutional Agreement confers substantial, intentional, and direct benefits on Plaintiff. The Court's finding that the Institutional Agreement unambiguously excludes Plaintiff as a third-party beneficiary is not a proper reading of the contract in its entirety. In total, the Institutional Agreement actually includes Plaintiff as the contract's beneficiary. Even if the Court was inclined to read § 16.16 narrowly, the benefits to Plaintiff that permeate the Institutional Agreement's other provisions create an ambiguity the Court was required to resolve against GSRMC. See Mathis v. Brown & Brown of S.C., Inc., 389 S.C. 299, 309, 698 S.E.2d 773, 778 (2010). Accordingly, Plaintiff is a third-party beneficiary to the Institutional Agreement and may assert claims arising from its breach. Helms Realty, Inc. v. Gibson-Wall Co., 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005) (allowing contract enforcement by non-party that contract parties "intended to directly benefit").

Second, the Court's ruling places South Carolina at odds with other states addressing this issue. In Tennessee, a patient like Plaintiff was deemed a third-party beneficiary to a functionally identical Institutional Agreement between a Blue Cross Blue Shield entity and a medical provider. Benton v. Vanderbilt Univ., 118 F. Supp. 2d 877 (M.D. Tenn. 2000); see also Benton v. Vanderbilt Univ., 137 S.W.3d 614 (Tenn. 2004) (holding on remand that patient is third-party beneficiary to her insurer's contract with hospital). The Tennessee upheld this principle just two years ago. West v. Shelby County Healthcare Corp., 459 S.W.3d 33, 45 (Tenn. 2014) ("We have already held that persons insured by an insurance company are intended third-party beneficiaries of the contract between their insurance company and a hospital") (citing Benton, 137 S.W.3d at

620). Similarly, in Dorr v. Sacred Heart Hospital, 597 N.W.2d 462 (Wis. Ct. App. 1999), the court held that an HMO's member was a third-party beneficiary to an agreement between an insurer and medical provider. Dorr noted a provision purporting to exclude third-party beneficiaries but held that it was inconsistent with other provisions within the same contract "designed specifically for the purpose of protecting HMO subscribers." 597 N.W.2d at 475. This Court's ruling should be reconsidered because it represents a substantial, unexplained divergence from recent case law in multiple jurisdictions interpreting very similar contracts.

Third, the Court failed to rule on Plaintiff's fiduciary duty and unjust enrichment claims as well as the parties' dispute over application of the Institutional Agreement's arbitration provision. Plaintiff properly alleged all required elements of her fiduciary duty and unjust enrichment claims. Moreover, even if the Court was correct in its third-party beneficiary analysis, the unjust enrichment claim does not depend on the existence of a binding contract. Unjust enrichment is a quasi-contract claim akin to restitution where the focus is on an improperly obtained benefit and the inequity of allowing the benefit's recipient to retain it. JASDIP Props. SC, LLC v. Estate of Richardson, 395 S.C. 633, 640, 720 S.E.2d 485, 489 (Ct. App. 2011)-(quoting Ellis v. Smith Grading & Paving, Inc., 294 S.C. 470, 473, 366 S.E.2d 12, 14 (Ct. App. 1988)) Plaintiff alleged these elements in her Complaint. Nothing more is required at this stage of the litigation.

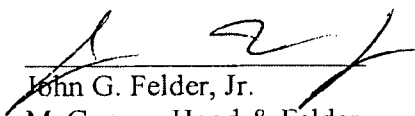
Finally, the Court should reconsider its ruling because it places the pernicious behavior alleged in the Complaint beyond any form of judicial review. If Plaintiff is unable to enforce a contract drafted with her in mind and that articulates tangible benefits for her, then no BCBSSC member has legal recourse to remedy a medical provider's similar insurance-related

malfeasance.¹ The Institutional Agreement is the deal GSRMC chose to make—i.e. limiting its reimbursement rate for Covered Services in exchange for access to BCBSSC's extensive membership. Whatever the financial conditions or other circumstances that has led GSRMC to systematically disregard this obligation, it should not be permitted to continue unabated, and Plaintiff's claims should not be plucked from the judicial sphere before they have been litigated.

CONCLUSION

Accordingly, Plaintiff respectfully requests an order altering or amending the Court's earlier judgment dismissing Plaintiff's Complaint. Under South Carolina contract law, Plaintiff was a third-party beneficiary who may pursue claims against GSRMC for violating the Institutional Agreement's terms. Moreover, Plaintiff's remaining claims should survive regardless of the Court's ruling on the third-party beneficiary issue. Finally, the Court's ruling overlooks persuasive authority interpreting similar contracts and denies medical insurance customers an avenue for seeking redress.

Respectfully submitted,



John G. Felder, Jr.
McGowan, Hood & Felder
1517 Hampton Street
Columbia, SC 29201
Telephone: (803)779-0100
Facsimile: (803) 256-0702
jfelder@mcgowanhood.com

¹ Evidence suggests the conduct Plaintiff alleges is common among medical providers in South Carolina and across the country. See Steve Everly, *St. Luke's Hospital Settles Health Insurance Cases with Accident Victims*, KANSAS CITY STAR, Apr. 25, 2014, available at <http://www.kansascity.com/news/business/article346893/St.-Luke%E2%80%99s-Hospital-settles-health-insurance-cases-with-accident-victims.html> (noting settlement of claims for similar conduct in Missouri and quoting a South Carolina attorney referring to the practice as "prevalent" in our state).

Chad A. McGowan
1539 Healthcare Drive
Rock Hill, South Carolina 29732
Telephone: (803) 327-7800
Facsimile: (803) 328-5656
cmcgowan@mcgowanhood.com

Roy Harmon
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
harmonmajor@gmail.com

Sidney L. Major, Jr.
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
sidmajor@bellsouth.net

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29577
Telephone: (843) 448-4357
jeffcchandler@aol.com

May 10, 2016.
Columbia, South Carolina.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	FIFTEENTH JUDICIAL CIRCUIT
	)	
Jeanne Beverly, individually and on behalf of	)	C.A. No. 2016-CP-26-0166
others similarly situated,	)	
	)	
Plaintiffs,	)	DEFENDANT GRAND STRAND
	)	REGIONAL MEDICAL CENTER,
vs.	)	LLC'S MEMORANDUM OF LAW IN
	)	OPPOSITION TO PLAINTIFF'S
Grand Strand Regional Medical Center, LLC,	)	MOTION TO ALTER OR AMEND
	)	JUDGMENT
Defendant.	)	
	)	

INTRODUCTION

Defendant Grand Strand Regional Medical Center, LLC ("Defendant"), by and through its undersigned counsel, hereby submits this Memorandum in Opposition to Plaintiff Jeanne Beverly's ("Plaintiff") Motion to Alter or Amend Judgment. Plaintiff's Motion should be denied as its sole purpose is to have the Court revisit claims and arguments that have been previously analyzed and properly dismissed. There are no proper grounds for Plaintiff's motion because there has been no intervening change in controlling law, there is no new evidence, and there is no clear error or manifest injustice in the Court's existing ruling.

FACTS AND PROCEDURAL HISTORY

On September 6, 2012, Plaintiff was injured in a motor vehicle accident and received treatment for her injuries on that date in Defendant's hospital. Plaintiff alleged that at the time of the collision and her treatment, she was covered under a health insurance policy issued by Blue Cross Blue Shield of South Carolina ("BCBS-SC").

Prior to the events in question, Defendant and BCBS-SC entered into a contract (the "Institutional Agreement") by which Defendant became a BCBS-SC Preferred Provider Organization. In the present action, Plaintiff asserts she is a third-party beneficiary under the

Institutional Agreement. In fact, the *sine qua non* of all claims in the Complaint is Plaintiff's contention that she is a third-party beneficiary with status to enforce the Institutional Agreement between Defendant and BCBS-SC.

According to Plaintiff, at the time she was treated, her insurance information was provided to Defendant; however, Defendant failed to submit her bills to BCBS-SC for payment. Further, Plaintiff alleges that Defendant disregarded the reimbursement rates agreed upon with BCBS-SC in the Institutional Agreement and billed her the full price for the medical services provided to her.

Based on these allegations, on January 11, 2016, Plaintiff filed an action for breach of contract, bad faith/breach of fiduciary duty, and unjust enrichment, arguing she is a third-party beneficiary entitled to enforce the Institutional Agreement.

On March 7, 2016, Defendant filed a Motion to Dismiss arguing (1) Plaintiff's claim for breach of contract fails because she is not a third-party beneficiary to the Institutional Agreement; (2) Plaintiff's claim for bad faith breach of contract fails because she is not a party entitled to enforce the Institutional Agreement and South Carolina law does not recognize the failure of a medical provider to file an insurance claim as a breach of a fiduciary duty; and (3) Plaintiff's claim for unjust enrichment fails because the Complaint does not allege Defendant charged or collected more than its regular rates.

On May 2, 2016, the Court granted Defendant's Motion to Dismiss based upon Plaintiff's failure to state a claim upon which relief may be granted. The Court found Plaintiff did not enjoy third-party beneficiary status under the Institutional Agreement and, therefore, Plaintiff was unable to bring claims asserting rights under its terms.

On May 13, 2016, after the Court had announced its decision to grant the Motion to Dismiss but prior to the Court's issuance of the full Order, Plaintiff filed a Motion to Alter or

Amend Judgment arguing (1) she is a third-party beneficiary to the Institutional Agreement, and (2) the Court failed to rule on her claims for breach of fiduciary duty and unjust enrichment.

STANDARD OF REVIEW

A motion to alter or amend a judgment pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure is available to parties when “an issue or argument has been raised to but not ruled upon by the trial court.” *Shirley’s Iron Works, Inc. v. City of Union*, 387 S.C. 389, 400, 693 S.E.2d 1, 6 (Ct. App. 2010). “A party cannot raise an issue for the first time in a Rule 59(e), SCRCF motion which could have been raised at trial.” *MailSource, LLC v. M.A. Bailey & Associates, Inc.*, 356 S.C. 370, 374, 588 S.E.2d 639, 641 (Ct. App. 2003); *see also R.E. Goodson Constr. Co v. Int’l Paper Co.*, No. 4:02-4184, 2006 WL 1677136, at *1 (D.S.C. June 14, 2006) (finding that motions made pursuant to Rule 59(e) are not “opportunities to rehash issues already ruled upon because a litigant is displeased with the result”).

ARGUMENT

Plaintiff’s Motion to Alter or Amend does not raise any new arguments, or cite to a change in the controlling law, or seek to correct an error of law. Plaintiff simply rehashes prior arguments that the Court rejected in its decision. Plaintiff merely attempts to re-argue to the Court that she is a third-party beneficiary entitled to enforce the terms of the Institutional Agreement. In her motion, Plaintiff continues to argue that she has the right to enforce a contract between two other entities even though the contract contains express language evidencing the contracting parties’ intent to deny third parties the ability to enforce its terms. There is no error of law in enforcing the plain language of a valid contract, and there is no need to alter or amend a judgment finding as such.

Additionally, in her motion, Plaintiff briefly argues the Court has not ruled upon her claims for breach of fiduciary duty or unjust enrichment.¹ A review of the Court's Order reveals clearly that it does address specifically, and expressly rule upon all of Plaintiff's claims. Throughout this litigation, Plaintiff's cornerstone position for all claims has been her alleged status as a third-party beneficiary of the Institutional Agreement. Without such third-party beneficiary status and the ability to enforce the terms of the Institutional Agreement, all of Plaintiff's claims fail as a matter of law.

I. The Court properly interpreted the plain language of the Institutional Agreement in finding Plaintiff is not a third-party beneficiary.

In Plaintiff's Motion to Alter or Amend Judgment, she argues the Court did not properly read the Institutional Agreement in its entirety and asserts that the Institutional Agreement carves out an exception to its exclusion of third-party beneficiaries. The Court has previously considered this argument and properly ruled that the plain language of the Institutional Agreement unambiguously excludes third-party beneficiaries.

A. The Institutional Agreement unambiguously excludes third-party beneficiaries.

South Carolina law is clear, "one not in privity of contract with another cannot maintain an action against him in breach of contract, and any damage resulting from the breach of a contract between the defendant and a third-party is not, as such, recoverable by the plaintiff." *Fabian v. Lindsay*, 410 S.C. 475, 488, 765 S.E.2d 132, 139 (2014) (quoting *Windsor Green Owners Ass'n v. Allied Signal, Inc.*, 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004)). The presumption is that a contract to which a plaintiff is not a party is not enforceable by the plaintiff and that presumption may only be overcome by the showing that the plaintiff was intended to be

¹ Plaintiff filed her Motion to Alter or Amend prior to the Court issuing its full formal written order.
PPAB 3249427v1

the direct beneficiary of the contract. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005).

“In construing or interpreting a contract, ‘it is axiomatic that the main concern of the court is to ascertain and give effect to the intention of the parties.’” *Bluffton Towne Ctr., LLC v. Gilleland-Prince*, 412 S.C. 554, 570, 772 S.E.2d 882, 891 (Ct. App. 2015) (quoting *Progressive Max Ins. Co. v. Floating Caps, Inc.*, 405 S.C. 35, 46, 747 S.E.2d 178, 184 (2013)). When construing terms in a contract, a court “must first look at the language of the contract to determine the intentions of the parties.” *C.A.N. Enters., Inc. v. S.C. Health & Human Servs. Fin. Comm’n*, 296 S.C. 373, 377, 373 S.E.2d 584, 586 (1988) (citation omitted). Contracting parties “are governed by their outward expressions and the court is not at liberty to consider their secret intentions.” *Ellie, Inc. v. Miccichi*, 358 S.C. 78, 94, 594 S.E.2d 485, 493-94 (Ct. App. 2004)

Section 16.16 of the Institutional Agreement unambiguously states the clear and express intention of the parties with respect to the exclusion of third-party beneficiary claims. It says:

This Agreement is not intended to, and shall not be construed to, make any person or entity a third party beneficiary. Notwithstanding the preceding, nothing in this section shall affect Plans rights under Article XV, or a Member’s right to receive Covered Services pursuant to the terms of this Agreement.

The Court properly and correctly found this language is clear, explicit, and unambiguous, and it evidences an undeniable intent to exclude third-parties from asserting any direct benefit under the Institutional Agreement. See *ERIE Ins. Co. v. Winter Const. Co.*, 393 S.C. 455, 461, 713 S.E.2d 318, 321 (Ct. App. 2011) (“Basic contract law provides that when a contract is clear and unambiguous, the language alone determines the contract's force and effect.” (citing *C.A.N. Enters*, 296 S.C. at 377, 373 S.E.2d at 586)).

Despite the clear and unequivocal expression of the parties’ intent, Plaintiff wants the Court to create ambiguity on the issue where none exists. Plaintiff wants the Court to elevate

indirect statements in other parts of the contract to override the unequivocal expression of intent in Section 16.16. Generally, it is not appropriate or proper to look for other isolated provisions in a contract to create an ambiguity. *See, Silver v. Aabstract Pools & Spas, Inc.*, 376 S.C. 585, 591, 658 S.E.2d 539, 542 (Ct. App. 2008) (*citing Yarborough v. Phoenix Mut. Life Ins. Co.*, 266 S.C. 584, 592, 225 S.E.2d 344, 348 (1976)).

Plaintiff's contention that the Court failed to consider the Institutional Agreement in its entirety is simply incorrect. The Court expressly applied the language of Section 16.16 in the context of the entire Institutional Agreement in ruling that Defendant and BCBS-SC expressed an overriding intention to exclude third-party beneficiary claims. The plain language of Section 16.16 states that the parties to the Agreement did not intend to make any person or entity a third-party beneficiary with legal rights. The Court applied this plain language to, and in the context of the entire contract. Plaintiff seemingly argues that the Court should interpret obtuse and indirect provisions of the Institutional Agreement that could work to her benefit, while disregarding the clear language denying her right to bring an action as a third-party beneficiary. Accordingly, the Court properly read the Institutional Agreement, in context and as a whole, and found Section 16.16 to be overriding and to bar third parties from asserting they are entitled to benefits under its terms.

B. There is no "Covered Services" exception in the Institutional Agreement.

Plaintiff again argues in her Motion to Alter or Amend Judgment that Section 16.16 allows for her to recover for the difference between the negotiated rates and the standard rates because Section 16.16 states that nothing in the section affects "a Member's right to receive Covered Services pursuant to the terms of this Agreement."² Section 2.6 of the Institutional Agreement defines "Covered Services" as "inpatient and outpatient hospital services, supplies,

² The Institutional Agreement defines a "Member" as "anyone who is covered for health care services under the terms of a Benefits Contract or who is eligible for Covered Services as a result of an agreement between [BCBS-SC] and an Associate Plan."

equipment and/or items to be delivered by or through [Defendant] to Members that are reimbursable [under the Members' insurance plans with BCBS-SC]." Plaintiff argues that when read together these provisions allow her to assert a right to recover the difference in the standard rate for covered services and the privately negotiated rates between Defendant and BCBS-SC. In actuality, a plain reading of the Institutional Agreement results in nothing more than an individual Member having the right to receive "inpatient and outpatient hospital services, supplies, equipment and/or items to be delivered" at Defendant's hospital. The plain language of the Institutional Agreement does not involve or implicate Defendant in an obligation to Plaintiff regarding the processing of claims and it does not entitle a third party to enforce the negotiated rates.

Furthermore, the Court properly found that nothing in the Institutional Agreement's definition of "Covered Services" indicated that BCBS-SC reimburses for costs incurred in filing an insurance claim and, therefore, that filing for insurance benefits is not a "reimbursable service so as to create an exception under Section 16.16 [or 2.6]." Therefore, because filing for insurance benefits is not a reimbursable service, the Court found Defendant does not have any obligation to file for insurance benefits on Plaintiff's behalf.

The Court interpreted the Institutional Agreement as a whole. Based on the plain language of the contract, the Court correctly held that Plaintiff was not a third-party beneficiary. Accordingly, the Court correctly held that Plaintiff's claim for breach of a contract fails because that she has no right to enforce the Institutional Agreement.

II. The Court properly ruled that Plaintiff failed to state a claim for either breach of fiduciary duty or unjust enrichment because Plaintiff is not a third-party beneficiary of the Institutional Agreement.

Plaintiff argues the Court failed to rule on her claims for breach of fiduciary duty and unjust enrichment. Plaintiff is wrong. The Court found Plaintiff's claims fail because she does

not enjoy third-party beneficiary status under the Institutional Agreement and does not have the right to bring a claim as a third-party beneficiary. Plaintiff's allegations require that she be able to enforce the terms of the Institutional Agreement and receive the negotiated rates. Without the ability to enforce the terms of the Institutional Agreement, her claims fail on their face.

A. Breach of a Fiduciary Duty

"To establish a claim for breach of fiduciary duty, the plaintiff must prove (1) the existence of a fiduciary duty, (2) a breach of that duty, and (3) damages proximately resulting from the wrongful conduct of the defendant." *Turpin v. Lowther*, 404 S.C. 581, 589, 745 S.E.2d 397, 401 (Ct. App. 2013) (citing *RFT Mgmt. Co. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 335-36, 732 S.E.2d 166, 173 (2012)).

Plaintiff alleged the following regarding her claim for breach of a fiduciary duty:

39. Defendant created a special relationship with Plaintiff and the other similarly situated class members by contracting with [BCBS-SC], thereby making Plaintiff . . . third party beneficiaries to [the Institutional Agreement].
40. Defendant breached the fiduciary duties owed to Plaintiff . . . by refusing to submit her insurance claims.

[Complaint ¶¶ 39-40].

In the Complaint, Plaintiff clearly argues the alleged "special relationship" was created by Defendant's contract with BCBS-SC and her status as a third-party beneficiary. As discussed above, Plaintiff is not a third-party beneficiary of the Institutional Agreement. Since Plaintiff is not a third-party beneficiary, she has not properly alleged that a "special relationship" existed. Without the existence of a special relationship, her claim for breach of fiduciary duty fails.

Moreover, it is clear that the "duty" she asserts and the "breach" she alleges do not relate. Plaintiff alleges a fiduciary duty was created because she "reasonably placed a level of trust in Defendant by choosing to seek medical care and treatment from Defendant based on Defendant's

status as a preferred provider.” [Complaint ¶ 45]. However, the breach Plaintiff alleges is based on Defendant’s alleged failure to submit the insurance claims. [See Complaint ¶ 40]. Plaintiff’s claim for breach of fiduciary duty fails due to the inconsistency between the alleged fiduciary duty and the alleged breach. Accordingly, the Court properly found that Plaintiff’s inability to bring a claim as a third-party beneficiary resulted in the failure of her claim for breach of a fiduciary duty.

B. Unjust Enrichment

Plaintiff incorrectly alleges the Court failed to rule on her claim for unjust enrichment. To state a cause of action for unjust enrichment, a plaintiff must allege the defendant unjustly retained benefits or money which in justice and equity belong to another. *Dema v. Tenet Physician Servs.-Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009). “To recover restitution in the context of unjust enrichment, the plaintiff must show: (1) he conferred a non-gratuitous benefit on the defendant; (2) the defendant realized some value from the benefit; and (3) it would be inequitable for the defendant to retain the benefit without paying the plaintiff for its value.” *56 Leinbach Inv’rs, LLC v. Magnolia Paradigm, Inc.*, 411 S.C. 466, 479, 769 S.E.2d 242, 249 (Ct. App. 2014) (quoting *Inglese v. Beal*, 403 S.C. 290, 297, 742 S.E.2d 687, 691 (Ct. App. 2013)).

The Court properly found that Plaintiff’s claim for unjust enrichment fails because she is not a third-party beneficiary of the Institutional Agreement. In the Complaint, Plaintiff alleged the following in support of her unjust enrichment claim:

52. Defendant was unjustly enriched through the collection of additional payments from Plaintiff . . . for payment of services at a higher value than contracted for with [BCBS-SC].
53. This conduct constitutes an unjust retention of a benefit to the detriment of Plaintiff . . . and Defendant’s retention of money is against the fundamental principles of justice and good conscious and is patently unfair.

54. It would be unconscionable for Defendant to retain the payments made by Plaintiff . . . because those funds were received with complete disregard of available insurance coverage and in contradiction to the agreed upon price for services bargained for between Defendant and [BCBS-SC].

[Complaint ¶¶ 52-54].

The alleged unjust benefit is derived from Plaintiff's alleged right to receive medical services at the value Defendant and BCBS-SC contracted for in the Institutional Agreement. Plaintiff is not entitled to enforce the terms of the Institutional Agreement and receive the negotiated rate. Plaintiff does not allege Defendant received an unjust benefit other than collecting the standard rate for the medical services it actually provided. Recovery of the standard rate is not the retention of an unjust benefit. Therefore, Plaintiff failed to allege an unjust benefit was received and the Court properly found that Plaintiff failed to state a claim for unjust enrichment based on her inability to assert a valid claim as a third-party beneficiary of the Institutional Agreement.

Additionally, Plaintiff argues her claim for unjust enrichment does not require her to be a third-party beneficiary of the Institutional Agreement. This argument was not previously raised to the Court. A party may not raise an issue for the first time in a motion to alter or amend. *MailSource*, 356 S.C. at 374, 588 S.E.2d at 641. Nonetheless, the claim is inextricably woven to Plaintiff's ability to enforce the discounted rates – which ability she does not enjoy because she is not a third-party beneficiary entitled to enforce the Agreement.

III. The Court is not required to rule on the validity of the Institutional Agreement's arbitration provision.

Plaintiff also argues the Court failed to rule on the application of the Institutional Agreement's arbitration provision. There is no need for the Court to rule on the Institutional Agreement's arbitration provision, because Plaintiff is not entitled to enforce the terms of the Institutional Agreement. A ruling on whether Plaintiff's claims arise from an arbitration

provision in a contract that she has no right to enforce would be meaningless, because the Court's resolution of the prior issues disposes of all of Plaintiff's claims. *See Fulch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (holding a reviewing court need not address remaining issues when resolution of a prior issue is dispositive). The application of the Institutional Agreement's apparently valid and binding arbitration provision only matters if Plaintiff enjoys rights under that Agreement – which she does not.

CONCLUSION

For the reasons set forth herein, and those clearly articulated in the Court's existing Order, Defendant respectfully requests the Court deny Plaintiff's motion to alter or amend.

Respectfully submitted,



James Lynn Werner

William R. Thomas

Katon E. Dawson Jr.

Parker Poe Adams & Bernstein LLP

1221 Main Street, Suite 1100

Post Office Box 1509 (29202)

Columbia, South Carolina 29201

Tel: 803-255-8000

Fax: 803-255-8017

jimwerner@parkerpoe.com

willthomas@parkerpoe.com

katondawson@parkerpoe.com

Attorneys for Defendant

Grand Strand Regional Medical Center, LLC

June 3, 2016

Columbia, South Carolina

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF HORRY) 2016-CP-26-166

Jeanne Beverly, Individually and)
On Behalf of Others Similarly)
Situating,)
Plaintiff,) Transcript of Record
vs.) April 26, 2016
Grand Strand Regional Medical)
Center, LLC,)
Defendant.)

B E F O R E:

Honorable Benjamin H. Culbertson
Horry County Courthouse
Conway, South Carolina

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

John G. Felder, Jr., Esquire
Jordan C. Calloway, Esquire
Attorneys for Plaintiff

James Werner, Esquire
Attorney for Defendant

Grace L. Hurley, CVR-CM-M
Circuit Court Reporter

1 (There were no exhibits marked during the hearing.)

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1 (On the record, April 26, 2016.)

2 THE COURT: All right. Next is 2016-CP-26-186, what is
3 it, oh, 166. I'm sorry. Misread it. This is the case of
4 Jeanne -- is it Jeanne Beverly?

5 MR. CALLOWAY: Yes, Your Honor.

6 THE COURT: Individually and on behalf of others
7 similarly situated versus Grand Strand Regional Medical
8 Center, LLC. According to my roster the matter is before the
9 Court on a motion to dismiss. Please give the court reporter
10 your name and who you represent.

11 MR. WERNER: I'm Jim Werner from Parker Poe. I represent
12 the Defendant.

13 THE COURT: All right.

14 MR. CALLOWAY: I'm Jordan Calloway on behalf of the
15 Plaintiffs.

16 MR. FELDER: And I'm Johnny Felder, McGowan, Hood &
17 Felder for the Plaintiffs.

18 THE COURT: All right. Mr. Werner, I understand this is
19 your motion?

20 MR. WERNER: It is, Your Honor. Preliminary to the, to
21 the hearing on the motion to dismiss, Your Honor, we have
22 filed -- we've executed and filed a consent protective order,
23 which I think really is applicable even in what we're going to
24 talk about today on the, on the motion to dismiss. It relates
25 to the institutional agreement which is involved in sort of

1 the core of this. We've filed it with the court. We -- I
2 just actually saw a notice that you're scheduled to hear it
3 about a month from now. I would ask if we could have that
4 order, that protective order entered.

5 THE COURT: Not right now. Let me hear the motion first.

6 MR. WERNER: Okay.

7 THE COURT: Because I, I mean, as you can see, we've got
8 a backlog docket. It's pretty packed. These are taking
9 awhile. So I, I'm not going to be able to get into that right
10 now.

11 MR. WERNER: All right.

12 THE COURT: All right.

13 MR. WERNER: All right. Your Honor, the, the, the
14 essence of this case is that the Plaintiff alleges that she
15 was involved in an automobile accident, that she presented at
16 the emergency room, the Defendant hospital, she received
17 treatment and then she alleges that they, they, the hospital,
18 the Defendant did not bill the Blue Cross Blue Shield program
19 in which she was enrolled, and that, therefore, they breached
20 a contract not with her, but a contract between the hospital
21 and Blue Cross Blue Shield of South Carolina. That's the
22 agreement that is the subject of the protective order. It's
23 called the institutional agreement between those two entities.
24 The Plaintiff claims that she is a third-party
25 beneficiary of that agreement and that is the basis of her

1 making a claim for a breach of contract. She also has alleged
2 breach of a fiduciary duty. She's claimed for unjust
3 enrichment as well, and so with respect to the key factual
4 issues in the complaint, she specifically does allege and
5 acknowledge that, that she is suing on this contract that she
6 claims to be a third-party beneficiary of. She's not claiming
7 that she is the party to a contract that was breached, and,
8 and she's claiming that breach of that contract was the
9 failure to submit claims to the health insurance plan. That's
10 in paragraph 35 of the complaint.

11 In paragraph 40 she says that the breach of fiduciary
12 duty was the failure to submit the insurance claims by the
13 Defendant, but she claims in paragraph 45 of the complaint
14 that the fiduciary duty owed to her was that she had placed a
15 level of trust in the Defendant, "by choosing to seek medical
16 care and treatment from the Defendant," not -- no allegation
17 of a specific duty related to the filing of the claims, and
18 then last the unjust enrichment claim in paragraph 52 the
19 Plaintiff says that it is through the collection of payments
20 from the Plaintiff at higher values than contracted for under
21 the medical insurance plan that that is the unjust enrichment.
22 So we'd move to dismiss on the basis that the institutional
23 agreement, which we have submitted in connection with our
24 motion to dismiss, as allowed under the practice because they
25 specifically allege, they place that agreement in issue, we

1 have presented that because there are several provisions of
2 that contract directly applicable to the Plaintiff's ability
3 to proceed. The first is that the contract in Section 16.16
4 specifically says the parties intend that there are no third-
5 party beneficiaries to the contract. The other thing is that
6 in that agreement there is a provision which says any claim
7 arising under or out of that agreement must be submitted to
8 arbitration. So based on the, the contract which the
9 Plaintiff claims she has the right to proceed under, it is
10 clear that she does not have the right to proceed. The issue
11 of a third-party beneficiaries making a claim is dependent on
12 the intent of the parties to the contract that she claims the
13 benefit, and the Court in looking at this must ascertain from
14 the plain language of that agreement what the intent of those
15 parties was. When the parties expressly and unequivocally say
16 that they intend, that there are no third-party beneficiary,
17 that there is no one who has a right to make a claim to
18 enforce that contract other than the parties there simply
19 cannot be such a claim.

20 THE COURT: Well, what is the contract for?

21 MR. WERNER: The contract is the agreement -- it's called
22 an institutional agreement between the hospital and Blue Cross
23 Blue Shield South Carolina whereby Blue Cross Blue Shield will
24 pay, the hospital will be paid for services to people who are
25 enrolled in the Blue Cross plan.

1 THE COURT: Okay. But Blue -- but the hospital doesn't
2 get paid unless they treat --

3 MR. WERNER: That's correct.

4 THE COURT: -- someone who's covered under --

5 MR. WERNER: That's correct. The hospital --

6 THE COURT: Okay.

7 MR. WERNER: -- provides treatment to an enrolled person
8 and, and then the claim is made and the payment is made from
9 Blue Cross Blue Shield to the hospital for the services
10 rendered.

11 THE COURT: Okay. But I guess the allegations in this
12 case is that your client didn't do that, didn't file the
13 claim.

14 MR. WERNER: Correct.

15 THE COURT: And as a result she had to pay it or she had
16 to pay more than she otherwise.

17 MR. WERNER: Well, interestingly, they never allege that
18 she paid it and they never allege what she paid. That's
19 nowhere in the complaint, but clearly --

20 THE COURT: Is she still being billed for it? Are they
21 --

22 MR. WERNER: -- clearly the implication is that, that she
23 either -- that someone paid a higher amount for the medical
24 services that she was provided. I think there, there is an
25 allegation that what the, what the charges for her services

1 were I think it was -- it's in the complaint. It was -- I
2 think it was like \$7,000 plus or minus, and so yes, their
3 claim, as I understand it, is that, that she was not billed
4 some lesser amount which would have been applicable under the
5 terms of the institutional agreement between Blue Cross Blue
6 Shield and the Plaintiff, excuse me, and the hospital, and so
7 she's claiming that someone paid more for the services that
8 she received.

9 THE COURT: But I mean does the contract dictate that if
10 Blue Cross Blue Shield pays this claim then they cannot charge
11 the insured but a certain amount?

12 MR. WERNER: Yes. Yes.

13 THE COURT: Okay.

14 MR. WERNER: I think that boiled down that is the essence
15 of the agreement.

16 THE COURT: So even though they say that there is no
17 third-party beneficiary under the contract you do have third
18 parties that are benefitting by adherence to the contract?

19 MR. WERNER: That, that's correct, Judge.

20 THE COURT: Okay.

21 MR. WERNER: But, but as Your Honor knows that's not the
22 test of whether you qualify as a third-party beneficiary who
23 has the right to sue under and to enforce the agreement.
24 Someone can benefit from an agreement and that does not make
25 them a third-party beneficiary under the law with rights to

1 sue under it or to enforce it. The parties must intend that
2 you are such a person, that you have those rights to enforce
3 and to sue for you to have them. The mere fact that you may
4 derive benefits as a result of the agreement between these two
5 other parties does not give you that right.

6 THE COURT: So what recourse does a Plaintiff have when
7 they say, "We've got insurance and we have to pay more because
8 they didn't file the claim like everybody thinks they're going
9 to do or like they're obligated to do, and therefore, the
10 insurance didn't pay the claim and we had to pay more because
11 of it?" What is their recourse?

12 MR. WERNER: Well, in, in practical terms what they could
13 do is they could say, "Hey, I've got Blue Cross Blue Shield.
14 Did you bill them? Will you bill them? Was there a mistake?
15 Why didn't you bill them?"

16 THE COURT: But if they say, "No. We're not going to do
17 that. We're not going to bill the insurance company," --

18 MR. WERNER: Then I think that we --

19 THE COURT: -- "you got to pay the \$7,000 more."

20 MR. WERNER: Again, I think in practical terms their
21 recourse is to go to Blue Cross Blue Shield with whom they
22 have a relationship by virtue of enrollment in a plan and say
23 a provider is not honoring your plan.

24 THE COURT: But, but I mean, still, if, if they still get
25 charged \$7,000 more because of that, what is their recourse?

1 If you've got -- if they go -- if they turn in the claim and
2 Blue Cross Blue Shield pays what they say they're obligated to
3 pay and they still get charged more what is their recourse?

4 MR. WERNER: I think that's, that's not what the
5 allegations are here, Judge. There's, there's not an
6 allegation here that Blue Cross Blue Shield paid what was
7 agreed to be paid and they were billed for the rest. That's
8 not the allegation here. That's not what happened.

9 THE COURT: Okay.

10 MR. WERNER: They're, they're saying -- what, what their
11 allegation is and I'm, I'm trying to stick to the --

12 THE COURT: Right.

13 MR. WERNER: -- to the -- what they've alleged,
14 regardless of whether or not it will turn out to be true or
15 not, what they've alleged is that she presented at the
16 emergency room and that she was enrolled in a Blue Cross
17 insurance plan, but that the hospital did not bill the Blue
18 Cross insurance plan, and therefore, did not bill at the rates
19 that would have been a part of the plan structure. They
20 billed at what are called standard charges.

21 THE COURT: I understand. I understand.

22 MR. WERNER: And did not bill Blue Cross Blue Shield at
23 all. So Blue Cross Blue Shield didn't pay what was agreed and
24 then they billed the plan for the rest. That's not what was
25 alleged and that's not what happened.

1 THE COURT: Okay. All right. Anything else?

2 MR. WERNER: Yeah. Well, yes, Your Honor. So, again, I
3 think when you, when you consider the law in South Carolina,
4 and we've given you a brief. I don't want to sit here and
5 read the cases to you, but if you would like them because I
6 know you haven't had a chance to read them, we'd certainly go
7 through and I can cite you the law, but --

8 THE COURT: Well, I mean, first my question is is can two
9 parties contract that there is no third-party beneficiary to
10 their contract and that as a matter of law mandates that it is
11 not a -- there are no third-party beneficiaries?

12 MR. WERNER: Absolutely.

13 THE COURT: Okay. So there is case law or statutory law
14 that says if a term of the contract is there's no third-party
15 beneficiaries then as a matter of law there's no third-party
16 beneficiaries?

17 MR. WERNER: Yes.

18 THE COURT: Okay.

19 MR. WERNER: Your Honor, there, there is case law in this
20 state, in fact we've cited it to you in the brief --

21 THE COURT: Okay.

22 MR. WERNER: -- one of the cases that actually is a very
23 significant case you look at although with a caveat. It's an
24 unpublished opinion. So you are certainly not bound by it,
25 but it's a very recent decision in all -- in a very similar

1 context where exactly that was the fact scenario and the
2 Plaintiff tried to argue essentially what Your Honor pointed
3 out, "Well, but, but clearly I would get benefits under this
4 agreement," and the court went through the analysis and said,
5 "Yeah, you, you may get benefits out of it," but the key to
6 whether or not you are a third-party beneficiary under the law
7 with the right to sue on that contract is dependent upon the
8 intent of the parties to the contract, and when we see an
9 unequivocal plain clause in that contract that says, "We do
10 not intend there to be any third-party beneficiaries," then
11 that is an obstacle which is very difficult to overcome. So,
12 yes.

13 THE COURT: Okay.

14 MR. WERNER: That's the first thing. With respect to the
15 fiduciary duty issue we've cited to Your Honor a case, a South
16 Carolina case. Again, the first thing is whether or not there
17 is a fiduciary duty and whether or not they've pled adequately
18 the existence of such a duty. They, of course, try to piggy
19 back it on the third-party beneficiary claim, which is failure
20 number one. Failure number two is, you know, fiduciary duties
21 are specific, and, and when you claim that there's been a
22 breach of a duty you have to establish what the duty was, it
23 did exist and then it was breached. In this case the duty
24 they allege they say they placed trust and confidence in the
25 Defendant hospital to provide medical services, but the breach

1 of fiduciary duty they claim is, "They didn't handle my
2 medical billing correctly." Well, the duty they allege and
3 the breach they allege don't match. That is a failure for
4 them, but we also have pointed out to Your Honor the decision
5 of the court in, in -- bear with me one second. I apologize.
6 In Wogan versus Kunze, which the case was convoluted a little
7 bit, but the bottom line is among the claims was a common law
8 claim for breach of fiduciary duty. Now, this claim arose
9 under Medicare, and so certainly while that's a third-party
10 payment, there are differences. There's no question about
11 that, but one of the claims was, "You breached a fiduciary
12 duty to me under state law by failing to bill Medicare and
13 collect for my -- for, for the charges that you agreed to take
14 from Medicare," and our court said, [as read], "Nor have our
15 courts found the failure of a medical provider to offer
16 assistance in filing a Medicare claim or other claim is a
17 breach of fiduciary duty," and so again, I believe that the
18 authority for Your Honor to consider suggests that no such
19 duty exists for a medical care provider as the Plaintiff seeks
20 to enforce in this case.

21 THE COURT: All right.

22 MR. WERNER: The third issue they've raised is the unjust
23 enrichment claim. They don't allege that they provided any
24 services or goods or anything to the Defendant. To the
25 contrary, they acknowledge the Defendant provided services to

1 the Plaintiff. Their, their complaint is that, "Well, we
2 weren't billed at the discounted rates that would have been
3 applicable under the Blue Cross Blue Shield plan. We were
4 billed at higher rates, and so there's an unjust enrichment
5 for the Defendant to receive those higher rates." Again, we
6 cited to Your Honor a case very similar, analogous that talks
7 about the fact that the failure to get a discount, to get
8 something preferential does not constitute unjust enrichment,
9 and in fact, there's no allegation that the charges were
10 unreasonable, that they were excessive. They were the
11 standard charges that would apply. They just weren't the
12 charges that might apply under a discounted agreement with
13 Blue Cross Blue Shield. So those are, those are the three
14 bases for our motion to dismiss, and then the last issue is
15 that while we don't think they have a claim, if they are
16 entitled to claim third-party beneficiary status under that
17 agreement between the Defendant and Blue Cross Blue Shield,
18 the law is very clear they have to take the burdens of that
19 contract along with any benefits. They can't pick and choose,
20 and therefore, they would be bound, the Plaintiff would be
21 bound to submit to arbitration under the arbitration clause of
22 that agreement. She can't say, "Oh, I have a right by virtue
23 of this agreement, but now I don't have to live by the
24 agreement in terms of pursuing that right." So if there is
25 any claim it must be compelled and referred to arbitration

1 under the terms of the contract.

2 THE COURT: All right. Thank you, sir. All right. Who
3 wants to argue?

4 MR. CALLOWAY: I will, Your Honor.

5 THE COURT: All right, sir.

6 MR. CALLOWAY: Good morning, Your Honor. I believe,
7 honestly, and I don't know if Defense will object to this, but
8 I think in order to really discuss this matter the Court would
9 be better off to have the institutional agreement in front of
10 it. So I don't know if the Defense would --

11 MR. WERNER: I, I, I do have a problem, Your Honor,
12 because it's -- it stipulates that it's a confidential
13 agreement. That's why I tried to take that up first, Your
14 Honor. We can't let that be in the record. I have no problem
15 with Your Honor looking at it, but it cannot become a part of
16 the file until --

17 THE COURT: Okay.

18 MR. WERNER: -- we have that order.

19 THE COURT: Let me take a look at it then.

20 MR. CALLOWAY: Yeah.

21 THE COURT: All right. Go ahead.

22 MR. CALLOWAY: Your Honor, Jeanne Beverly was injured in
23 a, in a car accident September 2012. She was a member of Blue
24 Cross Blue Shield of South Carolina. She was taken to Grand
25 Strand Regional Medical Center. She presented evidence of her

1 health insurance, which provided her the benefits of being a
2 member of Blue Cross Blue Shield's PPO, and then after she was
3 provided medical services, instead of providing her the
4 reimbursement rate to which Grand Strand Regional Medical
5 Center agreed, they then charged her -- basically charged
6 master rates that they would charge someone who was uninsured.
7 We have alleged breach of contract, unjust enrichment and
8 breach of fiduciary duty claims based on her status as a
9 third-party beneficiary to the institution agreement to which
10 Your Honor has in front of him.

11 The very basis of that contract is that Grand Strand
12 Regional Medical Center is by this contract becoming a member
13 of the PPO. Now, if you look at the front page of that
14 contract for recitals, Section 1.1, what they're joining, this
15 contract specifically says it's for the benefit of people like
16 us. It says, [as read], "Whereas, plan has established a PPO
17 for the benefit of its members," and so they are by this
18 contract joined in that PPO. That PPO was designed for the
19 benefit of these members.. If you turn the page and look at
20 how they define the word PPO on page three, Section 2.16, [as
21 read], "PPO means a network of providers under contract with
22 the plan whereby benefits contracts contain financial
23 incentive for members." That is the basis of the PPO that
24 they are contracting to join, and so as a -- the obligations
25 under that contract really are stated very clearly on page six

1 of the institutional agreement which is the compensation and
2 billing section, and the obligations are pretty clear. One,
3 they have an obligation, the institution, Grand Strand, to
4 seek payment for covered services solely from Plaintiff.
5 That's 6.1, the first sentence in point -- 6.1, [as read],
6 "Institution shall seek payment for covered services solely
7 from Plaintiff." They also have an obligation to submit
8 claims by Plaintiff's, by our Plaintiffs. Section 6.2, the
9 first four words, [as read], "Institution shall bill plan."
10 If you look at Section 6.3, [as read], "Institution shall
11 exercise reasonable efforts to submit all bills as soon as
12 practicable." If you look at Section 6.4, their third
13 obligation, [as read], "Grand Strand has an obligation to
14 accept the reimbursement rate to which they have agreed." It
15 says specifically, [as read], "Institution shall accept the
16 reimbursement terms and rates for covered services set forth,"
17 and so they're relying in this case and saying then based on
18 Section 16-16, which is the last page of the institution
19 agreement, that they can get around all of this by saying,
20 "Well, there are no third-party beneficiaries to this
21 contract." There's a problem with that language if you look
22 at page -- at that, at page 20, Section 16.16, but before you
23 even get there, when you look at the intent of the parties you
24 have to look at the entire contract. That's where we derive
25 the intent of the parties, not from one provision, but from a

1 contract as a whole, and so you've got one provision here
2 saying no third-party beneficiaries, but when you've got the
3 recitals and everything and the substantive provisions from
4 pages one through 19 saying these parties -- this person's
5 getting the benefit, this is who we're intending to benefit
6 from this contract, not incidentally but this PPO is for their
7 benefit, it's why it exists. That's why they're being induced
8 to pay their premiums and become those Blue Cross Blue Shield
9 members, but if you look specifically at the language of
10 Section 16-16 you'll see that there's a carve out for our
11 Plaintiffs. It says, [as read], "This agreement is not
12 intended and shall not be construed to make any person or any
13 of the third-party beneficiary notwithstanding the preceding.
14 Nothing in this section shall affect plans right under article
15 Exhibit B or a member's right to receive covered services
16 pursuant to the terms of this agreement," and so our claims
17 are she didn't receive covered services pursuant to the terms
18 of this agreement because if she had they would have looked
19 solely to Blue Cross Blue Shield for payment. If she had they
20 wouldn't have charged her, and if they had they would have
21 submitted her claim in a timely manner, and if they had then
22 they would have accepted the reimbursement rates to which they
23 had agreed. So our claims are she did not receive covered
24 services pursuant to the terms of the agreement. So we're not
25 even within Section 16-16 because they essentially carved us

1 out of that no third-party beneficiary's clause. In addition
2 to that, the entire language of the agreement is for these
3 Plaintiffs' benefits, and so for those reasons we are a third-
4 party beneficiary to this contract and certainly and the
5 pleadings state to the matter we should be allowed to pursue a
6 breach of contract claim under the bases. As it relates --

7 THE COURT: All right. What about the fact that you have
8 to submit it to arbitration?

9 MR. CALLOWAY: As it relates to arbitration, Your Honor,
10 if you will look specifically arbitration language, and I
11 apologize, I've not got the -- I've got the, the wrong -- the
12 -- I got the language, but I don't have the right place to
13 cite you to, Your Honor. Section 12.2 of the institution
14 agreement, again, if you look closely at the language that
15 they actually use you'll see that we're not included within
16 that arbitration provision. Section 12.2 says, [as read], "In
17 the event that the parties are not able to satisfactorily
18 resolve any problem or dispute." So there they've said,
19 "Okay. Arbitration for the parties," but they go further.
20 They also later say, the third line of that paragraph, [as
21 read], "If plan and institution agree to arbitrate such
22 problem or dispute using a single arbitrator." So they've
23 said two things there. Arbitration applies to dispute between
24 parties, but they -- as if to clarify if there are any
25 misunderstandings about that, they then go on to say those

1 parties here plan and institution. So disputes between plan
2 and institution no problem, those are clearly, completely
3 within the arbitration provision, and while I know there is a
4 state and federal policy in favor of arbitration, it also is
5 just as clearly both our Supreme Court and the United States
6 Supreme Court says parties or persons can't be subject to
7 arbitration unless they've agreed to, and even though we
8 interpret arbitration provisions broadly, we don't rewrite
9 them, our courts are not to rewrite them, and so based on just
10 the language of the arbitration agreement, Your Honor, we
11 don't believe it applies to our claims. Further, Your Honor,
12 you know, I think sort of procedurally when it comes to the
13 arbitration matter, they've filed a 12(B)(6) motion. They've
14 looked at our complaint and they say, "We believe your
15 complaint is legally insufficient." So they look at our
16 breach of contract claim and say that, "You don't meet the
17 elements of a breach of contract claim," the same for unjust
18 enrichment and for the breach of fiduciary duty. I think it's
19 a slightly different matter. If they're saying, "Okay, we --
20 you may or may not have a claim, but we think you have to
21 pursue it in arbitration." Most times we see that when the --
22 with them filing a motion to compel arbitration as opposed to
23 them just coming to us and saying that based on a 12(B)(6)
24 we're asking to dispute here, to, to dismiss your claim. I
25 think it's slightly different under Rule 12(B)(6) and, and

1 trying to compel arbitration like this. It's slightly
2 different, and I mean, I think we also have other issues. Our
3 complaint is, is a punitive class action. So we would be at
4 this point if they could compel arbitration at this juncture
5 they would be compelling against as to class members, and then
6 you get into sort of pragmatic issues, including things like,
7 "Well, who would decide class certification issues," and those
8 sorts of things. Is an arbitrator in position to do that, and
9 those sorts of matters would come to arbitration, but the core
10 of our arbitration defense for the purpose of this motion
11 today, the procedural issue I mentioned and the fact that our
12 claims aren't covered within this agreement because of the
13 language they chose when they drafted the institution
14 agreement, and if I could address the last two claims, breach
15 of fiduciary duty and as well as the unjust enrichment claim.

16 I'll start with the unjust enrichment claim. They cited
17 to you the Pitts case, and they said, "Well, failure to give a
18 discount is not an unjust enrichment," and they also said,
19 "Well, she basically just got charged the regular rates."
20 Well, she got charged the regular rates for an uninsured
21 person, not for a person who has Blue Cross Blue Shield. The
22 Pitts case they cited to you basically was a case where a
23 person went to get life insurance on himself and I believe a
24 family member, and basically they could have gotten a policy
25 with just as much coverage and paid a lesser premium, and they

1 said to the insurance agent, "Why didn't you tell us that and
2 we would have gone for that," and so the Court said, "Well,
3 that's not an unjust enrichment. That's not, that's not an
4 issue there because they didn't tell you about a potential
5 discount." That's not what we have here. We've got a
6 contract requiring them to follow the reimbursement rate.
7 It's right there in Section 6.4 of the contract, and so it's,
8 it's different than saying, "You know, you didn't offer us a
9 discount." We're saying, "You agreed to a rate and didn't
10 comply with it and got more money as a result, and it is
11 unfair and inequitable for you to retain that benefit."
12 That's the essence of an unjust enrichment claim.

13 Finally, as it relates to the breach of fiduciary duty
14 claim, they've cited for you the Wogan case. The Wogan case
15 where he said -- read a, a portion of it that said that
16 failure to submit a claim is not a breach of a fiduciary duty.
17 We don't dispute that as it relates to the fact of those --
18 that case, but as he mentioned very briefly that case dealt
19 specifically with the Medicare submission which is important
20 because the court found that the Medicare Act, the Federal
21 Medicare Act didn't provide a private cause of action under
22 those circumstances. That's one important factual difference.
23 The other important factual difference from Wogan is that
24 Wogan specifically found that there was no contractual duty in
25 that case to submit the claims, and so you can't say, "Well

1 you had a fiduciary to do this," when the contract didn't have
2 -- said you didn't have any obligation to do it. Here Section
3 6.3 says you've got to submit the claims. That's what they
4 agreed to do. That's a very big difference in Wogan and this
5 case. The breach is not based on -- the breach is actually
6 based on them not complying with their contractual
7 obligations, and so for those reasons, Your Honor, we, we ask
8 the Court to, to deny the Defendant's motion.

9 THE COURT: All right. Thank you. Anything in reply?

10 MR. WERNER: Your Honor, may I just reply very briefly on
11 -- I'm going to focus for a moment on the question raised
12 about arbitration. First of all, one of the cases which the
13 Defendants cited to you, the Vanderbilt University case out of
14 Tennessee, there was a, there was a federal court case first
15 and then it ended up in state court and the Supreme Court of /
16 Tennessee ultimately ruled on this very issue of the question
17 whether a -- someone claiming to be a third-party beneficiary
18 under a contract who was not a party to the contract, language
19 very similar to the language that you had read to you, is
20 bound by the arbitration provision, and the Supreme Court
21 said, of Tennessee said absolutely, you can't take any benefit
22 if it's not --

23 THE COURT: The Supreme Court of Tennessee?

24 MR. WERNER: Yes. That's correct.

25 THE COURT: Okay.

1 MR. WERNER: Well, let me share with you what our courts
2 have said.

3 THE COURT: All right.

4 MR. WERNER: In this state in the Wilson versus Willis
5 case, 2016 West Law 806063, South Carolina Court of Appeals
6 decision, [as read], "Well-established common law principles
7 dictate that a non-signatory can be bound by an arbitration
8 provision within a contract executed by other parties. A
9 party can be deemed to agree to submit to arbitration by means
10 other than personally signing a contract containing an
11 arbitration clause, such as where they claim to be able to
12 enforce it or derive benefits of it."

13 THE COURT: Well, no. They're saying the arbitration
14 agreement specifically does not address members but only
15 addresses these parties, and specifically addresses the
16 institution and the plan, whereas everywhere else if it is
17 applicable to the members it refers to members.

18 MR. WERNER: Well, it's the same contract that says those
19 members are not third-party beneficiaries, Your Honor. I
20 mean, you --

21 THE COURT: Well, then right after it says, [as read],
22 "Notwithstanding there's no third-party -- nothing in this
23 section shall affect the plans rights under the article or
24 members' rights to receive covered services."

25 MR. WERNER: Doesn't talk about the billing rights or

1 their ability to enforce it. It simply says nothing shall
2 prevent them from receiving the services under the agreement.
3 She wasn't prevented from receiving the services under the
4 agreement. There's a difference between receiving benefit,
5 Judge, and being an intended third-party beneficiary with the
6 rights of a party to enforce an agreement. Again, the, the,
7 the court in Tennessee and I admit to you, but I'm actually
8 citing a case that they cited to you to support their claim
9 that they ought to be able to be a third-party beneficiary,
10 and what the court said with very similar language about the
11 fact that the provision talked about the parties to the
12 contract, not third-party beneficiaries and, and the Court
13 said citing cases from all over the country, you can't take
14 benefits. You can't claim to be able to enforce the contract
15 and not take it subject to the arbitration clause. You cannot
16 pick and choose that way.

17 THE COURT: All right. Excuse me for interrupting.

18 MR. WERNER: Yes, sir.

19 THE COURT: And I'll give you an opportunity to respond
20 in a minute, but let me hear from them. Members' rights to
21 receive covered services under 16.16, well, covered services
22 in 2.6 does not identify billing under the plan.

23 MR. CALLOWAY: Right. Again, to complete that sentence
24 is the member's right to receive covered services pursuant to
25 the terms of this agreement.

1 THE COURT: Right.

2 MR. CALLOWAY: Our argument is that they didn't receive
3 them pursuant to the terms of the agreement.

4 THE COURT: But the covered services deal with inpatient
5 and outpatient hospital services, supplies, equipments and/or
6 items to be delivered by or through the institution to members
7 --

8 MR. CALLOWAY: Right.

9 THE COURT: -- that are reimbursable under the benefits
10 contract.

11 MR. CALLOWAY: Right. And so it even discusses the fact
12 that the reimbursement is a part of covered services.
13 Reimbursement is a part of the definition of covered services,
14 and so when you get into question --

15 THE COURT: Where is it -- where is -- I don't see that.

16 MR. CALLOWAY: Well, I thought you just read it.

17 MR. WERNER: It simply says that they would be
18 reimbursable. It doesn't talk about whether they are
19 reimbursed or whether they are billed, Your Honor.

20 MR. CALLOWAY: Well, and they're essentially saying
21 they're not reimbursable because they're charging us for them.
22 I mean, they're essentially saying, "Look, because you're
23 going to a third-party we're going to try to get some of your
24 tort recovery as opposed to doing what we agreed to do and
25 going to Blue Cross Blue Shield to get it," and yeah, I mean,

1 yeah, it, it reimbursable that's true but they're by their
2 actions they're saying they're not reimbursable, not for, not
3 for Plaintiffs injured in car accidents, "You've got to pay us
4 full price, even though you're a Blue Cross Blue Shield
5 member."

6 THE COURT: All right. Go ahead and finish your reply.

7 MR. WERNER: I just, I can't, you know, I tried to avoid
8 this because they didn't put it in the complaint, but you just
9 got the essence of what we're here for, Judge. The fact of
10 the matter is that it's going to be shown that the Plaintiff
11 didn't pay this bill. The third-party at fault for her
12 automobile accident paid this bill. That third-party at fault
13 wasn't a member of the Blue Cross Blue Shield plan, wasn't
14 covered by any discount program and they were not entitled to
15 a discount for whatever they paid. So, I mean, that's the
16 essence of what we're really here about, but the bottom line
17 is that Plaintiff is not a third-party beneficiary and the,
18 the provision simply says that doesn't mean she isn't entitled
19 to the benefits of receiving covered services. She received
20 covered services. It doesn't talk about that guaranteeing her
21 payment structure under that provision, and the fact of the
22 matter is, again, while I don't think that Your Honor should,
23 I don't think under the law it would be appropriate to give
24 her third-party beneficiary status, but if she is entitled to
25 third-party beneficiary status she is bound to arbitrate the

1 claim, and these issues about, "Well, how is that going to be
2 administered," the law is very clear on that. Once it's
3 determined that it's subject to arbitration the issues of
4 arbitrability are decided by the arbitrator. The arbitrator
5 decides what's covered or not, and no less than the United
6 States Supreme Court has dealt with the question of what the
7 arbitrator must do when they try to bring class claims in an
8 arbitration because unless the clause says you can arbitrate
9 on a class basis, there is no class action in arbitration, so
10 sayeth the United States Supreme Court.

11 THE COURT: All right.

12 MR. FELDER: Your Honor, we -- I just want to -- we
13 submitted authority on page six of our memo on nearly
14 identical facts, nearly identical institutional agreements
15 where the Court held that there were third-party -- that
16 exactly like our client we're third-party beneficiaries
17 despite a line saying that we're not third-party
18 beneficiaries. So we'd ask the Court to look at that, also.
19 It's on page six of our memo.

20 THE COURT: All right. I'll take a look at it.

21 MR. FELDER: And we would ask Your Honor on the
22 arbitration provision if the Court, if, if we are at that
23 point this juncture with the Court's permission could we
24 submit supplemental authority just on the arbitration
25 provision because the arbitration provision itself is so

1 scant. There's nothing in that provision about anything about
2 the forum, the arbitrators, discovery, nothing. It's just a
3 passing reference for the two parties to arbitration. So with
4 the Court's permission could we have, you know, ten days to
5 submit supplemental authority?

6 THE COURT: No. I've got enough. I'm going to go ahead.

7 MR. FELDER: Okay.

8 THE COURT: I'll take it under advisement. I'll look --
9 take a look at what's been submitted, and I'll make a
10 decision.

11 MR. FELDER: Thank you, Your Honor.

12 MR. WERNER: Thank you, Your Honor.

13 MR. CALLOWAY: Thank you, Your Honor.

14 THE COURT: All right. Thank you.

15 (Adjourned.)

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C E R T I F I C A T E

I, the undersigned, Grace L. Hurley, Official Court Reporter for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the Hearing held in the case of Jeanne Beverly, individually and on behalf of others similarly situated versus Grand Strand Regional Medical Center, LLC, held in the Court of Common Pleas for Horry County, Horry County Courthouse, Conway, South Carolina, on April 26, 2016.

I do hereby certify that I am neither of kin, counsel, nor interest to any party hereto.

Grace L. Hurley, CVR-CM-M
Official Reporter

August 4, 2016.

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No. 2016-CP-26-0166

80289
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SC Court of Appeals

 Jeanne Beverly, Individually
and on behalf of others
similarly situated

Appellant

v.

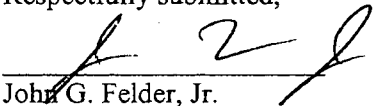
Grand Strand Regional,
Medical Center, LLC

Respondents.

NOTICE OF APPEAL

Appellant Jeanne Beverly, appeals from an order of the Honorable Benjamin H. Culbertson, II granting Respondent's Motion to Dismiss as well as the circuit court's order denying Appellant's Motion to Alter or Amend Judgment. Appellant received notice of the order granting dismissal on May 2, 2016 and filed a timely Rule 59(e), SCRCP motion on May 10, 2016. Appellant received written notice of entry of order denying Plaintiff's Motion to Alter or Amend Judgment on July 11, 2016. Pursuant to Rule 203(d)(1)(B), SCACR, a copy of the orders Appellant challenges on appeal are attached to this Notice.

Respectfully submitted,


John G. Felder, Jr.
McGowan, Hood & Felder, LLC
1517 Hampton Street
Columbia, SC 29201

Telephone: (803)779-0100
Facsimile: (803) 256-0702
jfelder@mcgowanhood.com

Chad A. McGowan
Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Healthcare Drive
Rock Hill, South Carolina 29732
Telephone: (803) 327-7800
Facsimile: (803) 328-5656
cmcgowan@mcgowanhood.com
jalloway@mcgowanhood.com

Roy Harmon
Sidney L. Major
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
harmonmajor@gmail.com
sidmajor@bellsouth.net

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29577
Telephone: (843)448-4357
jeffcchandler@aol.com

Attorneys for Appellant

Other attorneys of record:

James Lynn Werner
William R. Thomas
Katon E. Dawson, Jr.
Parker Poe Adams & Bernstein LLP
1201 Main Street, Suite 1450
Post Office Box 1509 (29202)
Columbia, SC 29201
Telephone: (803) 255-8000
jwerner@parkerpoe.com
willthomas@parkerpoe.com

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No. 2016-CP-26-0166
Appellate Case No. 2016-001499

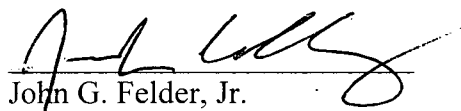
Jeanné Beverly, Individually Appellant
and on behalf of others
similarly situated

v.

Grand Strand Regional, ... Respondent.
Medical Center, LLC

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 210(g), SCACR, Appellant's counsel certifies that the Record on
Appeal contains all material proposed to be included by the parties no other material.


John G. Felder, Jr.
McGowan, Hood & Felder
1517 Hampton Street
Columbia, SC 29201
Telephone: (803)779-0100
Facsimile: (803) 256-0702
jfelder@mcgowanhood.com

Chad A. McGowan
Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, South Carolina 29732

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SC Court of Appeals

Telephone: (803) 327-7800
Facsimile: (803) 328-5656
cmcgowan@mcgowanhood.com
jalloway@mcgowanhood.com

Roy Harmon
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
harmonmajor@gmail.com

Sidney L. Major, Jr.
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
Telephone: (864) 467-1712
sidmajor@bellsouth.net

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29577
Telephone: (843)448-4357
jeffcchandler@aol.com

Attorneys for Appellant

March 31, 2017
Columbia, SC