

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No. 2016-CP-26-0166
Appellate Case No. 2020-000710

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S.C. SUPREME COURT

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

v.

Grand Strand Regional Medical Center, LLC Petitioner.

APPENDIX

James Lynn Werner; SC Bar No. 6029
William R. Thomas; SC Bar No. 16348
Katon E. Dawson Jr.; SC Bar No. 101167
PARKER POE ADAMS & BERNSTEIN LLP
1221 Main Street, Suite 1100
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 Petitioner
Grand Strand Regional Medical Center, LLC

Other Counsel of Record:

John G. Felder, Jr., SC Bar No. 7051
McGowan, Hood & Felder, LLC
1517 Hampton Street
Columbia, SC 29201
jfelder@mcgowanhood.com

Chad A. McGowan, SC Bar No. 9943
Jordan C. Calloway, SC Bar No. 78728
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, South Carolina 29732
cmcgowan@mcgowanhood.com
jcalloway@mcgowanhood.com

Roy F. Harmon, III, SC Bar No. 12516
Sidney L. Major, Jr., SC Bar No. 6276
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604
royharmon3@gmail.com
sidmajor@bellsouth.net

Jeff C. Chandler, SC Bar No. 16678
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29578
jeffcchandler@aol.com

Attorneys for Respondent

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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

v.

Grand Strand Regional Medical Center, LLC,
Respondent.

Appellate Case No. 2016-001499

Appeal From Horry County
Benjamin H. Culbertson, Circuit Court Judge

Opinion No. 5708
Heard November 8, 2018 – Filed January 15, 2020

**AFFIRMED IN PART, REVERSED IN PART, AND
REMANDED**

Sidney L. Major, Jr. and Roy F. Harmon, III, of Harmon
& Major, PA, of Greenville; John Gressette Felder, Jr., of
McGowan, Hood & Felder, LLC, of Columbia; Chad
Alan McGowan and Jordan Christopher Calloway, both
of McGowan, Hood & Felder, LLC, of Rock Hill; and
Jeffrey Christopher Chandler, of Chandler Law Firm, of
Myrtle Beach, for Appellant.

James Lynn Werner, William R. Thomas, and Katon
Edwards Dawson, Jr., all of Parker, Poe, Adams &
Bernstein, LLP, of Columbia, for Respondent.

MCDONALD, J.: Jeanne Beverly appeals the circuit court's order granting Grand Strand Medical Center, LLC's (Grand Strand's) motion to dismiss Beverly's claims for breach of contract, bad faith, and unjust enrichment. Beverly argues the circuit court erred in: (1) finding Beverly is not an intended third-party beneficiary of the preferred provider contract between Blue Cross Blue Shield (BCBS) of South Carolina and Grand Strand and (2) dismissing Beverly's claim for unjust enrichment, despite her complaint's allegation that Grand Strand impermissibly collected payments from Beverly and others "at a higher value than contracted for with BCBS." We affirm in part, reverse in part, and remand to the circuit court for further proceedings.

Facts and Procedural History

On April 29, 2005, Grand Strand contracted with BCBS of South Carolina to become a preferred provider within the BCBS preferred provider organization (PPO)¹. In exchange for this status and access to BCBS members (Members), Grand Strand promised to bill BCBS directly for certain medical services delivered to Members² and to accept a discounted reimbursement rate from BCBS for such services. Specifically, the Institutional Agreement (the Agreement) prohibits Grand Strand from "solicit[ing] any payment from Members"³ and requires Grand Strand to "accept the reimbursement terms and rates" BCBS established for the PPO. After executing the Agreement, Grand Strand began marketing itself to Members as a BCBS preferred provider.

¹ The PPO is a network of hospitals and medical practices marketed to Members as "preferred providers."

² The contract defines "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 Plan and an Associate Plan." A "Benefits Contract" is defined, in pertinent part, as "any PPO contract between Plan and Member entitling the Member to receive Covered Services or other services as designated in the Benefits Contract."

³ Exceptions to this provision include: co-payments, deductibles, coinsurance, non-covered services rendered, covered services deemed to be not medically necessary, or covered services provided to Members who are unable to provide sufficient information regarding eligibility and coverage either prior to receiving service or following services rendered.

On September 6, 2012, Beverly was injured in an automobile accident. That same day, she went to Grand Strand's emergency room, where she was evaluated and treated by an emergency room physician. Thereafter, Grand Strand sent Beverly a bill for \$8,000.00.⁴ Because Beverly had previously purchased a health insurance policy from BCBS—and thus became a Member with access to the PPO network—Beverly did not expect to receive such a bill.

Beverly filed suit against Grand Strand, asserting claims for breach of contract, bad faith, and unjust enrichment. Beverly claimed Grand Strand breached its contract with BCBS and violated its contractual and fiduciary duties to her (and other Members who contracted for access to the PPO network) by billing her directly and charging her an amount exceeding the contractual reimbursement rate.

Grand Strand moved to dismiss and, following a hearing, the circuit court dismissed Beverly's complaint. The circuit court denied Beverly's subsequent Rule 59(e), SCRCR, motion to alter or amend.

Standard of Review

"On appeal from the dismissal of a case pursuant to Rule 12(b)(6), an appellate court applies the same standard of review as the trial court." *Rydde v. Morris*, 381 S.C. 643, 646, 675 S.E.2d 431, 433 (2009). "In considering such a motion, the trial court must base its ruling solely on allegations set forth in the complaint." *Spence v. Spence*, 368 S.C. 106, 116, 628 S.E.2d 869, 874 (2006). "If the facts and inferences drawn from the facts alleged in the complaint, viewed in the light most favorable to the plaintiff, would entitle the plaintiff to relief on any theory, then the grant of a motion to dismiss for failure to state a claim is improper." *Id.* "At the Rule 12 stage, therefore, the first decision for the trial court is to decide only whether the pleading states a claim." *Skydive Myrtle Beach, Inc. vs. Horry Cty.*, 426 S.C. 175, 180, 826 S.E.2d 585, 588 (2019).

Law and Analysis

I. Third-Party Beneficiary

Beverly argues the circuit court erred in finding a Member is not an intended third-

⁴ Grand Strand billed Beverly \$7,031.25 for the initial medical treatment and \$968.75 for removal of staples.

party beneficiary of the Institutional Agreement between BCBS and Grand Strand because the Agreement adds Grand Strand to a PPO network structured to provide direct benefits to Members. She further asserts the Agreement's purported "beneficiary disclaimer" does not bar her claims because the disclaimer's own language renders it inapplicable to "a Member's right to receive Covered Services." We agree.

Under South Carolina law, it is well settled that a nonparty may enforce contractual terms that intentionally provide her direct benefits. *See, e.g., Kingman v. Nationwide Mut. Ins. Co.*, 243 S.C. 405, 412, 134 S.E.2d 217, 221 (1964) ("We have held in numerous cases that a contract between two persons, for the benefit of a third, even though such third party be not named therein, can be enforced by such third party."); *Jennings v. First of Ga. Underwriters Co.*, 283 S.C. 455, 457, 322 S.E.2d 694, 695 (Ct. App. 1984) (explaining contracts between two persons for the benefit of a third can be enforced by the third person even though she is not named therein). "The presumption that [a] contract is not enforceable by [a nonparty] may be overcome by showing he was intended to be the direct beneficiary of the contract." *Touchberry v. City of Florence*, 295 S.C. 47, 48–49, 367 S.E.2d 149, 150 (1988).

"The cardinal rule of contract interpretation is to ascertain and give legal effect to the parties' intentions as determined by the contract language." *Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012) (quoting *McGill v. Moore*, 381 S.C. 179, 185, 672 S.E.2d 571, 574 (2009)). "Courts must enforce, not write, contracts of insurance, and their language must be given its plain, ordinary and popular meaning." *Id.* (quoting *USAA Prop. & Cas. Ins. Co. v. Clegg*, 377 S.C. 643, 655, 661 S.E.2d 791, 797 (2008)). "A contract is read as a whole document so that one may not create an ambiguity by pointing out a single sentence or clause." *Williams v. Gov't Emps. Ins. Co. (GEICO)*, 409 S.C. 586, 595, 762 S.E.2d 705, 710 (2014) (quoting *McGill*, 381 S.C. at 185, 672 S.E.2d at 574). "Whether a contract is ambiguous is to be determined from examining the entire contract, not by reviewing isolated portions of the contract." *Id.*

The circuit court excluded Beverly as a third-party beneficiary based upon its examination of Section 16.16 of the Agreement, titled "No Third Party Beneficiaries," which states:

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 Services⁵ pursuant to the terms of this Agreement.

Construing Section 16.16's first sentence in isolation, the circuit court concluded BCBS and Grand Strand disclaimed the possibility of any third-party beneficiary claim by Members. However, the provision's second sentence clarifies that despite this provision "nothing in this section shall affect . . . a Member's right to receive Covered Services pursuant to the terms of this Agreement." A similar phrase is found in the Agreement's recitals: "Whereas, [Grand Strand] desires to become a PPO provider to allow it to provide Covered Services under the terms of this Agreement." Grand Strand's refusal to submit Beverly's bill directly to BCBS is arguably actionable because the language of the Agreement requires Grand Strand to do just that. Likewise, Beverly's allegation that Grand Strand's billing her and demanding an undiscounted sum for covered services states a claim because, pursuant to the terms of the Agreement, Grand Strand agreed to bill BCBS and to accept a discounted reimbursement for Member Beverly's benefit.

Moreover, the remaining twenty pages of the Agreement impose requirements on Grand Strand specifically intended to benefit Beverly and other Members. South Carolina courts have recognized that the parties' intent must be derived from the Agreement's language taken as a whole. This isolated sentence—when considered within the context of the entire Institutional Agreement—does not retract the benefits the Agreement repeatedly bestows upon BCBS PPO Members. Significantly, Section 16.16's second sentence recognizes a "Member's right to receive Covered Services pursuant to the Agreement," thus carving out related claims from any purported third-party beneficiary exclusion.

Further, interpreting Section 16.16's language as a bar to Beverly's claims disregards expressions of the parties' intent set forth elsewhere in the contract.

⁵ The Agreement defines "Covered Services" as "those inpatient and outpatient hospital services, supplies, equipment, and/or items to be delivered by or through Institution to Members that are reimbursable under the applicable Member Benefits Contract. Certain services, supplies, equipment and/or items are not included under this Agreement as Covered Services, including but not limited to services provided by skilled nursing facilities, durable medical equipment suppliers, outpatient retail pharmacies, and physician services other than radiology, pathology, anesthesiology, and emergency room that are combined billed on [a certain form]." Article XV addresses Associate Plans and is inapplicable here.

BCBS established its PPO "for the benefit of Members." The very first responsibility Grand Strand undertook in the "Institution Services and Responsibilities" section of the Agreement was to "provide Covered Services to any Member." Members are also direct beneficiaries of Grand Strand's promise to accept the negotiated reimbursement rate from BCBS as well as its promise to bill BCBS, not the Member, for covered services.

Other jurisdictions have found a third-party beneficiary disclaimer may not apply when substantive provisions in the contract contradict the purported disclaimer. In a case similar to Beverly's, the Wisconsin Court of Appeals found an insured covered by a health maintenance organization (HMO) was a third-party beneficiary of her insurer's HMO provider contract with the hospital where she was treated following an automobile accident. *Dorr v. Sacred Heart Hospital*, 597 N.W.2d 462, 475 (Wis. App. 1999). The contract's language expressing a general intent to disclaim third-party beneficiaries was ineffective as to the insured because it was inconsistent with other portions of the same contract protecting subscribers' rights. *Id.* (finding "hold harmless" provision's terms were "designed specifically for the purpose of protecting HMO subscribers"). Likewise, a federal district court in Pennsylvania applied similar principles to reject a third-party beneficiary exclusion offered to prevent a medical provider from enforcing a PPO contract between an insurer and a health insurance network. *See Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, Civil Action No. 13-03101, 2015 WL 1954287 (E.D. Pa. Apr. 30, 2015). Because the contract in question purported to exclude third-party beneficiaries while also granting specific benefits to nonparties, the contract was patently ambiguous and the third-party beneficiary claim could not be dismissed on a pre-answer motion. *Id.* at *10. Like the defendant in *Huntingdon Valley*, Grand Strand cannot selectively enjoy certain benefits of the Agreement while disregarding terms beneficial to Members. *Id.*

The Tennessee Supreme Court addressed whether a patient was a third-party beneficiary entitled to enforce a similar institutional agreement between a Tennessee hospital and BCBS of Tennessee in *Benton v. Vanderbilt University*, 137 S.W.3d 614 (Tenn. 2004). *Benton* involved an arbitration dispute, but the dispute arose in part because the court had recognized a BCBS insured was a third-party beneficiary of the hospital's agreement with BCBS of Tennessee. *Id.* at 620. The court explained:

Applying these principles, we conclude that the Court of Appeals correctly held that Benton was bound by the arbitration provision contained in the contract between

Vanderbilt and [BCBS]. Benton was a third-party beneficiary to the contract who filed an action seeking to enforce rights under the contract. Benton's claim was dependent on his status as a third-party beneficiary to the contract and Vanderbilt's alleged obligations under section 6.1 of the agreement. Accordingly, based on the general principle that a third-party beneficiary cannot enforce favorable terms of a contract while avoiding unfavorable terms, we conclude that Benton's claim seeking to enforce the contract is subject to the arbitration provision.

Id.; see also *West v. Shelby Cty. Healthcare Corp.*, 459 S.W.3d 33, 45 (Tenn. 2014) (citing *Benton* and noting the court had "already held that persons insured by an insurance company are intended third-party beneficiaries of the contract between their insurance company and a hospital. Thus, with regard to an insurance company's customers, 'reasonable charges' are the charges agreed to by the insurance company and the hospital.").

In another billing dispute between a Blue Cross insured and a hospital contracting with the insurer, an Arizona court found a provision requiring the hospital to accept a discounted reimbursement rate was "clearly a benefit to the subscriber; that benefit is both intentional and direct." *Nahom v. Blue Cross & Blue Shield of Arizona, Inc.*, 885 P.2d 1113, 1117 (Ariz. App. 1994). As further evidence that the insured was an intended third-party beneficiary, *Nahom* noted the numerous times the class of Blue Cross subscribers was named in the contract. *Id.* at 1118. The South Dakota Supreme Court reached the same conclusion when construing a hospital's contract with a self-insured health plan. *Jennings v. Rapid City Reg'l Hosp. Inc.*, 802 N.W.2d 918 (S.D. 2011). The health plan's members were third-party beneficiaries to the contract because "the contract language clearly expresses intent to benefit" the members. *Id.* at 922. The *Jennings* court made special note of the contract's recitals which, as in this case, identified the benefits to members the insurance plan expressly intended to provide. *Id.* *Jennings* rejected the notion that the members could not be third-party beneficiaries because the contract provided direct benefits to its parties, i.e. the hospital and insurer. Notwithstanding its benefits to the contracting parties, the contract also benefited the members, and as such, the members were permitted to protect those benefits by enforcing the contract's terms. *Id.* at 923 ("We look only at who was directly and primarily benefited. In this case, it is [the health plan's insured employees].").

Here, the Agreement's language, structure, and purpose directly benefit Members like Beverly. From its opening provision, the Agreement acknowledges its core objective is to support a PPO created "for the benefit of its Members." The Agreement defines a PPO as "a network of providers under contract with the Plan whereby Benefit Contracts contain financial incentives for Members to seek Covered Services from such providers." These financial incentives are made explicit later in the contract where Grand Strand agreed to accept reimbursement for its services for BCBS Members at a discounted rate. Beyond co-pays and deductibles, Grand Strand was prohibited from directly charging Members for covered services, even at the reduced rate. In clear terms, Grand Strand agreed it would not solicit any payment from Members. Indeed, the Agreement conferred an additional practical benefit on Members by placing on preferred providers such as Grand Strand the obligation to submit the Members' bills to BCBS.

Beverly's third-party beneficiary status is also evident from the PPO's structure, which is established by the Agreement. As a South Carolina district court has explained:

A PPO is a means of health insurance whereby the insurance company contracts with a network of health care providers, including hospitals. The insurer attempts to negotiate favorable rates of reimbursement for the cost of health care that reflects the volume of patients the insurer expects to deliver to the preferred health care provider. The insurer then passes through some of this cost saving to subscribers in the form of lower co-payments and reduced deductibles, which creates the incentive for the patient to use the preferred providers and, in turn, creates the volume to support the "discount."

Drs. Steuer & Latham, P.A. v. Nat'l Med. Enters., Inc., 672 F. Supp. 1489, 1513 (D.S.C. 1987).

Beverly argues and we agree the PPO here is intended to benefit its participants. Grand Strand gained access to BCBS's expansive membership along with guaranteed reimbursements from BCBS in exchange for accepting both reduced payments as well as the responsibility of submitting Members' claims to BCBS. BCBS gained greater cost control in exchange for promising prompt payment for Grand Strand's services and touting Grand Strand's PPO provider status to Members. Beverly's allegations that Grand Strand's failure to submit Beverly's bill

to BCBS and refusal to bill her at the reduced reimbursement rate state a claim that Grand Strand breached its contract in denying Beverly benefits arising from the Agreement. Therefore, the circuit court erred in dismissing Beverly's breach of contract claim.

II. Fiduciary Relationship

The circuit court dismissed Beverly's breach of fiduciary duty claims against Grand Strand as based on duties arising from a contract Beverly lacked standing to enforce. However, as discussed above, a nonparty may enforce a contract that intentionally provides her direct benefits.

Although Beverly's complaint alleges certain required elements of a breach of fiduciary duty claim, the circuit court concluded Beverly and Grand Strand did not have a relationship from which a fiduciary duty arose. Beverly claims Grand Strand and Beverly created a relationship of trust when Grand Strand became a PPO preferred provider and accepted the Agreement's terms, and Beverly sought out Grand Strand for medical services because it was a part of the BCBS PPO. By providing Grand Strand with her BCBS PPO insurance identification card, Beverly contends she met the requirements for Grand Strand to fulfill the duties arising from its relationship with BCBS. Thus, Beverly claims Grand Strand breached its duty of trust.

While South Carolina courts have recognized fiduciary relationships between agents and principals, attorneys and clients, the administrator and beneficiaries of an estate, business partners, officers and shareholders of a corporation, and doctors and their patients, there is no authority to support the proposition that a fiduciary relationship exists between a hospital and patient with respect to a hospital's contractual duty to submit 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) ("[T]his state has not found that medical negligence or malpractice will support a cause of action for breach of fiduciary duty. Nor have our courts found the failure of a doctor to offer assistance in filing a Medicare claim or other claim is a breach of fiduciary duty."); *see also Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707, 723-24 (E.D. Mich. 2005) (finding Michigan law does not authorize the imposition of a fiduciary duty related to a hospital's billing practices); *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 269 (3d Cir. 2008) ("It is clear, however, that in general New Jersey does not find fiduciary duty in the debtor-creditor context, and, given that the cases cited by both sides relate only to the provision of care and not the payment therefor, it is unlikely that

the New Jersey courts would expand a hospital's fiduciary duty to its billing practices. In the absence of a fiduciary duty, no cause of action exists for its alleged breach, and [the breach of fiduciary duty claim] will therefore be dismissed.").

Here, Beverly does not challenge the quality of the medical care she received. Rather, she complains only of Grand Strand's billing practices and its breach of the BCBS Agreement. Beverly attempts to expand the fiduciary relationship that may in certain circumstances exist between a doctor and patient to encompass a hospital's billing practices for medical services rendered. In essence, Beverly is asking the court to impose a fiduciary duty on a creditor-debtor relationship; South Carolina law does not impose such a duty in the absence of some special trust reposed in the creditor. *See Regions Bank v. Schmauch*, 354 S.C. 648, 671, 582 S.E.2d 432, 444 (Ct. App. 2003) ("South Carolina holds the normal relationship between a bank and its customer is one of creditor-debtor and not fiduciary in nature." (citing *Burwell v. South Carolina Nat'l Bank*, 288 S.C. 34, 40, 340 S.E.2d 786, 790 (1986))). The circuit court properly found South Carolina does not recognize a fiduciary duty related to a hospital's billing practices. Accordingly, we affirm the circuit court's dismissal of Beverly's claim for breach of fiduciary duty.

III. Unjust Enrichment/Quantum Meruit

Beverly argues the circuit court essentially found it equitable for Grand Strand to charge a Member in violation of its agreement with BCBS. While we disagree the circuit court's order so finds, we agree with Beverly's contention that the court erred in dismissing her quantum meruit claim. *See Columbia Wholesale Co. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994) ("Absent an express contract, recovery under quantum meruit is based on quasi-contract, the elements of which are: (1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value."); *Barnes v. Johnson*, 402 S.C. 458, 466, 742 S.E.2d 6, 10 (Ct. App. 2013) (explaining quantum meruit is a remedy for unjust enrichment); *Williams Carpet Contractors, Inc. v. Skelly*, 400 S.C. 320, 327–28, 734 S.E.2d 177, 181 (Ct. App. 2012) (allowing a party to allege an unjust enrichment cause of action as an alternative claim for breach of contract).

Grand Strand argues *Pitts v. Jackson National Life Insurance Co.*, 352 S.C. 319, 574 S.E.2d 502 (Ct. App. 2002), supports the circuit court's dismissal. We disagree. The asserted wrong in *Pitts* was a breach of an alleged "duty of insurer to

inform an applicant of the availability of an allegedly superior product." *Id.* at 338, 574 S.E.2d at 512. However, the court found it was not inequitable for an insurer to retain the price of an insurance policy where the insurer could have offered a policy with similar coverage at a lesser price. There simply was no duty to provide such a notification. *Id.* at 339, 574 S.E.2d at 512. *Pitts* also relied on the fact that the alleged wrongdoing was performed when the plaintiff was a mere insurance applicant. *Id.* at 331, 574 S.E.2d at 508. At that point, there was no existing relationship on which to build a fiduciary duty or to impose liability for unjust enrichment. *Id.*

But Beverly is not a mere insurance applicant; she is a defined Member in a PPO Agreement under which Grand Strand contracted to provide Covered Services. Additionally, Beverly's complaint does not allege a failure to inform; it alleges affirmative inequitable conduct seeking to deprive her of the benefit of her funds. While the *Pitts* defendant was permitted to refuse to offer a gratuitous discount, Grand Strand is not permitted to bill a Member for its services at a higher payment rate than it contractually agreed to accept. The complaint does not allege a mere matter of erroneous billing. When Grand Strand billed Beverly for covered services, it declined to bill her at the contracted for, discounted rate, and it sent her the bill in violation of its contract with BCBS. Accordingly, it was error for the circuit court to dismiss the quantum meruit claim at the 12(b)(6) stage.

Conclusion

We reverse the circuit court's dismissal of Beverly's breach of contract and quantum meruit claims. We affirm as to the dismissal of the claim for breach of fiduciary duty and remand this matter for further proceedings.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

KONDUROS and HILL, JJ., concur.

The South Carolina Court of Appeals

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

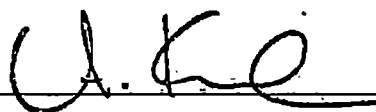
v.

Grand Strand Regional Medical Center, LLC,
Respondent.

Appellate Case No. 2016-001499

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

 J.

 J.

 J.

Columbia, South Carolina

cc:

John Gressette Felder, Jr., Esquire

Chad Alan McGowan, Esquire

Jordan Christopher Calloway, Esquire

FILED

March 31, 2020

Roy F. Harmon, III, Esquire
James Lynn Werner, Esquire
William R. Thomas, Esquire
Katon Edwards Dawson, Jr., Esquire
Sidney L. Major, Jr., Esquire
Jeffrey Christopher Chandler, Esquire
The Honorable Benjamin H. Culbertson

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Jeanne Beverly, Individually Appellant
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Grand Strand Regional, ... Respondents.
Medical Center, LLC

FINAL BRIEF OF APPELLANT

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

Greenville, SC 29604
Telephone: (864) 467-1712
harmounmajor@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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STATEMENT OF THE ISSUES ON APPEAL

1. Whether the circuit court erred in finding a Blue Cross member was not an intended third-party beneficiary to a contract between Blue Cross and Grand Strand in which Grand Strand agreed to submit bills for member services to Blue Cross and never seek payment from members.
2. Whether the circuit court erred in finding no fiduciary relationship between a Blue Cross member and Grand Strand, a hospital which touted its Blue Cross PPO provider status and solicited Blue Cross members to seek services at its facility.
3. Whether the circuit court erred in finding it was equitable for Grand Strand to charge a Blue Cross member when it promised not to and for Grand Strand to retain payments at a rate far higher than the agreed upon rate.

STATEMENT OF THE CASE

Appellant Jeanne Beverly filed and served her Complaint on January 6, 2016, alleging claims for (1) breach of contract; (2) bad faith; and (3) unjust enrichment. (R. pp. 23-26). All of Ms. Beverly's claims arise out of an emergency room visit at Respondent Grand Strand Regional Medical Center ("Grand Strand") following an auto accident. The Complaint was filed on behalf of Ms. Beverly and other similarly situated Grand Strand patients. Pursuant to Rule 12(b)(6), SCRCP, Grand Strand filed a motion to dismiss on March 3, 2016, asking the circuit court to dismiss all three of Ms. Beverly's claims. (R. pp. 28-29). Both parties submitted memoranda of law, and the Honorable Benjamin H. Culbertson heard oral arguments on April 26, 2016. The circuit court entered an order granting Grand Strand's motion, and Ms. Beverly filed a Rule 59(e), SCRCP, motion on May 10, 2016. (R. pp. 55-59). The circuit court denied this motion, and Ms. Beverly's counsel received written notice of the order on July 11, 2016. Ms. Beverly filed and served a timely notice of appeal on July 19, 2016. (R. p. 102).

STATEMENT OF THE FACTS

Ms. Beverly was injured in an auto accident caused by another driver on September 6, 2012. (R. p. 20 ¶ 12). On that same day, she presented to Grand Strand's emergency room for diagnosis and treatment of her injuries. (R. p. 20 ¶ 13). Ms. Beverly was evaluated by an emergency room physician, and Grand Strand personnel treated a wound she suffered in the accident. (R. pp. 20-21 ¶¶ 13, 22). A short time later, Grand Strand mailed Ms. Beverly an unexpected \$8,000 bill for emergency room services. (R. p. 21 ¶ 22). The bill was unexpected because Ms. Beverly previously purchased a health insurance policy from Blue Cross Blue Shield of South Carolina ("Blue Cross") that made her a Blue Cross "member" and granted her access to Blue Cross's Preferred Provider Organization ("PPO"). (R. p. 20 ¶ 14). The PPO was a

network of hospitals and medical practices marketed to Blue Cross members as “preferred” providers. (R. pp. 20-24 ¶¶ 16, 41-43; R. p. 116 § 11.2). Ms. Beverly was supposed to benefit from the PPO because PPO providers like Grand Strand were prohibited from billing her. (R. pp. 20-23 ¶¶ 17, 34; R. p. 109 §§ 6.1-6.2).

In the Institutional Agreement, Grand Strand became a PPO provider in exchange for a promise to bill Blue Cross directly for medical services to Blue Cross members. (R. pp. 20-24 ¶¶ 17, 34, 43; R. p. 109 §§ 6.2-6.3). Grand Strand also promised to accept from Blue Cross a discount reimbursement rate for these services. (R. pp. 20-24 ¶¶ 17, 34; R. p. 109 § 6.4). Specifically, the Institutional Agreement¹ prohibited Grand Strand from “solicit[ing] any payment from [Blue Cross] Members” and required Grand Strand to “accept the reimbursement terms and rates” Blue Cross established for the PPO. (R. p. 109 §§ 6.1, 6.4). After signing the Institutional Agreement in 2005, Grand Strand began marketing itself to Blue Cross members as a PPO provider. (R. p. 24 ¶¶ 41-43). Ms. Beverly was aware of Grand Strand’s PPO provider status and expected Grand Strand to function accordingly when she sought out the hospital after her auto accident. (R. p. 24 ¶ 45).

However, the Complaint alleges Grand Strand chose to disregard its contractual duties for Ms. Beverly and similarly situated patients. (R. p. 23 ¶¶ 33-36). Emergency room services for auto accident victims are a poor economic performer for Grand Strand, especially given the discount reimbursement rate Grand Strand agreed to accept from Blue Cross. (R. p. 21 ¶ 19). By charging Ms. Beverly directly and for an amount exceeding the Institutional Agreement’s reimbursement rate, Ms. Beverly alleges Grand Strand acted in its own economic interest and in violation of its contractual duties. (R. pp. 21-25 ¶¶ 21, 22, 24, 46-49). Ms. Beverly demanded

¹ The Complaint alleges Ms. Beverly, as a Blue Cross member, is a third-party beneficiary of the Institutional Agreement. (R. p. 21 ¶ 25).

damages for Grand Strand's breach of contractual and fiduciary duties and, in the alternative, an equitable recovery to remedy Grand Strand's unjust enrichment. (R. pp. 23-26 ¶¶ 36, 50, 56).

STANDARD OF REVIEW

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 a complaint merely because the court doubts the plaintiff will prevail. Plyler, 373 S.C. at 645, 647 S.E.2d at 192. An appellate court must apply the same standard. Dawkins v. Union Hosp. Dist., 408 S.C. 171, 176, 758 S.E.2d 501, 503 (2014).

ARGUMENT

In the age of modern medicine, and a booming health care industry, a hospital stay is rarely a simple two-party transaction between doctor and patient. Since medical services are costly and unpredictable, it is advisable and now required by federal law² that patients invite a third party to the transaction by procuring health insurance. A patient's relationship with her medical provider is directly affected by the provider's relationship with her insurer since insurers often reach agreements with providers regarding which services the insurer will cover and how the provider will be compensated. Although the provision and payment of health care services is inherently trilateral, the governing contracts often name just two of the participants—e.g. a patient's policy with her insurer or the insurer's reimbursement contract with the provider. When coverage or reimbursement disputes arise, the participants may find themselves seeking relief from a party with whom they lack contractual privity. Medical providers may seek to enforce provisions of their patient's policy with her insurer, and a patient may seek to enforce provisions of her insurer's contract with the provider.

This case asks whether South Carolina contract law and equity principles recognize the core structure of the health insurance market by allowing its participants to enforce duties specifically intended to benefit them even when memorialized in someone else's contract. Several jurisdictions have held that medical providers like Grand Strand may rely on provisions of an insurer-insured contract to demand reimbursement for health care services. Other jurisdictions have also held that patients like Ms. Beverly may rely on provisions within an insurer-provider contract to demand the discount for medical services her provider agreed to accept and to avoid the bill for those services her provider agreed not to send.

² See 26 U.S.C. § 5000A (requiring individuals to "maintain minimum essential coverage" for medical expenses).

South Carolina contract law recognizes the enforcement rights for intended third-party beneficiaries like Ms. Beverly. Yet, the circuit court dismissed Ms. Beverly's contract and equitable claims by concluding she was not a third-party beneficiary and Grand Strand was justified in bypassing her insurer altogether while charging her directly at rates far above what it had agreed to accept. As it stands, Grand Strand's profit-driven decision to ignore its contractual obligation to submit claims is a wrong for which Ms. Beverly lacks a remedy. The circuit court's order should be reversed because it overlooks key provisions of the relevant contract and South Carolina law.

1. Ms. Beverly is an Intended Third-Party Beneficiary of the Institutional Agreement Empowered to Enforce its Claim Submission and Reimbursement Rate Provisions.

While the Institutional Agreement names only Blue Cross and Grand Strand as parties, Blue Cross members like Ms. Beverly are directly benefited by its provisions. Those benefits are not incidental; Grand Strand joined the PPO by entering the Institutional Agreement, an insurance arrangement designed for the purpose of saving Blue Cross members money and the administrative inconvenience inherent to processing medical bills.

Under South Carolina law, it is well-settled that a non-party may enforce contractual terms that intentionally provide her direct benefits. Kingman v. Nationwide Mut. Ins. Co., 243 S.C. 405, 412, 134 S.E.2d 217, 221 (1964). Determining whether a third-party may enforce a contract is a matter of contract interpretation. Touchberry v. City of Florence, 295 S.C. 47, 49, 367 S.E.2d 149, 150 (1988). The circuit court incorrectly interpreted the Institutional Agreement to exclude Ms. Beverly as a third-party beneficiary based on a purported third-party beneficiary disclaimer provision. (R. p. 7) (citing R. p. 123 § 16.16). The court erred because it failed to give effect to the remaining twenty pages of the Institutional Agreement, which imposes requirements on Grand Strand specifically intended to benefit Ms. Beverly and other Blue Cross members.

Additionally, the circuit court failed to give effect to the full language of the purported disclaimer provision which expressly carves out Ms. Beverly's claims.

a. The Institutional Agreement Adds Grand Strand to a PPO Network Structured to Provide Direct Benefits to Blue Cross Members.

The Institutional Agreement's language, structure, and purpose demonstrate its parties' intent to provide direct benefits to Blue Cross members like Ms. Beverly. From its opening provision, the Institutional Agreement acknowledges its core objective is to support a "Preferred Provider Organization" created "for the benefit of [Blue Cross] Members." (R. p. 104 § 1.1). The Institutional Agreement defines PPO as a health insurance network containing "financial incentives for Members." (R. p. 106 § 2.16). Those financial incentives are made explicit later in the contract when Grand Strand agreed to accept reimbursement for its services from Blue Cross at a discount rate. (R. p. 109 § 6.4). Beyond co-pays and deductibles, Grand Strand was prohibited from charging Blue Cross members for Covered Services, not even at the reduced rate. (R. p. 109 § 6.1).³ In clear terms, Grand Strand agreed it would "not solicit any payment from Members." (R. p. 109 § 6.1). Furthermore, the Institutional Agreement also conferred practical benefits on Blue Cross members by placing on Grand Strand the obligation to submit the members' bills to Blue Cross. (R. p. 109 § 6.3) (providing Grand Strand "shall . . . submit all bills as soon as practicable").

Ms. Beverly's third-party beneficiary status is also evident from the PPO's structure—established by the Institutional Agreement. This is significant because the court must consider not only the contract language but the circumstance of the parties and their purpose at the time the contract was formed. M & M Group, Inc. v. Holmes, 379 S.C. 468, 477 666 S.E.2d 262, 266

³ Grand Strand was also prohibited from charging Blue Cross members for Covered Services that were not medically necessary. (R. p. 113 § 7.2).

(Ct. App. 2008) (quoting Ellie, Inc. v. Miccichi, 358 S.C. 78, 94, 594 S.E.2d 485, 493 (Ct. App. 2004)); see also Holden v. Alice Mfg., Inc., 317 S.C. 215, 221, 452 S.E.2d 628, 631 (Ct. App. 1994) (noting that to understand the meaning of the terms chosen for the contract, it is important to consider its “subject matter and purpose”).

The Institutional Agreement was created to further a PPO, a health insurance structure with inherent benefits to insureds. A PPO is a form of health insurance that links an insurance company to a network of medical providers who are granted “preferred” status by the insurer only if they agree to provide discounts to the insurer’s members. As described by South Carolina’s federal district court, a contract adding a hospital to an insurer’s existing PPO is meant to net advantages for the insurer’s members:

A PPO is a means of health insurance whereby the insurance company contracts with a network of health care providers, including hospitals. The insurer attempts to negotiate favorable rates of reimbursement for the cost of health care that reflects the volume of patients the insurer expects to deliver to the preferred health care provider. The insurer then passes through some of this cost saving to subscribers in the form of lower co-payments and reduced deductibles, which creates the incentive for the patient to use the preferred providers and, in turn creates the volume to support the ‘discount.’

Drs. Steuer & Latham, P.A. v. Nat’l Med. Enters., Inc., 672 F. Supp. 1489, 1513 (D.S.C. 1987).

In other words, a PPO is “a network of health care providers organized to offer medical services at discounted rates.” HCA Health Servs. of Ga. Inc. v. Employers Health Ins. Co., 240 F.3d 982 (11th Cir. 2001) *overruled on other grounds by* Doyle v. Liberty Life Assurance Co. of Boston, 542 F.3d 1352 (11th Cir. 2008). A PPO is intended to benefit all three participants. Grand Strand gained access to Blue Cross’s expansive membership along with guaranteed reimbursements from Blue Cross in exchange for accepting reduced payments and taking on the responsibility of submitting members’ claims. See HCA Health Servs. of Va., Inc. v. Aetna Life Ins. Co., 803 F. Supp. 1132, 1134 (E.D. Va. 1992). Blue Cross gained greater cost control in

exchange for promising prompt reimbursements and best efforts to tout Grand Strand's PPO provider status to Blue Cross members.

Grand Strand argues these are the only benefits the Institutional Agreement confers. However, that argument is no more consistent with the contract language cited above than it is with the structure of the PPO that Grand Strand was joining. PPOs directly benefit Blue Cross's members by assuring "a lesser cost than would have been otherwise charged." First Health Group Corp. v. United Payors & United Providers, Inc., 95 F. Supp. 2d 845, 849 (N.D. Ill. 2000) (citing Office of the Inspector General, Office of Personnel Management, Rep. No. 99-00-97-054, Report on the Use of Silent PPOs in the Federal Employees Health Benefits Program 20-23 (1998)); see also Elizabeth S. Rolph et al., *State Laws and Regulations Governing Preferred Provider Organizations*, Rand Corporation (1986), at 3 (noting all PPOs "offer enrollees incentives to limit their care to a panel of 'preferred' providers . . . Typical incentives include lower deductibles and copayments, or coverage of more services when a PPO provider is used").

By refusing its contractual duty to submit Ms. Beverly's bill to Blue Cross and its duty to accept the agreed-upon reimbursement rate, Grand Strand denied Ms. Beverly the fundamental benefits of her participation in the PPO network. Grand Strand was expressly prohibited from sending Ms. Beverly an \$8,000 bill when it had agreed to accept far less and promised not to seek any payment from Ms. Beverly. As the person aggrieved by Grand Strand's conduct and the direct recipient of Grand Strand's contractual obligations, Ms. Beverly is entitled to enforce the Institutional Agreement against Grand Strand. By dismissing Ms. Beverly's breach of contract claim, the circuit court disregarded the Institutional Agreement's language and the core structure of a PPO.

b. Insurance Customers are Recognized as Third-Party Beneficiaries to PPO Provider Contracts in Other Jurisdictions.

The Complaint alleges Grand Strand has a systemic, nefarious billing practice for auto accident victims entering their emergency room with medical insurance coverage. (R. pp. 20-21 ¶¶ 17-24). Grand Strand is not the only hospital defying its contracts with insurers to enhance its profits and harm its patients.⁴ Several other jurisdictions have considered the issue and held that patients like Ms. Beverly are third-party beneficiaries entitled to enforce insurer-provider contracts like the Institutional Agreement. In fact, the Tennessee Supreme Court addressed the issue for this same Institutional Agreement between a Tennessee hospital and Blue Cross Blue Shield of Tennessee. Benton v. Vanderbilt Univ., 137 S.W.3d 614 (Tenn. 2004). While the court specifically considered an arbitration dispute, that dispute only arose because the court recognized a Blue Cross insured was a third-party beneficiary of the hospital's Institutional Agreement with the Tennessee Blue Cross affiliate. See also West v. Shelby Cnty. Healthcare Corp., 459 S.W.3d 33, 45 (Tenn. 2014) (citing Benton and noting the court had "already held that persons insured by an insurance company are intended third-party beneficiaries of the contract between their insurance company and a hospital").

In another billing dispute between a Blue Cross insured and a hospital contracting with the insurer, an Arizona court found that a provision requiring the hospital to accept a discount reimbursement rate was "clearly a benefit to the [Blue Cross] subscriber [and] that benefit is both intentional and direct." Nahom v. Blue Cross & Blue Shield of Ariz., Inc., 885 P.2d 1113, 1117

⁴ Evidence suggests the conduct Ms. Beverly 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).

(Ariz. App. 1994). As further evidence that the insured was an intended third-party beneficiary, Nahom noted the numerous times Blue Cross members were named in the contract. Id. at 1118. This same scenario was addressed in Dorr v. Sacred Heart Hospital, 597 N.W.2d 462, 475 (Wis. App. 1999). Dorr held that a provision in the hospital's provider agreement barring the hospital from billing an insurer's members was "designed specifically for the purpose of protecting" the members and was intended to make each member a third-party beneficiary to the contract. Id.

The South Dakota Supreme Court reached the same conclusion when construing a hospital's contract with a self-insured health plan. Jennings v. Rapid City Reg'l Hosp. Inc., 802 N.W.2d 918 (S.D. 2011). The health plan's members were third-party beneficiaries to the contract because "the contract language clearly expresses intent to benefit" the members. Id. at 922. Jennings made special note of the contract's recitals which, like this case, identified the benefits to members the insurance plan expressly intended to provide. Id. Jennings also rejected the notion that the members could not be a third-party beneficiary because the contract provided direct benefits to its parties—i.e. hospital and insurer. Notwithstanding its benefits to its parties, the contract intended to directly benefit the members, and as such the members must be permitted to protect those benefits by enforcing the contract's terms. Id. at 923 ("We look only at who was directly and primarily benefited. In this case, it is [the insured]"); see also Premovic v. Northshore Univ. Healthcare Sys., 2015 IL App. (1st) 133466-U, 2015 WL 71708, at *1 n. 2 (Ill. App. Jan. 5, 2015) (noting trial court denied a motion to dismiss insured's third-party beneficiary claim).

Thus, the circuit court's order not only fails to account for the Institutional Agreement's language and the PPO's structure, it also overlooks substantial persuasive authority allowing patients like Ms. Beverly to enforce contracts like the Institutional Agreement. These cases

recognize the crucial role an insurer's members play in a PPO provider contract even without being named as parties.

c. The Purported Third-Party Beneficiary Disclaimer Does Not Affect Ms. Beverly's Claims.

After nineteen pages of laying out the intricacies of a three-participant PPO network and its express benefits for Blue Cross members, the Institutional Agreement includes one sentence indicating the contract "is not intended to, and shall not be construed to, make any person or entity a third[-]party beneficiary." (R. p. 123 § 16.16). Construing that sentence in isolation, the circuit court concluded Blue Cross and Grand Strand disclaimed the possibility of any third-party beneficiary claim by Blue Cross members. (R. p. 7). However, the parties' intent must be derived from the Institutional Agreement's language taken as a whole. The Institutional Agreement repeatedly confers benefits on Blue Cross members that one isolated sentence cannot retract. Moreover, the disclaimer provision itself protects Ms. Beverly's right to pursue her current claims. Section 16.16 recognizes a "Member's right[s]" provided by the Institutional Agreement and carves related claims out of any purported third-party beneficiary exclusion.

Interpreting the purported disclaimer provision to bar Ms. Beverly's claims disregards expressions of the parties' intent elsewhere in the Institutional Agreement. As discussed above, the PPO Grand Strand entered was designed for the benefit of Blue Cross members. (R. p. 104 § 1.1). The very first responsibility Grand Strand undertook in the "Institution Services and Responsibilities" section was a duty owed directly to Blue Cross members. (R. p. 107 § 4.1) (stating Grand Strand "will provide Covered Services to any Member"). The benefit of Grand Strand's duty to refrain from billing patients flows not to Blue Cross but directly to its members. (R. p. 109 § 6.1). Blue Cross members are also a direct beneficiary of Grand Strand's promise to accept the negotiated reimbursement rate. (R. p. 109 § 6.4).

One sentence from the purported disclaimer provision cannot displace these numerous substantive provisions granting extensive benefits to Blue Cross members. The substantive provisions must be accepted as the true expression of the parties' intent. By overlooking these provisions, the circuit court violated a crucial South Carolina contract interpretation rule. See Williams v. Government Employees Ins. Co., 409 S.C. 586, 595, 762 S.E.2d 705, 710 (2014) (finding that on insurance question, contract parties' intent must be "determined from examining the entire contract, not by reviewing isolated portions of the contract"). The circuit court was required to examine the Institutional Agreement from the perspective of a "reasonably intelligent person who has examined the entire agreement." Progressive Max Ins. Co. v. Floating Caps, Inc., 405 S.C. 35, 46, 747 S.E.2d 178, 184 (2013). When reviewing in whole, it is evident that through the Institutional Agreement, Grand Strand and Blue Cross did far more to include Blue Cross members than to exclude them.

Significantly, several courts have found that a third-party beneficiary disclaimer may not be applied when the contract as a whole contradicts the purported disclaimer. See e.g., MEA-NEA Local I v. Mount Clemens Cmty. Schools, No. 248794, 2004 WL 2387650, at *7 (Mich. App. Oct. 26, 2004) ("Despite the general clause disclaiming any third party benefit status, the substantive provision of [contract] clearly directly benefit plaintiff"); La Joya Indep. Sch. Dist. v. Villarreal, No. 13-13-00325-CV, 2014 WL 3050484, at *7 (Tex. App. July 3, 2014) (refusing to apply contract's third-party beneficiary exclusion based on other contract language recognizing third party's rights). Several other courts have refused to apply a third-party beneficiary disclaimer to prevent enforcement of health insurance contracts.

In a very similar case, the Wisconsin Court of Appeals held that an insured covered by an health maintenance organization (“HMO”)⁵ was a third-party beneficiary of her insurer’s HMO provider contract with the hospital where she was treated following an auto accident. Dorr, 597 N.W.2d at 475. The contract’s attempt to disclaim third-party beneficiaries was ineffective as to the insured because it was inconsistent with other portions of the same contract directing benefits to her. Id. (finding contract’s terms “are designed specifically for the purpose of protecting HMO subscribers”). Similarly, a federal district court in Pennsylvania recently applied the same principles to reject a third-party beneficiary exclusion offered to prevent a medical provider from enforcing a PPO contract between an insurer and a health insurance network. Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr., Civil Action No. 13-03101, 2015 WL 1954287 (E.D. Pa. Apr. 30, 2015). Since the contract in question purported to exclude third-party beneficiaries while also granting specific benefits to non-parties, the contract was patently ambiguous and the third-party beneficiary claim could not be dismissed on a pre-answer motion. Just like the defendant in Huntingdon Valley, Grand Strand should not be allowed to “have it both ways” by enjoying the benefits of an Institutional Agreement with terms designed to benefit Blue Cross members while also preventing members from enforcing those terms. Id. at * 10.⁶

Even if the third-party beneficiary disclaimer is generally valid, it does not bar Ms. Beverly’s claims because they are specifically carved out. The circuit court misconstrued the provision’s second sentence which indicates that any restriction on potential third-party beneficiaries does not apply to “a Member’s right to receive Covered Services pursuant to the

⁵ An HMO is a medical insurance program that “undertakes to provide or arrange for basic health care services to enrollees for a fixed prepaid premium.” S.C. Code Ann. § 38-33-20(8).

⁶ See also Cates v. Integris Health, Inc., No. CIV-12-0763-F, 2013 WL 3923512, at *6-7 (W.D. Okla. July 29, 2013) (refusing to apply third-party beneficiary disclaimer rendered ambiguous by other provisions in contract).

terms of this Agreement.” (R. p. 123 § 16.16). This crucial phrase is actually a succinct summary of the claims alleged in Ms. Beverly’s Complaint. Along with her equitable claims, Ms. Beverly is suing Grand Strand precisely because its conduct denied her the right to receive Covered Services **pursuant to** the Institutional Agreement’s terms.

Ms. Beverly alleges she presented to Grand Strand as a Blue Cross member to receive Covered Services.⁷ (R. p. 20 ¶¶ 12-14). She alleges she provided clear notice to Grand Strand of her status as a Blue Cross member. (R. p. 20 ¶ 15). She alleges Grand Strand was a PPO provider with an obligation to submit the bill for her treatment to Blue Cross and to accept the resulting discounted reimbursement rate Blue Cross would provide. (R. pp. 20-23 ¶¶ 16-17, 34). She further alleges Grand Strand wrongly sent her an undiscounted bill for treatment qualifying as “covered services.” (R. pp. 21-23 ¶¶ 18, 21-24, 35). Finally, Ms. Beverly alleged Grand Strand’s violation of its contractual duties was an intentional, profit-driven act that damaged Ms. Beverly by denying her the contractual benefits to which she is entitled. (R. pp. 21-23 ¶¶ 19-20, 24, 35, 36).

Grand Strand’s alleged failure to provide Covered Services “pursuant to the terms of” the Institutional Agreement is the Complaint’s overarching theme. Grand Strand’s refusal to submit a bill to Blue Cross is actionable because the Institutional Agreement required it. (R. p. 109 § 6.2) (providing Grand Strand “shall bill” Blue Cross). The same is true for Grand Strand’s submission of a bill to Ms. Beverly and its demand for an undiscounted sum. These acts are

⁷ The Complaint does not specifically reference the contract term “Covered Services” which the Institutional Agreement defines, in pertinent part, as “inpatient and outpatient hospital services . . . to be delivered by or through Institution or Members that are reimbursable under the applicable Member Benefits Contract.” (R. p. 104 § 2.6). However, since “benefits contract” simply refers to Ms. Beverly’s insurance policy with Blue Cross (R. p. 104 § 2.2), the Complaint references “Covered Services” by alleging Grand Strand failed to properly bill for services covered by her policy. (R. pp. 20-23 ¶¶ 14, 17, 18, 21, 33, 35).

improper because, **pursuant to the terms of the Institutional Agreement**, Grand Strand promised to bill only Blue Cross and to accept a discounted reimbursement. (R. p. 109 § 6.1) (Grand Strand “will not solicit any payment from Members”); § 6.4 (Grand Strand “shall accept the reimbursement terms and rates”).

The circuit refused to apply the carve out provision to Ms. Beverly’s claims by finding the provision is limited to “Covered Services” which, as defined in the Institutional Agreement, does not include submission of a patient’s bill or acceptance of discounted reimbursement. (R. p. 9) (concluding Complaint did not relate to a reimbursable service). The circuit court’s conclusion suggests Blue Cross members may only allege claims under the Institutional Agreement when the medical care they received was substandard. However, this interpretation fails to account for the provision’s express intent and the contract’s purpose.

The circuit court’s interpretation fails to account for the phrase that immediately follows “Covered Services” in the carve out provision. Blue Cross members are not excluded as third-party beneficiaries for any claim relating to the provision of Covered Services **“pursuant to the terms of this Agreement.”**⁸ (R. p. 123 § 16.16) (emphasis added). The bolded language expands the carve out provision’s reach by incorporating the contract’s earlier provisions including Grand Strand’s duties to bill Blue Cross only and to accept discounted reimbursements. The Institutional Agreement uses a similar phrase in its recitals where it indicates the entire contract’s purpose is for Grand Strand to become a PPO provider “to provide Covered Services **under the terms of this Agreement.**” (R. p. 104 § 1.2) (emphasis added). In both instances, the highlighted

⁸ The Institutional Agreement does not define “pursuant to,” and 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).

language is meant to apply broadly to all of Grand Strand's contractual obligations including the ones referenced in Ms. Beverly's Complaint.

To read the carve out provision otherwise overlooks the contract's purpose. The Institutional Agreement did not just require Grand Strand to bandage Ms. Beverly's wounds and diagnose her injury, it also required Grand Strand to process the bill for those services in a very specific way to a very specific source for a predetermined amount of compensation. In fact, when viewed as a whole, the Institutional Agreement focused heavily on how Covered Services would be paid for and how payment would be processed. Portions of Article IV and Article VIII discuss the quality of medical care Grand Strand provides, but the voluminous provisions of Articles VI and VII are dedicated to the administrative and financial aspects of providing Covered Services.

In sum, the Institutional Agreement's purported third-party beneficiary disclaimer provision does not represent the parties' intent because it is repeatedly contradicted by more specific provisions earlier in the contract. Moreover, the disclaimer provision cannot apply here because it carves out Ms. Beverly's claims. The Complaint alleges Grand Strand provided Ms. Beverly "Covered Services" but not "pursuant to" the Institutional Agreement's terms, which prevented Grand Strand from billing her and required Grand Strand to accept a discount. Ms. Beverly's claims fall squarely within the carve out provision's plain language.

2. The Complaint States a Claim for Breach of Grand Strand's Fiduciary Duty to Bill Blue Cross and to Accept Discount Reimbursements.

When Ms. Beverly purchased her Blue Cross policy, she reasonably expected to receive financial benefits from Blue Cross and all medical providers who contracted to participate in the Blue Cross PPO. When Grand Strand committed to the PPO by entering the Institutional Agreement, it agreed to provide financial benefits to Blue Cross members and to act in members'

best interest by not charging them directly for Covered Services, by submitting bills for those services to Blue Cross, and by accepting the bargained-for discount reimbursement rate. The PPO cannot function effectively unless Blue Cross members can trust medical providers like Grand Strand to honor their Institutional Agreement duties. When Grand Strand ignored these duties by sending Ms. Beverly an undiscounted bill for Covered Services, it violated her trust and provided the basis for her breach of fiduciary duty claim.

The circuit court dismissed the fiduciary duty claim as based on duties arising from a contract Ms. Beverly lacked standing to enforce. (R. pp. 9-10). However, as discussed above, South Carolina law allows a non-party to enforce a contract that intentionally provides her direct benefits. The circuit court also concluded Ms. Beverly and Grand Strand do not have a relationship from which a fiduciary duty arises. (R. pp. 9-10). A fiduciary duty is created when one party places trust or confidence in another's integrity and fidelity. Ellis v. Davison, 358 S.C. 509, 519, 595 S.E.2d 817, 822 (Ct. App. 2004). Ms. Beverly properly states a claim for breach of fiduciary duty if her Complaint alleges (1) the existence of a fiduciary duty; (2) a breach of that duty owed to her by Grand Strand; and (3) damages proximately resulting from Grand Strand's wrongful conduct. Moore v. Moore, 360 S.C. 241, 250-51, 599 S.E.2d 467, 472-73 (Ct. App. 2004).

The Complaint effectively alleges all required elements of a breach of fiduciary duty claim. Grand Strand and Ms. Beverly created a relationship of trust when Grand Strand became a PPO provider bound to the Institutional Agreement's terms, and Ms. Beverly sought out Grand Strand for medical services because it was a Blue Cross PPO provider. (R. pp. 20-24 ¶¶ 17, 39, 45). By presenting to a Blue Cross PPO provider and showing her Blue Cross membership card, Ms. Beverly did all she was required to do to expect Grand Strand to fulfill the duties arising

from this relationship. (R. p. 20 ¶ 15). Grand Strand breached its duty of trust by refusing to submit the bill for Ms. Beverly's services to Blue Cross, and in the process proving that it valued profit maximization over its fiduciary relationship. (R. p. 24 ¶¶ 40, 46). Grand Strand's conduct damaged Ms. Beverly because she paid a bill she did not owe at a rate higher than Grand Strand agreed to charge. (R. p. 21 ¶¶ 22-24).

The circuit court's order incorrectly concluded Ms. Beverly's fiduciary duty claim was based entirely on her actions. Order at 8 (citing Moore, 360 S.C. at 251, 599 S.E.2d at 472). Ms. Beverly acknowledges that a breach of fiduciary duty claim may not be based on unilateral acts. Moore, 360 S.C. at 251, 599 S.E.2d at 472 (citing Regions Bank v. Schmauch, 354 S.C. 648, 670, 582 S.E.2d 432, 444 (Ct. App. 2003)). However, the Complaint alleges both that Ms. Beverly justifiably placed her trust in Grand Strand (R. p. 24 ¶ 45) and that Grand Strand courted and accepted that trust. Specifically, Grand Strand held itself out as a Blue Cross PPO provider to potential patients and represented to Blue Cross members that it would provide medical treatment and seek reimbursement in keeping with its Blue Cross PPO provider status. (R. p. 24 ¶¶ 41-43). In fact, Grand Strand negotiated for the ability to tout its Blue Cross PPO provider status in the Institutional Agreement. Grand Strand bargained for the right to "publically state that it is a provider in [Blue Cross's] provider network" because such declarations were "desirable . . . to [Grand Strand] in the course of its business operations." (R. p. 116 § 11.2). The Complaint's allegations reject the notion that Ms. Beverly's fiduciary duty claim relies on unilateral acts.

The circuit court also concluded the fiduciary duty claim was defective because medical providers cannot have a fiduciary duty to submit health insurance claims. (R. p. 11) (citing 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)). Yet, the formation of a fiduciary relationship is not as rigid and narrow as the circuit court's ruling suggests. South Carolina law makes every effort to avoid imposing strict limitations on the types of relationships from which a fiduciary duty may arise. Island Car Wash, Inc. v. Norris, 292 S.C. 595, 599, 358 S.E.2d 150, 152 (Ct. App. 1987). Instead, South Carolina courts "broadly construe fiduciary obligations to protect the interests of those placing trust in others." Armstrong v. Sch. Dist. 5 of Lexington & Richland Counties, 26 F. Supp. 2d 789, 797 (D.S.C. 1998). The guiding principles for any fiduciary duty analysis lie in "the particulars of the relationship between the parties." Armstrong v. Collins, 366 S.C. 204, 222, 621 S.E.2d 368, 377 (Ct. App. 2005). This is especially true "with regard to transactions in which the dominant party secures a profit or advantage at the expense of a person under his influence." Island Car Wash, Inc., 292 S.C. at 599, 358 S.E.2d at 152 (citing 36A C.J.S. Fiduciary at 388 (1983)).

Taking the Complaint allegations as true, Grand Strand has devised a scheme to draw Blue Cross members to its facility with the promises inherent in its Blue Cross PPO provider status and then pulled the rug out from beneath them by sending bills for charges Grand Strand knows it may not pursue. Ms. Beverly alleges Grand Strand actively participated in building a relationship of trust with Blue Cross members and exploited that trust for profit. This is a very different situation than Wogan where a doctor did not have a fiduciary duty to seek Medicare reimbursement on a patient's behalf for a costly medication likely not covered by Medicare anyway. 366 S.C. at 588, 623 S.E.2d at 110. For one, the patient in Wogan was explicitly told that the doctor would not file a claim for reimbursement. Id. The opposite is true here as Grand Strand expressly promised to seek reimbursement from Blue Cross on Ms. Beverly's behalf (R.

p. 109 §§ 6.2-6.3) and communicated that promise to Blue Cross members by touting its PPO provider status. (R. p. 24 ¶ 41).

Plus, the Wogan plaintiff's claim was dismissed because the Medicare Act rejected a civil claim for violation of the proposed claim submission duty. 366 S.C. at 601, 623 S.E.2d at 117. There is no corresponding statutory hurdle in this case. In the end, Wogan did not reject a fiduciary duty claim because a medical provider and patient may never form a relationship of trust. To the contrary, Wogan recognized the doctor-patient relationship can create a fiduciary duty. Id. at 605, 623 S.E.2d at 119 (citing McCormick v. England, 328 S.C. 627, 639, 494 S.E.2d 431, 437 (Ct. App. 1997)). Ultimately, it was a federal statute, not a deficient pleading that doomed the fiduciary duty claim in Wogan. 366 S.C. at 606, 623 S.E.2d at 119 (finding that a fiduciary duty claim under these circumstances "would render meaningless our ruling that there is no private right of action arising under the Medicare Act"). Wogan does not apply here and the Complaint alleges all required elements of a fiduciary duty claim.

3. Grand Strand was Unjustly Enriched by Ms. Beverly's Payment for Covered Services.

The Complaint properly alleges a claim for unjust enrichment, an equitable cause of action in no way dependent on a valid contract between the parties. Ms. Beverly alleged an unjust enrichment claim in her Complaint as an alternative cause of action should a factfinder conclude there is no valid contract or that she lacks standing to enforce the Institutional Agreement. See Williams Carpet Contractors, Inc. v. Skelly, 400 S.C. 320, 734 S.E.2d 177, 181 (Ct. App. 2012) (allowing a party to allege an unjust enrichment cause of action as an alternative claim for breach of contract). 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) Ms. Beverly conferred on Grand Strand a benefit; (2) Grand Strand realized that

benefit; and (3) it would be inequitable for Grand Strand to retain the benefit under these circumstances without paying Ms. Beverly 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”).

The circuit court erred in concluding Ms. Beverly’s unjust enrichment 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. The alleged wrong in Pitts was a breach of an alleged “duty of insurer to inform an applicant of the availability of an allegedly superior product.” Id. at 338, 574 S.E.2d at 512. There simply was no duty to provide this notification. Pitts also relied on the fact that the alleged wrongdoing was performed when the plaintiff was a mere insurance applicant. At that point, there was no existing relationship on which to build a fiduciary duty or to impose liability for unjust enrichment. 352 S.C. at 331, 574 S.E.2d at 508 (finding that, at the application stage, “the insurer is in a decidedly different position than after the contract has been entered into”).

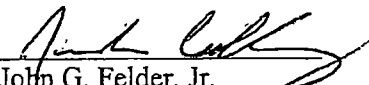
Ms. Beverly’s claim is substantially different. Ms. Beverly was not a mere insurance applicant, she was a bona fide Blue Cross member to whom Grand Strand had existing legal obligations. (R. p. 25 ¶ 52). Plus, Ms. Beverly does not allege a failure to inform, she alleges affirmative inequitable conduct that took money away from her. While the Pitts defendant was permitted to refuse to offer a gratuitous discount, Grand Strand is not permitted to collect for its services at a much higher payment rate than it contractually agreed to accept. (R. p. 109 § 6.4). Grand Strand did far more than just refuse to offer a discount. Rather, it agreed to one rather and then maneuvered to charge a higher rate ignoring its very own agreement. (R. p. 25 ¶ 52). All

funds Grand Strand collected from Plaintiff is a benefit that Grand Strand came by inequitably. (R. p. 25 ¶ 53). It is unjust for Grand Strand to retain these funds (R. p. 25 ¶ 54), and Ms. Beverly's unjust enrichment/*quantum meruit* claim is a proper claim to seek a remedy for this wrong.

CONCLUSION

Based on the arguments stated above, Ms. Beverly respectfully requests the Court reverse the circuit court's order granting Grand Strand's motion to dismiss. Ms. Beverly is an intended third-party beneficiary of the Institutional Agreement empowered by South Carolina law to enforce the contract's provisions. If the circuit court's order is permitted to stand, then insurance customers like Ms. Beverly will be barred by law from recovering insurance benefits they paid to receive from the party who authored a scheme to divert those funds for its own use. Moreover, given the relationship of trust Grand Strand fostered with Blue Cross members, the circuit court erred in dismissing Ms. Beverly's breach of fiduciary duty claim. Finally, even if the Court concludes Ms. Beverly lacks standing to enforce the Institutional Agreement's provisions, Grand Strand's blatant abdication of the billing requirements inherent to a PPO is inequitable and all funds Grand Strand obtained from Ms. Beverly must be returned.

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 Health Care Drive
Rock Hill, South Carolina 29732
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

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Columbia, South Carolina

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

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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 Respondent.

**RESPONDENT GRAND STRAND REGIONAL MEDICAL CENTER, LLC'S
FINAL BRIEF**

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 Respondent
Grand Strand Regional Medical Center, LLC*

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STATEMENT OF ISSUES ON APPEAL

1. WHETHER THE CIRCUIT COURT ERRED IN FINDING BEVERLY IS NOT AN INTENDED THIRD-PARTY BENEFICIARY WITH THE RIGHT TO ENFORCE THE INSTITUTIONAL AGREEMENT BETWEEN GRAND STRAND REGIONAL MEDICAL CENTER, LLC AND BLUE CROSS BLUE SHIELD OF SOUTH CAROLINA.
2. WHETHER THE CIRCUIT COURT ERRED IN FINDING BEVERLY FAILED TO STATE A CLAIM FOR BREACH OF FIDUCIARY DUTY BECAUSE GRAND STRAND DOES NOT OWE BEVERLY A FIDUCIARY DUTY TO FILE HER INSURANCE CLAIMS.
3. WHETHER THE CIRCUIT COURT ERRED IN FINDING GRAND STRAND WAS NOT UNJUSTLY ENRICHED BY COLLECTING NON-DISCOUNTED PAYMENT FOR MEDICAL SERVICES RENDERED.

STATEMENT OF THE CASE

This case is about whether a person who is admittedly not a party to a contract between two other entities may enjoy legal status as a third-party beneficiary of that contract with the power to sue on the contract and to enforce such terms in the contract as she chooses when the parties to the contract included a specific and express term that “[t]his Agreement is not intended to, and shall not be construed to make any person or entity a third-party beneficiary.”

On September 6, 2012, Appellant Jeanne Beverly (“Beverly”) was in an automobile accident and received treatment for her injuries at a hospital operated by Respondent Grand Strand Regional Medical Center, LLC (“Grand Strand”). After medical services were rendered to Beverly, Grand Strand billed Beverly the standard (non-discounted) rates for the medical services Beverly received.

Blue Cross Blue Shield of South Carolina (“BCBS”) and Grand Strand are, and have been, parties to a contract (the “Institutional Agreement”) through which those two entities memorialized the logistics by which Grand Strand would provide medical services and bill for those services at discounted rates through an organized and convenient process for Grand Strand and BCBS.

Beverly asserts she is a BCBS policyholder, but alleges that Grand Strand billed her directly at standard (non-discounted) rates for the medical service she received. As a result of receiving a bill for the medical services she was provided by Grand Strand’s hospital, Beverly filed this action.

In her complaint, Beverly argues (1) she is a third-party beneficiary with the right to enforce the Institutional Agreement and to sue Grand Strand for breach of the Institutional Agreement when it billed her directly at standard (non-discounted) rates for the medical services she received instead of billing BCBS; (2) Grand Strand breached a fiduciary duty to Beverly by

billing her standard (non-discounted) rates for the medical services provided to her; and (3) Grand Strand was unjustly enriched by billing Beverly standard (non-discounted) rates for medical services.

In response to Beverly's complaint, Grand Strand filed a motion to dismiss arguing, (1) the plain language of the Institutional Agreement precludes her status as a third-party beneficiary with the right to enforce and sue upon the Institutional Agreement and, therefore, Beverly does not have standing to bring the action for breach of the Institutional Agreement; (2) Grand Strand does not owe Beverly a fiduciary duty to file her insurance claims; and (3) Grand Strand was not unjustly enriched by billing her standard (non-discounted) rates for the medical services rendered to Beverly.

The circuit court agreed with Grand Strand and dismissed Beverly's complaint. Beverly filed this appeal arguing the circuit court erred in granting Grand Strand's motion to dismiss.

Grand Strand respectfully requests the Court affirm the circuit court's order granting its motion to dismiss because (1) Beverly is not an intended third-party beneficiary under the Institutional Agreement and, therefore, lacks standing to maintain her claim for breach of contract; (2) Beverly's claim for breach of fiduciary duty fails because Grand Strand does not owe Beverly a fiduciary duty to file her insurance claims; and (3) Beverly's claim for unjust enrichment fails because Grand Strand's bill for the non-discounted cost of the services rendered to Beverly does not constitute an inequitable benefit.

FACTS / PROCEDURAL HISTORY

On September 6, 2012, Beverly was injured in an auto accident. (R. 20). Beverly sought treatment for the injuries she suffered in that accident at Grand Strand's hospital. (R. 20). At the time of her injury, Beverly was covered under a BCBS health insurance policy. (R. 20).

Grand Strand and BCBS are, and have been parties to a contract—the Institutional Agreement—in which Grand Strand agreed to accept certain rates for the services it provides to BCBS policyholders in exchange for BCBS directing its policyholders to Grand Strand's hospital for medical treatment. (R. 104).

Grand Strand billed Beverly directly and at standard (non-discounted) rates for the medical services rendered to Beverly. (R. 21). As a result of receiving a bill for the medical services rendered to her, Beverly filed a complaint against Grand Strand asserting claims for (1) breach of contract, (2) breach of fiduciary duty, and (3) unjust enrichment. (R. 23-26).

In response to Beverly's complaint, Grand Strand filed a motion to dismiss, arguing Beverly's claims should be dismissed because (1) Beverly lacks standing to enforce the Institutional Agreement because she is not a third-party beneficiary with the right to enforce its terms, (2) Grand Strand does not owe Beverly a fiduciary duty to file insurance claims on her behalf, and (3) Grand Strand was not unjustly enriched by billing Beverly the standard rates for the medical services she received. (R. 28-29).

The circuit court found the Institutional Agreement contains provisions expressly stating that there are no third-party beneficiaries. (R. 6-9). The circuit court found the third-party beneficiary disclaimer barred Beverly from enforcing the Institutional Agreement and, therefore, Beverly's claim for breach of contract must be dismissed because Beverly does not have standing to enforce the Institutional Agreement. (R. 6-9). Additionally, the circuit court found Beverly's claim for breach of fiduciary duty failed because Grand Strand does not owe Beverly a fiduciary duty. (R. 9-11). Finally, the circuit court found that Beverly failed to state a claim for unjust enrichment, because Grand Strand was not unjustly enriched when it billed Beverly the standard rate for the medical services provided to Beverly. (R. 11-13).

Beverly filed this appeal in an effort to convince this Court that the plain language of the Institutional Agreement should be disregarded and she should be allowed to enforce an agreement between a hospital and an insurance company.

STANDARD OF REVIEW

“On appeal from the dismissal of a case pursuant to Rule 12(b)(6), an appellate court applies the same standard of review as the [circuit] court.” *Rydde v. Morris*, 381 S.C. 643, 646, 675 S.E.2d 431, 433 (2009) (citation omitted). “That standard requires the [appellate] [c]ourt to construe the complaint in a light most favorable to the nonmovant and determine if the facts alleged and the inferences reasonably deducible from the pleadings would entitle the plaintiff to relief on any theory of the case.” *Id.* (internal quotations marks omitted) (citation omitted). The appellate court may sustain the dismissal when “the facts alleged in the complaint do not support relief under any theory of law.” *Flateau v. Harrelson*, 355 S.C. 197, 202, 584 S.E.2d 413, 416 (Ct. App. 2003).

ARGUMENT

I. The circuit court correctly held that Beverly is not an intended third-party beneficiary with the right to enforce the Institutional Agreement.

The circuit court properly held that Beverly is not a third-party beneficiary with the right to enforce or sue upon the Institutional Agreement. This Court should affirm the circuit court’s decision on the following grounds: (1) the plain and unambiguous language of the Institutional Agreement precludes the existence of third-party beneficiaries with status to enforce its terms; (2) the authority Beverly relies upon from other jurisdictions is inapplicable and readily distinguishable from the present action; and (3) the Institutional Agreement does not include an exception to the third-party beneficiary disclaimer.

A. The plain and unambiguous language of the Institutional Agreement precludes third-parties from enforcing its terms.

The circuit court correctly held that Beverly does not have standing to bring a claim for breach of the Institutional Agreement because the plain and unambiguous language of the Institutional Agreement precludes the existence of any third-party with intended beneficiary status to enforce or sue upon the terms of the Agreement. (R. 6-9).

In South Carolina, the law presumes that parties contract exclusively for their own benefit, and that presumption may only be overcome by showing the parties to the contract intended to create the right for a third party to enforce the contract as an intended and direct beneficiary. *Touchberry v. City of Florence*, 295 S.C. 47, 48-49, 367 S.E.2d 149, 150 (1988). The law does not recognize such status or rights for a party who is merely an incidental or consequential beneficiary of the contract. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005); 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 clearly intended to create a direct 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).

To determine whether 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 plain language of their contract. *Gilbert v. Miller*, 356 S.C. 25, 30, 586 S.E.2d 861, 864 (Ct. App. 2003) (holding the lease agreement at issue did not intend to make the plaintiff a third-party beneficiary allowed to enforce its terms). If a contract's language is clear and capable of

legal construction, a court is to interpret the contract's language according to its lawful meaning and the intent of the parties as expressed in the instrument. *Id.* (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) (citation and internal quotation marks omitted).

Courts are bound to interpret the intent of the contracting parties based upon the four corners of the contract. *Silver v. Aabstract Pools & Spas, Inc.*, 376 S.C. 585, 591, 658 S.E.2d 539, 542 (Ct. App. 2008). Thus, when the parties to the contract include an express third-party beneficiary disclaimer, the court must find the contracting parties did not intend to convey a direct benefit to third-parties or to create for those third parties a right to enforce or sue upon the contract. *See 1500 Range Way Partners, LLC v. JPMorgan Chase Bank, Nat. Ass'n*, 800 F. Supp. 2d 716, 721 n.3 (D.S.C. 2011) (dismissing a plaintiff's claim for breach of contract because a court may not ignore the plain and unambiguous terms of a contract containing a third-party beneficiary disclaimer and allow a third-party to bring an action to enforce a contract to which the plaintiff is not a party); *see also 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); *Balsam v. Tucows Inc.*, 627 F.3d 1158, 1163 (9th Cir. 2010) (holding that in the "absence of any evidence to the contrary, . . . the 'No Third Party Beneficiaries' clause unambiguously manifest[ed] an intent *not* to create any obligations to third parties through the

[agreement].”); *Old Stone Bank v. Fid. Bank*, 749 F. Supp. 147, 152 (N.D. Tex. 1990) (enforcing a contract’s third-party beneficiary disclaimer on the grounds that courts are bound to interpret the intent of the contracting parties based upon the four corners of the instrument); *RPC Liquidation v. Iowa Dept. of Transp.*, 717 N.W.2d 317, 321-322 (Iowa 2006) (considering a similar third-party beneficiary disclaimer and holding a third party could not recover under the terms of the contract because the disclaimer evidenced the express intent of the contracting parties to exclude third-party beneficiaries); *Richmond Shopping Center, Inc. v. Wiley N. Jackson Co.*, 220 Va. 135, 142 (Va. 1979) (finding 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); *Atherton v. Tenet Healthcare Corp.*, No. 2005-UP-362, 2005 WL 7084013, at *4 (Ct. App. May 25, 2005) (holding the contract’s third-party disclaimer conveyed an unambiguous expression of the parties’ intent to exclude third-parties from being able to enforce its terms).¹

The circuit court did not err in finding the express language of the Institutional Agreement evidenced the express intent of Grand Strand and BCBS to preclude third-parties from enforcing their contract. In reaching this conclusion, the circuit court relied on the plain and unambiguous language of the Institutional Agreement, which language determines its force and effect. Thus, the circuit court properly construed the terms of the Institutional Agreement 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

¹ 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.

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)).

Specifically, the circuit court relied on Section 16.16 of the Institutional Agreement to find Grand Strand and BCBS did not intend their contract to be enforceable by third-parties. Section 16.16 states the following:

No Third Party Beneficiaries. 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.

(R. 123). The circuit court properly found this language to be a clear, explicit, and unambiguous expression of BCBS and Grand Strand’s intent to preclude third-parties from asserting legal status as third-party beneficiaries and from enforcing the Institutional Agreement. (R. 7). It is undeniably clear from this provision that Grand Strand and BCBS did not intend for third-parties to be able to enforce their contract. To conclude otherwise would require a court to exceed its authority and read words into the Institutional Agreement to impart an intent that is contrary to the express intent of the contracting parties, and wholly unexpressed by them. *See Pee Dee Stores, Inc. v. Doyle*, 381 S.C. 234, 241, 672 S.E.2d 799, 802 (Ct. App. 2009) (“The court is without authority to consider parties’ secret intentions, and therefore words cannot be read into a contract to impart an intent unexpressed when the contract was executed.” (citing *Blakeley v. Rabon*, 266 S.C. 68, 73, 221 S.E.2d 767, 769 (1976))).

Beverly argues the circuit court erred in applying the direct and express language of Section 16.16 and, instead, argues the circuit court should have relied on purported intimations elsewhere in the Institutional Agreement to ascertain whether Grand Strand and BCBS intended for a third-party to have the right to enforce the Institutional Agreement. In an effort to persuade

this Court that the circuit court erred in interpreting the plain language of the contract, Beverly distorts selected provisions of the Institutional Agreement.

In her brief, Beverly asserts that “[t]he Institutional Agreement acknowledges its core objective is to support a ‘Preferred Provider Organization’ created ‘for the benefit of [Blue Cross policyholders].’” (Appellant’s Brief at 6). In fact, nowhere in the Institutional Agreement does it “acknowledge its core objective is to support a Preferred Provider Organization” for the benefit of BCBS policyholders.

Such benefit as Beverly or other insureds of BCBS may receive by virtue of their BCBS insurance plan participation is ancillary and incidental to the direct benefit intended for BCBS and Grand Strand. *See Bob Hammond Const. Co.*, 312 S.C. at 425, 440 S.E.2d at 892 (holding that the mere fact that the plaintiff might ultimately and indirectly benefit from the defendant’s contract is not sufficient to allow a plaintiff to maintain a breach of contract action).

In an effort to convince the Court that Grand Strand contracted for her benefit, Beverly seeks to misconstrue Section 2.16 of the Institutional Agreement. Section 2.16 describes a “Preferred Provider Organization” to be a network of providers under contract with the Plan whereby Benefit Contracts contain financial incentives for Members to seek Covered Services from such providers.² (R. 106). Under the Institutional Agreement, a “Benefits Contract” is essentially the insurance policy between BCBS and a Member entitling the Member to receive Covered Services. (R. 104). Although Beverly attempts to argue that “[t]he Institutional Agreement defines PPO as a health insurance network containing “financial incentives for Members,” (Appellant’s Brief at 6), the fact is that any “financial incentive for Members” is

² The Institutional Agreement defines “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 Plan and an Associate Plan.” Institutional Agreement § 2.11. (R. 105).

found in the Members' policies with BCBS. The financial incentives or benefits for insureds such as Beverly flow from their policy with BCBS. The Members' individual policies contain financial incentives for seeking treatment at selected providers, and BCBS incentivizes its Members to seek treatment from such providers, because it pays a reduced rate for services rendered by those providers. The Institutional Agreement, in contrast, is about the terms of the relationship between Grand Strand and BCBS. It is disingenuous to represent that the Institutional Agreement contains financial incentives for BCBS policyholders. Any financial incentives in the Institutional Agreement are for Grand Strand and BCBS.

Beverly also asserts that Section 6.1 of the Institutional Agreement shows that Grand Strand and BCBS intended to authorize BCBS members to independently enforce the Institutional Agreement. (Appellant's Brief at 6; 11-12). This is incorrect. Section 6.1 states, "[Grand Strand] shall seek payment for Covered Services solely from [BCBS]." (R. 109). This section allows Grand Strand to provide medical services to BCBS policyholders, and submit a bill for the medical services rendered directly to BCBS. This provision allows Grand Strand to collect payment from a single entity even though it provides treatment to multiple patients. This provision prevents Grand Strand from having to collect small amounts from multiple patients and, instead, allows Grand Strand to collect a larger amount directly from BCBS for the medical services rendered to BCBS policyholders. Removing the individual patients from the billing process is simply more economical, and for the benefit of the entities (Grand Strand and BCBS) who have agreed to conduct business in such a manner. Even if not being contacted for payment were construed as an incidental benefit for BCBS members, Section 6.1 in no way contradicts the express disclaimer of Section 16.16 against third party beneficiaries — *i.e.*, the clear

renunciation of any right of BCBS policyholders to independently enforce the Institutional Agreement.

The language of the Institutional Agreement is plain and unambiguous—Grand Strand and BCBS do not intend for third-parties to enjoy legal status as third-party beneficiaries able to enforce the terms of their contract. This Court should reject Beverly's assertions to the contrary, because they are based upon a distorted interpretation of the Institutional Agreement's express language. This Court should find the circuit court did not err in relying on the plain and unambiguous language of the Institutional Agreement to find that Beverly was not an intended third-party beneficiary and, therefore, Beverly lacks standing to bring a claim for breach of contract. Accordingly, this Court should affirm the circuit court's order dismissing Beverly's breach of contract claim for lack of standing.

B. Beverly relies on distinguishable authorities for support of her argument that other jurisdictions recognize insurance customers as third-party beneficiaries to PPO Provider Contracts.

Beverly relies on a series of plainly inapplicable and readily distinguishable authorities from other jurisdictions in an effort to support her argument that BCBS and Grand Strand intended the Institutional Agreement to provide a direct benefit to third-parties. The authorities relied upon by Beverly may be distinguished in two primary ways. First, Beverly cites several cases that do not involve provider agreements containing express third-party beneficiary disclaimers. Second, Beverly cites to several cases in which the contract at issue contained a third-party beneficiary disclaimer; however, in those cases each contract contained express language that exempted the plaintiff from the third-party beneficiary disclaimer.

In contrast, the Institutional Agreement contains an express disclaimer of third-party beneficiaries, and does not include any language that would exempt Beverly from its third-party beneficiary disclaimer.

1. **Authorities from other jurisdictions that do not address third-party beneficiary disclaimers in the agreements are inapplicable and unpersuasive.**

Beverly cites to the Tennessee Supreme Court's holding in *Benton v. Vanderbilt University*, 137 S.W.3d 614, 616 (Tenn. 2004) for the proposition that "[s]everal other jurisdictions have considered [whether an insured is a third-party beneficiary to a provider agreement] and held that patients like Ms. Beverly are third-party beneficiaries entitled to enforce insurer-provider contracts like the Institutional Agreement." (Appellant's Brief at 9). In *Benton*, the Tennessee Supreme Court found the plaintiff was a third-party beneficiary to the provider agreement between Vanderbilt Hospital and Blue Cross Blue Shield of Tennessee and compelled the plaintiff to arbitration pursuant to the arbitration clause in the provider agreement. *Benton*, 137 S.W.3d at 616. Beverly incorrectly asserts that the court in *Benton* addressed "the issue for this same Institutional Agreement." (Appellant's Brief at 9) (emphasis in original). Based upon a review and comparison of the sections quoted by the court in *Benton* versus the Institutional Agreement, it is obvious that the contract in *Benton* is not the same as the Institutional Agreement in this case and Beverly's assertion is patently false.

In *Benton*, the court described Section 6.1 of the provider agreement in that case and when compared to Section 6.1 of the Institutional Agreement in this case they are clearly about different provisions. (R. 109). The same is true with respect to Section 8.2 in the agreement applicable to the *Benton* case, which is an arbitration clause, as compared with section 8.2 of the Institutional Agreement which has nothing to do with arbitration and relates to a quality assurance committee. (R. 114). After comparing the sections of the provider agreement quoted in *Benton* with the Institutional Agreement, it is obvious that the agreements are not the same as Beverly contends.

Most importantly, when the Tennessee court in *Benton* found the patient was a third-party beneficiary of the provider agreement, it specifically noted that the patient was only entitled to enforce the terms of the provider agreement if “the parties to the contract have not otherwise agreed.” *Id.* at 618. Unlike the circuit court in this case, the court in *Benton* made no reference to a clause in the agreement in that case precluding the existence of third-party beneficiaries. A third-party beneficiary disclaimer in the applicable agreement—such as the one existing here—would clearly have altered the *Benton* court’s analysis and conclusion. Such a clause would have provided undeniable evidence that the parties to the contract had “otherwise agreed” that third-parties were not entitled to enforce the terms of their contract. Therefore, reliance on the holding in *Benton* is unwarranted and inappropriate because the provider agreements at issue are obviously different. Unlike the provider agreement in *Benton*, the Institutional Agreement in this case contains an express disclaimer of third-party beneficiaries.

Next, Beverly seeks to rely on the Arizona court of appeals’ opinion in *Nahom v. Blue Cross & Blue Shield of Arizona, Inc.*, 885 P.2d 1113, 1118 (Ariz. Ct. App. 1994) for the proposition that “a provision requiring the hospital to accept a discount reimbursement rate was ‘clearly a benefit to the [Blue Cross] subscriber [and] that benefit is both intentional and direct.’” (Appellant’s Brief at 9) (quoting *Nahom*, 885 P.2d at 1117). In *Nahom*, the Arizona court of appeals found the plaintiff was a third-party beneficiary of the Blue Cross Blue Shield of Arizona and Scottsdale Memorial Hospital provider agreement. *Nahom*, 885 P.2d at 1117. However, in reaching this conclusion, the Arizona court of appeals made no mention of a provision in the applicable agreement excluding third-party beneficiaries. Such a provision would have altered the court’s analysis because a disclaimer of third-party beneficiaries provides unequivocal evidence that the contracting parties do not intend their contract to be for the direct

benefit of a third-party and the *Nahom* court recognized that the controlling principle under Arizona law was the clear intention in the contract that the parties to the contract intend to recognize the third-party beneficiary. *Id.* The lack of a third-party beneficiary disclaimer is paramount in distinguishing the holding in *Nahom* from the instant case. Therefore, the holding in *Nahom* is inapplicable because the provider agreement at issue did not include a provision stating the express intent of the contracting parties to exclude third-party beneficiaries. *See Bob Hammond Const. Co.*, 312 S.C. at 425, 440 S.E.2d at 892 (stating that without evidence that the parties to a contract intended to create a direct, rather than incidental or consequential, benefit to a third party, the third party is not entitled to enforce the contract).

Beverly also argues the South Dakota Supreme Court reached a similar conclusion in *Jennings v. Rapid City Regional Hospital, Inc.*, 802 N.W.2d 918, 922-23 (S.D. 2011). In *Jennings*, the South Dakota Supreme Court found that the employees were third-party beneficiaries of their employer's self-insurance contract with a managed care organization and the managed care organization's contract with a hospital. 802 N.W.2d at 923-24. The South Dakota Supreme Court found that even though the agreements provided benefits to the contracting parties, the primary beneficiaries of the contracts were the employees. *Id.* at 923. In reaching this conclusion, the South Dakota court made no mention of a third-party beneficiary disclaimer in the contract and even noted that the defendant made no argument to overcome the conclusion that the contract was primarily for the benefit of the third-party employees.

In the instant case, Beverly failed to provide any argument that overcomes the plain language of the contract that there are no intended third-party beneficiaries. A court's role is to interpret the language of a contract—not to redraft a contract. *See Gilstrap*, 283 S.C. at 86, 320 S.E.2d at 447. The Institutional Agreement contains an express disclaimer of third-party

beneficiaries, and the circuit court was correct in relying on the contract's plain language to find that Beverly lacked standing to bring her claim. This Court should find that Beverly cannot overcome the plain language of the Institutional Agreement. Accordingly, this Court should affirm the circuit court's dismissal of Beverly's breach of contract claim.

2. The Institutional Agreement does not contain any language that exempts Beverly from the third-party beneficiary disclaimer, as in cases cited from other jurisdictions.

Beverly relies on authorities from other jurisdictions for support of the argument that the Institutional Agreement's third-party beneficiary disclaimer is inapplicable because the contract as a whole is inconsistent with the purported disclaimer. In fact, the third-party beneficiary disclaimer in the Institutional Agreement does more than merely disclaim the existence of any third-party beneficiary, it expresses an overriding intent by the contracting parties that the Agreement "*shall not be construed to make any person or entity a third-party beneficiary.*" (R. 123) (emphasis added). This language removes all doubt and expresses an absolute prohibition of the general interpretation Beverly seeks to have applied. The authorities upon which Beverly seeks to rely are readily distinguishable from the instant case, because in each of those cases the courts relied upon separate specific provisions in the contract that exempted the plaintiff from the third-party beneficiary disclaimer by providing express, direct and intentional benefits to the plaintiff. See *MEA-NEA Local I v. Mount Clemens Community School*, No. 248794, 2004 WL 2387650, at *1 (Mich. Ct. App. Oct. 26, 2004) (finding the third-party beneficiary disclaimer in the contract between the school district and the management company did not apply to the plaintiffs because the plaintiffs' contract with the school district—which contained provisions for the direct benefit of the plaintiffs—was incorporated into the school district's contract with the management company); *La Joya Independent School District v. Villarreal*, No. 13-13-00325-CV, 2014 WL 3050484, at *6 (Tex. App. July 3, 2014), review denied (June 5, 2015) (finding

the subject contract contained a provision disclaiming third-party beneficiaries; however, the third-party beneficiary disclaimer was inapplicable because the subject contract “exempt[ed] Villarreal from exclusion by specifically naming Villarreal as the owed recipient of commissions for broker services”); *Cates v. Integris Health, Inc.*, No. CIV-12-0763-F, 2013 WL 3923512, at *6 (W.D. Okla. July 29, 2013) (holding the provider agreement did not unambiguously prohibit third-party beneficiaries from enforcing its terms because the clause the plaintiffs were attempting to enforce stated expressly that it “shall be construed to be for the benefit of the Member”); *Dorr v. Sacred Heart Hospital*, 597 N.W.2d 462, 475-76 (Wis. Ct. App. 1999) (finding the third-party beneficiary disclaimer did not apply to the plaintiff because the provision the plaintiff was attempting to enforce expressly stated that it “shall be construed to be for the benefit of [the policyholders]”); *Aetna Life Insurance Company v. Huntingdon Valley Surgery Center*, No. CIV.A. 13-03101, 2015 WL 1954287, at *2 (E.D. Pa. Apr. 30, 2015) (noting the third-party beneficiary disclaimer expressly stated the insurance company was a third-party beneficiary and holding that the insurance company may not “have it both ways” by both arguing that it could enforce a contract as a third-party beneficiary but could not be sued under a related contract because it was not a party).

Unlike the cases relied upon by Beverly, there is no evidence BCBS and Grand Strand intended Beverly to be a direct—rather than incidental or consequential—beneficiary of the Institutional Agreement. There is no language in the Institutional Agreement that directly identifies Beverly as an intended beneficiary of the instrument. To the contrary, the Institutional Agreement contains an express disclaimer of third-party beneficiaries. Therefore, the authorities Beverly relies upon in support of her argument are easily distinguishable and are inapplicable to the instant case.

C. Beverly is not exempt from the third-party beneficiary disclaimer in the Institutional Agreement.

The circuit court properly found there is no “covered services” exception to the third-party beneficiary disclaimer in the Institutional Agreement. Section 16.16 of the Institutional Agreement states:

No Third Party Beneficiaries. 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.

(R. 123). While Beverly seeks to argue that the second sentence of this section is an exception to the disclaimer in the first sentence, it is not. The intent of Grand Strand and BCBS is undeniably clear from the first sentence of this provision: they did not intend for anyone to have third-party beneficiary rights under the Institutional Agreement.

The second sentence of Section 16.16—which Beverly argues creates a “Covered Services Exception”—merely serves to clarify the parties’ intent regarding the exclusion of third-party beneficiaries. The second sentence of Section 16.16 establishes that a BCBS policyholder is entitled to receive “Covered Services” from Grand Strand, and the third-party beneficiary disclaimer does not allow Grand Strand to refuse to provide a BCBS policyholder a Covered Service. Filing an insurance claim is not a Covered Service.

Generally, a contract is “interpreted according to the terms the parties have used, and the terms are to be taken and understood in their plain, ordinary, and popular sense.” *Stanley v. Atlantic Title Ins. Co.*, 377 S.C. 405, 414, 661 S.E.2d 62, 67 (2008) (citation omitted). A court may rely on dictionary definitions to ascertain the plain, ordinary and popular meaning of terms that are not defined by a contract. *See Doe v. S.C. Dep’t of Soc. Servs.*, 407 S.C. 623, 634-35, 757 S.E.2d 712, 718 (2014).

The Institutional Agreement does not define the terms “notwithstanding” or “pursuant to,” as contained in Section 16.16; therefore, the Court may rely on dictionary definitions to ascertain the plain meaning of the undefined terms and, thereby, to understand the context of the entire section.

Black’s Law Dictionary defines “Notwithstanding” as “despite” or “in spite of.” *Black’s Law Dictionary, Notwithstanding*, (10th Ed. 2014); *see also* Merriam-Webster.com. Merriam-Webster, *Notwithstanding*, n.d. Web. 28 Nov. 2016. (“without being prevented by (something)”; “in spite of what has just been said”; “although”; “nevertheless”).

Black’s Law Dictionary defines the term “pursuant to” to mean “as authorized by.” *Black’s Law Dictionary, Pursuant To*, (10th ed. 2014). Courts have also interpreted “pursuant to” to mean “as authorized by” in determining plain meaning of the phrase. *See Fruitt v. Astruë*, 604 F.3d 1217, 1220 (10th Cir. 2010) (“An on-point definition is that ‘pursuant to’ means ‘[a]s authorized by’”) (citation omitted); *Gulf Islands Leasing, Inc. v. Bombardier Capital Inc.*, No. 02 CIV. 2839 (WHP), 2006 WL 314523, at *4 (S.D.N.Y. Feb. 10, 2006) (“Black’s Law Dictionary defines the term ‘pursuant to’ to mean ‘in compliance with; in accordance with; under; as authorized by;’ or ‘in carrying out.’” (citation omitted)).

Section 2.6 of the Institutional Agreement defines “Covered Services” as

those inpatient and outpatient hospital services, supplies, equipment and/or items to be delivered by or through [Grand Strand] to Members ***that are reimbursable*** under the applicable Member Benefits contract

(emphasis added).

Thus, applying these straightforward definitions, Section 16.16 may be read as follows:

This Agreement is not intended to, and shall not be construed to, make any person or entity a third party beneficiary. [In spite of] the preceding sentence, nothing in this section shall affect

[BCBS']s rights under Article XV, or a [BCBS policyholder's] right to receive [reimbursable inpatient and outpatient hospital services] [as authorized by] the Terms of this Agreement.

Properly read and interpreted, the second sentence of Section 16.16 does not imply a BCBS policyholder is excepted from the third-party beneficiary disclaimer in the first sentence, or that she has the right to enforce the terms of the Institutional Agreement. The second sentence of Section 16.16 merely affirms a BCBS policyholder's right to receive services that are covered by their BCBS policies and authorized by the Institutional Agreement.

Additionally, as noted by the circuit court, "Covered Services" are those services that *are reimbursable* under a BCBS policy. Nothing in the Institutional Agreement indicates that BCBS reimburses for costs incurred in filing an insurance claim. Therefore, filing for insurance benefits is not a "reimbursable service," and Grand Strand does not have any obligation to file for insurance benefits on Beverly's behalf.

Accordingly, this Court should affirm the circuit court's holding and find the Institutional Agreement does not contain a "Covered Services Exception" that would allow Beverly to circumvent the Institutional Agreement's third-party beneficiary disclaimer.

II. The circuit court properly ruled that Beverly failed to state a claim for breach of fiduciary duty.

The circuit court properly dismissed Beverly's claim for breach of fiduciary duty because (1) South Carolina law does not recognize a fiduciary duty for a health care provider to file an insurance claim, (2) Beverly failed to allege she has a relevant "special relationship" with Grand Strand, (3) Beverly's alleged unilateral actions cannot create a fiduciary relationship with Grand Strand, and (4) the alleged fiduciary relationship ("medical care and treatment") was incongruent with the alleged breach of a fiduciary duty (failing to submit insurance claims).

“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.*; *Spence v. Wingate*, 395 S.C. 148, 160, 716 S.E.2d 920, 926-27 (2011).

“A fiduciary relationship exists when one imposes a special confidence in another, so that the latter, in equity and good conscience, is bound to act in good faith and with due regard to the interests of the one imposing the confidence.” *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) (citing *Hendricks v. Clemson Univ.*, 353 S.C. 449, 458, 578 S.E.2d 711, 715 (2003)).

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. The circuit court properly held South Carolina law does not recognize a fiduciary duty to file an insurance claim.

The circuit court properly held that, as a matter of law, Grand Strand does not owe Beverly a fiduciary duty to file her insurance claims.

South Carolina courts have recognized fiduciary relationships between agents and principals, attorneys and clients, beneficiaries of an estate and the administrator of the estate, partners in a partnership, officers of a corporation and shareholders of the corporation, and a doctor’s duty to maintain a patient’s confidentiality. *See Peoples Fed. Sav. & Loan Ass’n v.*

Myrtle Beach Golf & Yacht Club, 310 S.C. 132, 145-46, 425 S.E.2d 764, 773 (Ct. App. 1992) (agent and principal); *Spence v. Wingate*, 395 S.C. 148, 158, 716 S.E.2d 920, 926 (2011) (attorney and client); *Ex parte Wheeler v. Estate of Green*, 381 S.C. 548, 555, 673 S.E.2d 836, 840 (Ct. App. 2009) (beneficiaries of an estate and the administrator of the estate); *Landvest Assoc. v. Owens*, 276 S.C. 22, 274 S.E.2d 433 (1981) (partners in a partnership); *Talbot v. James*, 259 S.C. 73, 190 S.E.2d 759 (1972) (officers and directors of a corporation and shareholders); *Darby v. Furman Co.*, 334 S.C. 343, 346-47, 513 S.E.2d 848, 849 (1999) (real estate agents and clients); *McCormick v. England*, 328 S.C. 627, 643-44, 494 S.E.2d 431, 439 (Ct. App. 1997) (doctor's fiduciary duty to maintain a patient's confidentiality). However, there is no authority for the proposition that a fiduciary relationship exists between a hospital and a patient involving the hospital's duty to submit an insurance claim. *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) ("[T]his state has not found that medical negligence or malpractice will support a cause of action for breach of fiduciary duty. Nor have our courts found the failure of a doctor to offer assistance in filing a Medicare claim or other claim is a breach of fiduciary duty."); *see also Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707, 724 (E.D. Mich. 2005) (finding Michigan law does not authorize the imposition of a fiduciary duty related to a hospital's billing practices); *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 269 (3d Cir. 2008) ("It is clear however, that in general New Jersey does not find fiduciary duty in the debtor-creditor context, and, given that the cases cited by both sides relate only to the provision of care and not the payment therefor, it is unlikely that the New Jersey courts would expand a hospital's fiduciary duty to its billing practices. In the absence of a fiduciary duty, no cause of action exists for its alleged breach, and [the plaintiff's claim for breach of fiduciary duty] will therefore be dismissed.").

Beverly does not challenge the quality of the medical care she received. Rather, she complains only of Grand Strand's billing practices. Beverly attempts to stretch the logic of the fiduciary relationship that exists between a doctor and a patient to encompass a hospital's billing practices for medical services rendered. In essence, Beverly is asking the Court to impose a fiduciary duty on a creditor-debtor relationship. South Carolina law does not authorize the imposition of such a duty. See *Regions Bank v. Schmauch*, 354 S.C. 648, 671, 582 S.E.2d 432, 444 (Ct. App. 2003) ("South Carolina holds the normal relationship between a bank and its customer is one of creditor-debtor and not fiduciary in nature." (citing *Burwell v. South Carolina Nat'l Bank*, 288 S.C. 34, 40, 340 S.E.2d 786, 790 (1986))). Therefore, the circuit court properly found that South Carolina does not recognize a fiduciary duty related to a hospital's billing practices. Accordingly, this Court should affirm the circuit court's dismissal of Beverly's claim for breach of fiduciary duty.

B. The circuit court properly found Beverly does not have an applicable "special relationship" with Grand Strand and, therefore, Grand Strand does not owe Beverly a fiduciary duty to file her insurance claim.

The circuit court correctly held that Beverly's claim for breach of fiduciary duty fails because Beverly is not a third-party beneficiary to the Institutional Agreement.

In the Complaint, Beverly alleges a "special relationship" was created by her status as a third-party beneficiary of the Institutional Agreement. (R. 24). However, as explained above Beverly is not a third-party beneficiary of the Institutional Agreement and she does not have the right to enforce the Agreement. Beverly's only alleged basis for a fiduciary duty is her status as a third-party beneficiary to the Institutional Agreement. Since Beverly is not a third-party beneficiary with the right to enforce the Institutional Agreement, 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. Therefore, the circuit court properly dismissed her claim for

breach of fiduciary duty. Accordingly, this Court should affirm the circuit court's dismissal of Beverly's claim for breach of fiduciary duty on the grounds that Beverly failed to properly allege the existence of a "special relationship" between herself and Grand Strand.

C. The circuit court properly found Beverly's unilateral actions may not create a fiduciary relationship with Grand Strand.

The circuit court properly held that Beverly's claim for breach of fiduciary duty fails because the alleged duty was created by Beverly's unilateral actions.

"[A] fiduciary relationship cannot be created by the unilateral action of one party." *Moore*, 360 S.C. at 251, 599 S.E.2d at 472 (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).

Beverly 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 Grand Strand's hospital. Therefore, Beverly's claim fails as a matter of law, because these are both unilateral actions by Beverly and a fiduciary relationship cannot be created by unilateral action. See *Moore*, 360 S.C. at 251, 599 S.E.2d at 472. Accordingly, this Court should affirmed the circuit court's dismissal of Beverly's claim for breach of fiduciary duty on the grounds that a fiduciary duty may not be created by a party's unilateral action.

D. The circuit court properly dismissed Beverly's claim for breach of fiduciary duty because the alleged fiduciary relationship is incongruent with the alleged breach.

Beverly cannot assert a legitimate claim for breach of a fiduciary duty by merely alleging she placed a level of trust in Grand Strand by choosing to seek medical care and treatment at Grand Strand's hospital and then claiming a fiduciary duty was breached when Grand Strand 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 (emphasis added)). A duty relating to providing medical care and treatment is not the same as a duty to file insurance claims.

Moreover, it is clear that the "duty" Beverly asserts and the "breach" she alleges do not relate. Beverly alleges a fiduciary duty was created because she "reasonably placed a level of trust in [Grand Strand] by choosing to seek medical care and treatment from [Grand Strand] based on [Grand Strand]'s status as a preferred provider." (R. 24). However, the breach Beverly alleges is based on Grand Strand's alleged failure to submit her insurance claims. (R. 24-25). Beverly's claim for breach of fiduciary duty fails due to the inconsistency between the alleged fiduciary duty and the alleged breach. Accordingly, the Court should affirm the circuit court's dismissal of Beverly's claim for breach of fiduciary duty on the grounds the duty Beverly alleges Grand Strand owes her is not the duty that she alleges Grand Strand breached.

III. The circuit court properly ruled that Beverly failed to state a claim for unjust enrichment because Beverly is not a third-party beneficiary of the Institutional Agreement and the unjust enrichment claim is completely derivative of the Institutional Agreement claim.

Beverly's unjust enrichment claim requires her to be able to enforce the terms of the Institutional Agreement and receive medical services at the discounted rates negotiated in the

Institutional Agreement. The circuit court properly found Beverly's unjust enrichment claim fails because the Institutional Agreement's plain language bars third-parties like her from enforcing its terms and the discounted rates set forth therein.

To state a cause of action for unjust enrichment, Beverly must allege Grand Strand unjustly retained benefits or money which in justice and equity belong to her. *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, Beverly must show: (1) she conferred a non-gratuitous benefit on Grand Strand; (2) Grand Strand realized some value from the benefit; and (3) it would be inequitable for Grand Strand 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); *Inglese v. Beal*, 403 S.C. 290, 297, 742 S.E.2d 687, 691 (Ct. App. 2013).

Grand Strand provided Beverly with medical treatment and, in exchange for that treatment, billed Beverly at non-discounted rates. Beverly does not allege Grand Strand charged her more than its non-discounted rates for the medical services or for services which she did not receive and accept. Likewise, Beverly does not allege the non-discounted rates are unjust, inequitable, or excessive. It is not inequitable for Grand Strand to charge Beverly non-discounted rates, because the discounted rates she seeks to obtain are only available through the Institutional Agreement as part of the bargain between Grand Strand and BCBS. Beverly is neither a party, nor a third-party beneficiary, of the Institutional Agreement, and she does not have the right to enforce its terms. Her unjust enrichment claim is inextricably woven to her ability to enforce the Institutional Agreement's terms, because the alleged unjust benefit is derived exclusively from Beverly's alleged right to receive medical services at the discounted

rates Grand Strand and BCBS contracted for between themselves in the Institutional Agreement. Since Beverly is not capable of enforcing the Institutional Agreement and receiving the discounted rates, she did not confer a non-gratuitous benefit on Grand Strand when it billed her at the non-discounted rate. Therefore, Beverly failed to allege Grand Strand received an unjust benefit when it billed her at the non-discounted rate.

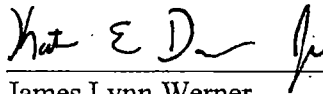
This Court's decision in *Pitts v. Jackson National Life Insurance Company*, illustrates the fallacy of Beverly's alleged unjust enrichment claim. 352 S.C. 319, 574 S.E.2d 502 (Ct. App. 2002). In *Pitts*, the plaintiff brought an unjust enrichment claim against an insurance company based upon the allegation that the insurance company failed to issue a refund to customers who qualified for a preferred policy that charged lower premiums. *Id.* at 337-38, 574 S.E.2d at 511. The court in *Pitts* found no benefit was conferred upon the insurance company that would be unjust for it to retain. *Id.* at 339, 574 S.E.2d at 512. In the instant case, Grand Strand provided Beverly medical services and, according to the Complaint, Beverly was charged the non-discounted rates in exchange for those services. Similar to the plaintiff in *Pitts*, Beverly claims Grand Strand was unjustly enriched by failing to charge a discounted rate for its services. Like the court in *Pitts*, this Court should find that Beverly's claim fails because she does not have a contractual right to receive the discounted rates from Grand Strand and the failure to charge a discounted rate that a plaintiff is not legally entitled to is an insufficient basis to sustain a claim for unjust enrichment.

Accordingly, this Court should affirm the circuit court's finding that Beverly failed to state a claim for unjust enrichment because Beverly did not confer a non-gratuitous benefit upon Grand Strand.

CONCLUSION

For the reasons set forth above, Grand Strand respectfully requests the Court affirm the circuit court's order granting Grand Strand's Motion to Dismiss.

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 Respondent
Grand Strand Regional Medical Center, LLC*

April 20, 2017
Columbia, SC

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

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SC Court of Appeals

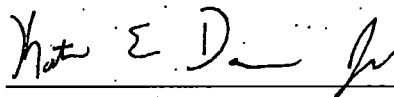
Jeanne Beverly, Individually and on behalf of others similarly situated,.....Appellant,

v.

Grand Strand Regional Medical Center, LLC Respondent.

**RESPONDENT GRAND STRAND REGIONAL MEDICAL CENTER, LLC'S
CERTIFICATE OF COUNSEL**

The undersigned hereby certifies on April 20, 2017, that the forgoing Final Brief of
Respondent complies with Rule 211(b), SCACR.



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 Respondent
Grand Strand Regional Medical Center, LLC*

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Benjamin H. Culbertson, Circuit Court Judge

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v.

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

FINAL REPLY BRIEF

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
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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REPLY ARGUMENT

Despite her pain and stress in the hours following an auto accident, Appellant Jeanne Beverly made sure to show her Blue Cross Blue Shield of South Carolina (“Blue Cross”) membership card when she arrived at Grand Strand Regional Medical Center, LLC’s (“Grand Strand”) emergency room. (R. p. 20 ¶ 15). To Ms. Beverly, her membership card had meaning. It meant her out-of-pocket costs would be limited to her co-pay and that Grand Strand, a Blue Cross “preferred provider,” would be turning to Blue Cross for payment—not her. Moreover, it meant Grand Strand agreed to provide her care for a lower rate than for non-Blue Cross members. However, in Grand Strand’s eyes Ms. Beverly’s membership card meant nothing. Grand Strand charged her directly for the full cost of her medical services. There is simply no way to reconcile Grand Strand’s conduct with the contractual duties Grand Strand accepted when it joined the Blue Cross Preferred Provider Organization (“PPO”). There is also no way to square Grand Strand’s litigation stance with the representations it made to Ms. Beverly and the following representations it continues to make to the public to this day:

- “If you are insured, a claim will be sent to your insurance company.”
- “If you have insurance or other coverage, we will expect you to pay your copayment, coinsurance and/or deductible . . .” Beyond that, Grand Strand recognizes that “the insurance company pays us.”
- Grand Strand professes a commitment to “pricing transparency.”

“About Our Pricing Commitment,” Grand Strand Health, *available at* http://grandstrandmed.com/patient-financial/?page_name=about (last visited Jan. 11, 2017); (R. p. 24 ¶¶ 41-43).

I. Ms. Beverly May Assert a Breach of Contract Claim as a Third-Party Beneficiary.

Grand Strand argues the circuit court properly dismissed Ms. Beverly’s breach of contract claim because (1) the Institutional Agreement does not directly benefit her; (2) the Institutional Agreement’s purported third-party beneficiary disclaimer is the only relevant

provision for determining its parties' intent; and (3) the disclaimer's exception does not apply to Ms. Beverly's claim. However, to assert these arguments, Grand Strand takes a myopic, revisionist perspective of the Institutional Agreement's language going so far as to at one point literally rewrite a contract provision in an attempt to support Grand Strand's position. Resp't Br. at 18-19. The actual contract language does not support Grand Strand's arguments or the circuit court's order because a plain reading of the contract language demonstrates that Grand Strand was agreeing to participate in a PPO that cannot function effectively if Grand Strand behaves toward its patients as it has toward Ms. Beverly. The Institutional Agreement also includes promises by Grand Strand that could only inure to the benefit of Blue Cross members like Ms. Beverly. While it is true Ms. Beverly is not one of the Institutional Agreement's parties, she is integral to its purpose and must be permitted to enforce the promises it makes to her.

a. The Institutional Agreement Directly Benefits Ms. Beverly.

The Court should reject Grand Strand's suggestion that Ms. Beverly's benefits from the Institutional Agreement are "ancillary" and that her financial benefits from participating in the PPO are solely derived from her insurance policy with Blue Cross. See Resp't Br. at 9-10. Grand Strand cannot deny the Institutional Agreement's foundation is a PPO expressly created "for the benefit of [Blue Cross] Members." (R. p. 104 § 1.1). Nor can it deny that, through the Institutional Agreement, Grand Strand became a participant in the PPO and contractually required to comply with the PPO's rules. (R. p. 104 § 1.2) (noting Grand Strand's desire to join PPO "to provide Covered Services under the terms of this Agreement"). Further, Grand Strand cannot deny the PPO was intended to provide financial benefits to Ms. Beverly and all other Blue Cross members. (R. p. 106 § 2.16).

Instead, Grand Strand argues Ms. Beverly's benefits from the PPO are derived only from her policy with Blue Cross with no connection to the promises Grand Strand made in the Institutional Agreement. Resp't Br. at 9-10. Grand Strand's argument is unsupported by the contract language and a reasonable understanding of the financial benefits Ms. Beverly was guaranteed to receive from the PPO. First, the Institutional Agreement imposes duties on Grand Strand that flow to the benefit of Blue Cross members *only*, including the Agreement's payment solicitation restriction. (R. p. 109 § 6.1). Grand Strand argues this section imposes on it duties directed only to Blue Cross. Resp't Br. at 10 (quoting R. p. 109 § 6.1) (stating that Grand Strand "shall seek payment . . . solely from" Blue Cross). According to Grand Strand, this language proves Section 6.1 is nothing more than a suggestion¹ that Grand Strand route patient bills through Blue Cross rather than seeking payment from patients themselves.

However, Grand Strand ignores the very next sentence. Section 6.1 not only demands Grand Strand bill Blue Cross it also expressly forbids Grand Strand from billing patients by stating "Institution will not solicit any payment from Members" This sentence demonstrates the flaw in Grand Strand's argument. If, as Grand Strand contends, Section 6.1 was merely a discussion of administrative convenience between Grand Strand and Blue Cross, then the second sentence would be superfluous. Neither of those parties is benefited by bills not being sent to

¹ On multiple occasions in this portion of its brief, Grand Strand argues Section 6.1 is permissive only and does not even impose a mandate regarding patient bills. Resp't Br. at 10 (arguing Section 6.1 "allows Grand Strand to provide medical services" and "allows Grand Strand to collect payment" from Blue Cross). This is a misrepresentation of the Institutional Agreement's language which states that Grand Strand "shall" seek payment from Blue Cross alone and "will not" seek payment from Blue Cross members. (R. p. 109 § 6.1); see also S. Atl. Fin. Servs., Inc. v. Middleton, 356 S.C. 444, 448, 590 S.E.2d 27, 30 (2003) (citing Collins v. Doe, 352 S.C. 462, 574 S.E.2d 739 (2002) (use of words such as "shall" or "must" indicates a mandatory requirement)). There is nothing permissive or discretionary about Section 6.1's provisions.

patients. That promise is made by Grand Strand directly to Blue Cross members like Ms. Beverly and it is that promise that forms the core of Ms. Beverly's contract claim.

Second, Grand Strand's attempt to segregate the Institutional Agreement from Ms. Beverly's intended PPO benefits is at odds with the practical realities of a PPO's operation. Ms. Beverly's primary PPO benefits include decreased costs of medical services and the administrative convenience of not being billed directly by medical providers. She cannot receive either benefit *unless* Grand Strand complies with the Institutional Agreement. (R. p. 109 § 6.1) (limiting payment solicitation to patient's insurer), § 6.4 (requiring Grand Strand to accept discount reimbursements). Grand Strand contends that it is "disingenuous" to assert a connection between Ms. Beverly's benefits from the PPO and the Institutional Agreement. Resp't Br. at 10. However, this case proves just how crucial that connection can be.

Ms. Beverly was forced to pay a bill she never should have received at an amount that never should have been charged only because Grand Strand ignored its duties under the Institutional Agreement. In every setting other than this litigation, Grand Strand openly acknowledges a connection between its contract with an insurer and the price of services provided to the insurer's customers. See "About Our Pricing Commitment," Grand Strand Health, available at http://grandstrandmed.com/patient-financial/?page_name=about (last visited Jan. 11, 2017) (advertising to its insured patients that "[t]he prices for your services are based on the contract terms negotiated by your insurance company with the hospital"). The PPO system malfunctioned for Ms. Beverly, and she rightly seeks compensation from the party responsible for the breakdown.

b. Ms. Beverly is an Intended Third-Party Beneficiary of the Institutional Agreement Viewed as a Whole.

Relying solely on one sentence from Section 16.16, Grand Strand argues the Institutional Agreement unambiguously excludes third-party enforcement by Blue Cross members. Resp't Br. at 8, 11. However, Grand Strand's argument fails to give effect to other portions of Section 16.16 and other Institutional Agreement provisions.

The Institutional Agreement is replete with provisions that both recognize and benefit Blue Cross members. Ms. Beverly was promised that a Blue Cross membership card (or other equivalent indications of membership status) would relieve her of any responsibility to guarantee payment for medical treatment. (R. p. 108 § 5.3). She was also promised she would not be billed even for "medically unnecessary" treatment in most instances. (R. p. 113 § 10.2). Most crucially, Ms. Beverly was directly promised that she would not be billed for any covered services. (R. p. 109 § 6.1). As such, it is not an anomaly or a surprise that the Institutional Agreement identifies Blue Cross members as the PPO's intended beneficiaries. (R. p. 104 § 1.1). The contract was based on the understanding that Grand Strand's participation in the PPO depended on how it behaved toward Blue Cross *and* how it behaved toward Blue Cross's members.

Grand Strand's argument suggests Section 16.16 is a blanket third-party beneficiary disclaimer and that a disclaimer provision is the only pertinent contract language for determining whether its parties intended to benefit third-persons. However, intent is derived from the contract's language examined as a whole. Schulmeyer v. State Farm Fire & Cas. Ins. Co., 353 S.C. 491, 495, 579 S.E.2d 132, 134 (2003). While South Carolina's courts have not addressed the effect of a purported disclaimer on a third-party beneficiary claim,² this foundational contract

² Grand Strand relies on an unpublished court of appeals ruling to suggest South Carolina has applied a disclaimer to prevent hospital patients from asserting third-party beneficiary status.

interpretation rule must guide the analysis. Consistent with this rule, several courts have allowed third-parties to enforce a contract with a disclaimer because, taken as a whole, the contract intended to provide direct third-party benefits. See e.g., Osprey-Troy Officentre L.L.C. v. World Alliance Fin. Corp., 822 F. Supp. 2d 700, 707 (E.D. Mich. 2011) (finding that purported disclaimer provision “cannot be viewed in isolation from the foregoing provisions, which paints a compelling picture of [the plaintiff] as an intended third-party beneficiary”); Versico, Inc. v. Engineered Fabrics Corp., 520 S.E.2d 505, 508-09 (Ga. App. 1999) (finding trial court’s decision to allow third-party contract enforcement despite third-party beneficiary disclaimer was proper application of contract interpretation rule requiring application of specific over general provisions).

An analysis of contract parties’ intent toward third-persons cannot begin and summarily end with a purported disclaimer provision. Determining a litigant’s status as a third-party beneficiary “is not always all or nothing.” Futurewei Techs., Inc. v. Acacia Research Corp., 737 F.3d 704, 709 (Fed. Cir. 2013) (citing Prouty v. Gores Tech. Group, 121 Cal. App. 4th 1225, 1234-35 (Cal. App. 2004)). When a contract contains a general third-party beneficiary disclaimer and separate provisions conferring benefits on a third-party, the proper interpretation of the disclaimer may be to apply it only to those portions of the contract not conferring benefits on third parties. Prouty, 121 Cal. App. 4th at 1235 (finding provision granting third person a direct

Resp’t Br. at 7 (citing Atherton v. Tenet Healthcare Corp., No. 2005-UP-362, 2005 WL 7084013, at *4 (Ct. App. May 25, 2005)). This opinion should not be considered by the Court. See Rule 268(d)(2), SCACR (stating that unpublished memorandum opinions “should not be cited except in proceedings in which they are directly involved”). Moreover, Grand Strand’s reliance on Atherton is misplaced. Atherton does not provide “clear and directly applicable guidance” in this case. Resp. Br. at 7 n. 1. There, the court of appeals considered a construction contract between a governmental entity and hospital. Atherton did not concern the relationship among a PPO insurer, provider, and insured. Unlike this case, the contract at issue in Atherton did not guarantee patients would not be billed and did not establish firm reduced payments the hospital must accept.

benefit was an “exception” to the contract’s third-party beneficiary disclaimer). A third-party beneficiary disclaimer may be some evidence on the parties’ intent but it cannot override contrary indications of intention elsewhere in the same contract. Walsh Chiropractic, Ltd. v. StrataCare, Inc., 752 F. Supp. 896, 907 (S.D. Ill. 2010) (quoting Roche v. Zenith Ins. Co., Civ. No. 07-875-MJR, 2009 WL 635503, at *4 (S.D. Ill. March 12, 2009) (finding that “the presence of [a disclaimer provision] in a contract is not dispositive of whether a third[-]party is entitled to enforce an agreement”)); Twin City Constr. Co. of Fargo, N.D. v. ITT Indus. Credit Co., 358 N.W.2d 716, 719 (Minn. App. 1984) (finding a contract intended to benefit third-party “regardless of the disclaimer”).

Courts taking a holistic view of similar hospital-insurer contracts have consistently held that insurance customers are intended third-party beneficiaries. In fact, at least two states have reached this conclusion in their review of contracts between hospitals and Blue Cross entities. Benton v. Vanderbilt University, 137 S.W.3d 614 (Tenn. 2004); Nahom v. Blue Cross & Blue Shield of Arizona, Inc., 885 P.2d 1113 (Ariz. App. 1994). Grand Strand does not offer any authority to counter Benton and Nahom, rather Grand Strand asserts baseless speculation over matters these courts did not consider. Resp’t Br. at 12-13. Grand Strand attempts to distinguish these cases by suggesting the contracts at issue in Benton and Nahom did not contain purported third-party beneficiary disclaimers equivalent to Section 16.16. Grand Strand goes on to argue that the outcome would have been different if the Tennessee and Arizona courts had been confronted with such a disclaimer. Resp’t Br. at 12-13. Notably, these arguments are presented without citation. Grand Strand has no basis for concluding either of these cases lacked a purported disclaimer and no basis for concluding a disclaimer would have altered their outcome.

Significantly, at least three cases have found hospital patients are third-party beneficiaries notwithstanding a contract provision purporting to exclude them. App. Br. at 13 (citing Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr., Civil Action No. 13-03101, 2015 WL 1954287 (E.D. Pa. Apr. 30, 2015); Cates v. Integris Health, Inc., No. CIV-12-0763-F, 2013 WL 3923512, at *6-7 (W.D. Okla. July 29, 2013); Dorr v. Sacred Heart Hospital, 597 N.W.2d 462, 475 (Wis. App. 1999)). For these cases, Grand Strand merely counters that the contractual intent to benefit third-parties was stronger than in the Institutional Agreement. Resp't Br. at 16. However, as discussed *supra*, the Institutional Agreement makes promises directly to Blue Cross members and imposes on Grand Strand duties that could inure only to their benefit. As recognized by other courts considering this issue, insurance customers are third-party beneficiaries of hospital-insurer contracts and the circuit court erred in refusing to allow Ms. Beverly to enforce the Institutional Agreement.

c. Ms. Beverly May Demand Grand Strand Provide Covered Services "Pursuant To" the Institutional Agreement's Terms.

The circuit court's finding that Ms. Beverly may not enforce the Institutional Agreement as a third-party beneficiary is inconsistent with the contract language as a whole and ignores the unambiguous language of the purported third-party beneficiary disclaimer provision. As stated in that provision, Grand Strand agreed Blue Cross members like Ms. Beverly were entitled to "receive Covered Services *pursuant to the terms of*" the Institutional Agreement. (R. p. 123 § 16.16) (emphasis added). The medical treatment Ms. Beverly received at Grand Strand was a "covered service." (R. p. 20 ¶¶ 14-17). Yet, as alleged in the Complaint, that service was not provided pursuant to the Institutional Agreement's terms. Specifically, Ms. Beverly's services were not provided pursuant to the Institutional Agreement's mandatory claim submission requirement, payment solicitation restriction, or reimbursement rate cap. (R. p. 21 ¶¶ 18, 21; R.

p. 109 §§ 6.1-6.4). Accordingly, what Ms. Beverly alleges in her Complaint is exactly the type of suit Grand Strand should have envisioned when it negotiated and entered the Institutional Agreement.

Grand Strand's brief argues the Institutional Agreement does not permit third-party claims under any circumstances, but Grand Strand misconstrues both the language of Section 16.16 and the substance of Ms. Beverly's claims. After initially purporting to disclaim third-party beneficiaries generally, Section 16.16's second sentence makes an express exception for Blue Cross members like Ms. Beverly demanding covered services pursuant to the Institutional Agreement's terms. Grand Strand argues this crucial sentence does not authorize Ms. Beverly's claims but only bars Grand Strand from refusing to treat her. Resp't Br. at 17, 19. The Court should reject this interpretation because it is both illogical and incomplete. Grand Strand need not promise by contract to provide medical treatment to emergency room patients like Ms. Beverly because mandatory treatment of emergency room patients is already guaranteed by federal law. Pursuant to the Emergency Medical Treatment and Labor Act, Grand Strand "must provide" medical treatment to "any individual [that] comes to the emergency department." 42 U.S.C. § 1395dd(a). Grand Strand asks the Court to construe Section 16.16's second sentence as a superfluous reiteration of an existing statutory duty when the logical and plain reading of this sentence is as a recognition of Blue Cross members' role in the PPO and their right to core benefits as provided in the PPO.

Grand Strand's argument also fails to account for a key portion of Section 16.16's second sentence. Blue Cross members are not just promised covered services, they are promised covered services provided "pursuant to" the Institutional Agreement's terms. Grand Strand argues the "pursuant to" clause intends only to define the parameters of the term "covered services" and

does not address Grand Strand's compliance with the contract's payment provisions. Resp't Br. at 19. In support of this argument, Grand Strand relies on the same dictionary definition for "pursuant to" that Ms. Beverly cites in her brief. Resp't Br. at 18; App. Br. at 15 n. 8 (both citing Black's Law Dictionary entry for "pursuant to"). The only difference is that Grand Strand relies on the term's secondary definition. See Black's Law Dictionary (10th ed. 2014) (defining "pursuant to" first as "in compliance with" or "in accordance with" and second as "authorized by"). Given South Carolina's policy of adopting an undefined contract term's "plain, ordinary, and popular" meaning, Grand Strand offers no explanation for why the secondary meaning of "pursuant to" should be applied here. MGC Mgmt. of Charleston, Inc. v. Kinghorn Ins. Agency, 336 S.C. 542, 549, 520 S.E.2d 820, 823 (Ct. App. 1999) (citing Fritz-Pontiac-Cadillac-Buick v. Goforth, 312 S.C. 315, 440 S.E.2d 367 (1994)). Thus, the reimagining of Section 16.16's text in Grand Strand's brief (Resp't Br. at 18-19) should be rejected as an effort to support its misguided position. Properly interpreted, the crucial sentence recognizes not only Ms. Beverly's right to receive medical services but also her right to receive those services "in compliance with" all the Institutional Agreement's terms including those related to Grand Strand's compensation and how it may be pursued.

Finally, Grand Strand contends that what Ms. Beverly challenges in her Complaint is actually unrelated to the covered services she received. Resp't Br. at 17 (arguing that filing an insurance claim is not a covered service). Grand Strand portrays Ms. Beverly's claim as an officious endeavor to enforce two other parties' insurance claim submission agreement. However, claim submission is not the core of Ms. Beverly's suit. She is suing because Grand Strand ignored its express promise not to bill her. Candidly, whether Grand Strand seeks reimbursement from Blue Cross for Ms. Beverly's emergency room visit is far less important to

Ms. Beverly than Grand Strand's illicit yet successful efforts to extract payment from her. If Grand Strand is uninterested in seeking reimbursement from Blue Cross at the agreed upon reimbursement rate, then Grand Strand is perhaps at liberty to write the debt off. But, Grand Strand has agreed it "will not solicit any payment from" Ms. Beverly (R. p. 109 § 6.1), and this case seeks primarily to vindicate that promise.

Accordingly, the Court should reverse the circuit court's finding that Ms. Beverly's claim is barred by a third-party beneficiary disclaimer provision. That provision recognizes Ms. Beverly's right to receive covered services "pursuant to" the Institutional Agreement's terms, and the Complaint alleges Grand Strand violated those terms.

II. Grand Strand Breached a Fiduciary Duty by Billing Ms. Beverly.

Ms. Beverly placed special trust in Grand Strand to function as the Blue Cross "preferred provider" Grand Strand held itself out to be, and she sustained damages when forced to pay an unwarranted bill. Grand Strand argues it was merely Ms. Beverly's creditor and owed her no fiduciary duty. Grand Strand also contends Ms. Beverly improperly constructs her claim on unilateral conduct that does not match Grand Strand's alleged breach. The first argument misunderstands the nature of the parties' relationship and the second misconstrues the Complaint's allegations.

Grand Strand argues its relationship with Ms. Beverly is akin to a creditor and debtor and, therefore, Grand Strand does not qualify as fiduciary under South Carolina law. Resp't Br. at 22 (citing Regions Bank v. Schmauch, 354 S.C. 648, 671, 582 S.E.2d 432, 444 (Ct. App. 2003)). However, the parties' relationship lacks an inherent component of the typical debtor-creditor—namely, a debt. Pursuant to the Institutional Agreement, Ms. Beverly owed Grand Strand nothing for the covered services Grand Strand provided her the hours following her auto

accident. (R. p. 109 § 6.1) (“[Grand Strand] will not solicit any payment from [BCBS] Members”). The effect of contracts like the Institutional Agreement is to eliminate any prospective debt obligation from patient to hospital for covered services. Morgan v. Saint Luke’s Hospital of Kansas City, 403 S.W.3d 115, 120 (Mo. App. 2013) (finding that a contract requiring claim submission and barring bills to patients “extinguished” the patient’s alleged debt to the hospital and precluded hospital from asserting a lien).

Moreover, South Carolina law on the scope of fiduciary relationships is not as narrow as Grand Strand suggests. South Carolina courts “broadly construe” fiduciary duties to encompass the many different situations in which one party places special trust in another. Armstrong v. Sch. Dist. 5 of Lexington & Richland Counties, 26 F. Supp. 2d 789, 797 (D.S.C. 1998). Even Regions Bank refused to draw the hard line Grand Strand suggests and instead noted there are instances where a bank takes on duties that extend the relationship with its customer beyond the typical creditor-debtor. 354 S.C. at 671, 582 S.E.2d at 444. Grand Strand’s relationship with Ms. Beverly is also quite different than those at issue in the foreign-state cases Grand Strand cites. Resp’t Br. at 21 (citing Burton v. William Beaumont Hosp., 373 F. Supp. 2d 707, 724 (E.D. Mich. 2005); DiCarlo v. St. Mary Hosp., 530 F.3d 255, 269 (3d Cir. 2008)). In both of those cases, uninsured patients alleged hospitals took advantage of their lack of insurance by charging unreasonably high prices for medical services. Burton, 373 F. Supp. 2d at 710; DiCarlo, 530 F.3d at 259. When there is no underlying insurance arrangement in place, the hospital-patient relationship is limited to creditor-debtor, and the patient may not complain about standard prices because they not are entitled to a discount. Here, however, Ms. Beverly had insurance and reasonably trusted Grand Strand to respect her status as a Blue Cross member.

This Court should also reject Grand Strand's argument that Ms. Beverly's fiduciary duty claim is pled improperly by focusing on claim submission and failing to demonstrate how Grand Strand participated in the alleged breach. First, Grand Strand is incorrect in suggesting the fiduciary duty claim alleges only that Grand Strand failed to file an insurance claim. A review of the Complaint demonstrates that Ms. Beverly alleges Grand Strand breached its fiduciary duty when it prioritized profits over its responsibilities as a Blue Cross preferred provider and billed Ms. Beverly when it had agreed not to. (R. p. 24 ¶ 46). By focusing on the improper bill rather than the unsubmitted insurance claim, Ms. Beverly's Complaint is further distinguished from Wogan v. Kunze, 366 S.C. 583, 605, 623 S.E.2d 107, 119 (Ct. App. 2005), where the court found no fiduciary duty for a physician to submit a Medicare claim that he told his patient he would not submit.

Second, Grand Strand errs in arguing the Complaint attempts to construct a fiduciary duty claim on Ms. Beverly's unilateral acts. The Complaint alleges Grand Strand performed multiple acts to create a fiduciary relationship including affirmative efforts to court Blue Cross members' business and direct representations that Grand Strand would adhere to the requirements imposed on Blue Cross preferred providers. (R. p. 24 ¶¶ 42-44). Grand Strand also overstates the unilateral conduct objection to a fiduciary duty claim. Regions Bank held only that a defendant cannot be charged with a fiduciary duty if it has no reason to believe it is the recipient of the plaintiff's trust. 354 S.C. at 671, 582 S.E.2d at 444 (finding that a fiduciary "must have actually accepted or induced the confidence placed in him"). The Complaint alleges Grand Strand induced Ms. Beverly to trust it and accepted that trust when Ms. Beverly sought treatment in Grand Strand's emergency room. (R. p. 24 ¶¶ 42-44).

Finally, Grand Strand is wrong in concluding Grand Strand's alleged fiduciary duty and its alleged violation are fatally inconsistent. Resp't Br. at 24. Ms. Beverly alleges she trusted Grand Strand would do all things required of a Blue Cross preferred provider and Grand Strand breached this duty by billing her at an undiscounted rate. (R. p. 24 ¶ 45) (alleging Ms. Beverly trusted Grand Strand would act "based on [Grand Strand's] status as a preferred provider"); (R. p. 24 ¶ 46) (alleging Grand Strand breached its duty by billing Ms. Beverly). In sum, the Complaint properly alleges all required elements for a breach of fiduciary duty, and Ms. Beverly should be allowed to proceed to discovery on this claim.

III. South Carolina Law Provides an Equitable Remedy for Grand Strand's Dishonest Conduct.

The circuit court erred in finding Ms. Beverly may not pursue an equitable claim for unjust enrichment. In support of the circuit court's order, Grand Strand argues Ms. Beverly may not seek equitable relief without standing to enforce the contract. Resp't Br. at 24-25. However, as discussed *supra*, Ms. Beverly is the Institutional Agreement's intended third-party beneficiary and may enforce its terms. Moreover, Grand Strand's argument falsely equates contract and unjust enrichment claims. Unjust enrichment is the modern designation of a quasi-contract claim. Ellis v. Smith Grading & Paving, Inc., 294 S.C. 470, 473 366 S.E.2d 12, 14 (Ct. App. 1988). Unjust enrichment sounds in equity and does not graft in any of the elements or requirements for a breach of contract claim. Instead, an unjust enrichment claim has its own distinct elements, and each is properly alleged in the Complaint. See Gignilliat v. Gignilliat, Savitz & Bettis, 385 S.C. 452, 684 S.E.2d 756 (2009) (listing elements for unjust enrichment claim). Ms. Beverly alleges she conferred a benefit on Grand Strand when she paid over \$8,000 for medical treatment. (R. pp. 21-25 ¶¶ 22, 52). Ms. Beverly alleges it is inequitable for Grand Strand to retain that benefit because it was barred from pursuing payment from Ms. Beverly. (R. p. 25 ¶ 54).

Rather than limiting its argument to the unjust enrichment elements, Grand Strand affirmatively asserts that its conduct in this case is perfectly equitable. Grand Strand concludes there was nothing unfair, dishonest, or untoward in billing Ms. Beverly. Resp. Br. at 23 ("It is not inequitable for Grand Strand to charge Beverly non-discounted rates . . ."). However, what Grand Strand has done here is an affront to equity. Equity "stands on the very foundations of right and fair dealing, and it considers and weighs conduct of men in their dealings with each other and gives that effect and meaning to their actions which common sense and justice dictate." Kelly v. McGray, 278 S.C. 88, 90, 292 S.E.2d 587, 589 (1982) (citing Gen. Motors Acceptance Corp. v. Herlong, 248 S.C. 55, 159 S.E.2d 51 (1966)). A court may "look beneath the rigid rules of the law" or even search beyond a document's language to resolve a dispute because equity's primary objective is to "seek substantial justice" and to prevent a party from profiting from its own wrongdoing. State ex rel. Daniel v. Strong, 185 S.C. 27, 192 S.E. 671, 681 (1937); Smith v. Todd, 155 S.C. 323, 152 S.E. 506, 509 (1930).

In fact, Grand Strand's scheme only works because it is dishonest. If Grand Strand candidly admitted to Blue Cross members walking through its doors that Grand Strand refuses to honor its promises to submit claims, refrain from sending bills to patients, and to accept discount reimbursements, then rational Blue Cross members would seek medical services elsewhere. What Blue Cross members receive, however, are unambiguous representations that Grand Strand is a Blue Cross "Preferred Provider" and the implicit promise that Grand Strand will act accordingly. (R. p. 24 ¶¶ 41-45). With those representations, Grand Strand attracts participants from a major private health insurance pool. Patients are unlikely to discover they have been misled until they receive a surprise bill like the one that arrived in Ms. Beverly's mailbox.

Dishonesty is not an ancillary or collateral component here. Grand Strand needs the lie at the center of this case to secure the revenue bump its scheme yields.

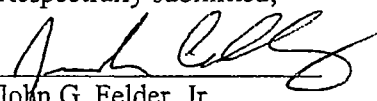
In arguing that its handling of Ms. Beverly's case was equitably sound, Grand Strand also does not explain how its conduct could possibly lead to a functioning PPO. If the Institutional Agreement allows Grand Strand to charge patients directly at non-discounted rates, then there is no reasonable basis for Ms. Beverly to "prefer" Grand Strand to other similarly competent medical providers. Grand Strand was sold to Ms. Beverly as a "preferred" provider specifically because Grand Strand promised not to do the very things it has done in this case. What's worse, Grand Strand was the one doing the selling. Grand Strand negotiated for the right to tout its preferred provider status to patients and made that representation to Ms. Beverly. (R. p. 116 § 11:2; R. p. 24 ¶¶ 42-43).

Grand Strand's conduct is all the more insidious because it is easily repeatable. The circuit court's order dismissed Ms. Beverly's claims on a Rule 12(b)(6), SCRCP motion, which challenged the legal sufficiency of her claims. In essence, the circuit court found Ms. Beverly and similarly situated Blue Cross members can have no legal or equitable qualms with a hospital that disregards the claim submission and discount reimbursement duties a hospital undertakes when joining a PPO. Should this Court affirm that order, the implications are substantial. This case would become a sword Grand Strand may use to quell any complaints Blue Cross members dare raise regarding an unwarranted bill like the one Ms. Beverly received. Nothing would stop Grand Strand from expanding this practice to patients covered by other insurers. Nothing would stop other unscrupulous hospitals from adopting a similar tactic. Ultimately, what Grand Strand seeks here is nothing less than a judicially sanctioned license to bait-and-switch its customers.

CONCLUSION

Based on the arguments stated above and those in her earlier brief, Ms. Beverly requests the Court reverse the circuit court's order dismissing Ms. Beverly's contract, fiduciary duty, and equitable claims. Grand Strand's conduct is a blatant attempt to increase its profits at the expense of all Blue Cross members like Ms. Beverly. Grand Strand should not get to reap the benefits of being a Blue Cross "preferred provider" without accepting the corresponding duties to Blue Cross members. Ms. Beverly is directly contemplated and intentionally benefitted by the Institutional Agreement, and she should be permitted to enforce it. Alternatively, Grand Strand must at the very least disgorge the proceeds of its inequitable conduct.

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 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
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

~~June~~
~~March~~ 8, 2017
Columbia, South Carolina

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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APPEAL FROM HORRY COUNTY
Court of Common Pleas

SC Court of Appeals

Benjamin H. Culbertson, Circuit Court Judge

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

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

v.

Grand Strand Regional Medical Center, LLC Respondent.

**RESPONDENT GRAND STRAND REGIONAL MEDICAL CENTER, LLC'S
PETITION FOR REHEARING**

James Lynn Werner; SC Bar No. 6029
William R. Thomas; SC Bar No. 16348
Katon E. Dawson Jr.; SC Bar No. 101167
PARKER POE ADAMS & BERNSTEIN LLP
1221 Main Street, Suite 1100
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 Respondent
Grand Strand Regional Medical Center, LLC*

INTRODUCTION

The Court erred in (1) reversing the circuit court's dismissal of Jeanne Beverly's ("Beverly") claim for breach of contract and (2) reversing the circuit court's dismissal of Beverly's claim for unjust enrichment/*quantum meruit*.

The Court erred in finding that Beverly enjoys standing as an intended third-party beneficiary to pursue a claim for breach of the contract (the "Institutional Agreement") between Grand Strand Regional Medical Center, LLC ("Grand Strand") and Blue Cross Blue Shield ("BCBS"). The Court committed multiple errors to reach this improper conclusion. First, the Court erred when it failed to find that the Institutional Agreement's third-party beneficiary disclaimer is a plain and unambiguous statement of Grand Strand and BCBS's intent that the Institutional Agreement is not enforceable by third-parties. Next, the Court erred in its interpretation and application of the second sentence of the Institutional Agreement's third-party beneficiary disclaimer because that sentence neither carves out an exception to the disclaimer of third-party beneficiaries, nor does it state an express intent of Grand Strand and BCBS for third-parties to have the right to sue to enforce the Institutional Agreement. Finally, the Court erred in elevating various incidental and consequential benefits allowed to third-parties by the Institutional Agreement to the status of intended and direct benefits necessary to provide non-signatory third-parties the right to sue to enforce the Institutional Agreement.

After concluding that Beverly has the right to pursue a claim for breach of the Institutional Agreement, the Court erred in finding that she may also continue to pursue a claim for unjust enrichment/*quantum meruit*. Although a plaintiff is permitted to pursue a claim for breach of contract and, in the alternative, a claim for unjust enrichment/*quantum meruit*; such alternative claims are not permissible when the contract between the parties is no longer in question. Once the Court found Beverly had the right to pursue an action to enforce an express contract (the

Institutional Agreement), then Beverly could no longer pursue an alternative claim for breach of a quasi-contract.

ARGUMENTS

I. The Court erred in reversing the circuit court's dismissal of Beverly's claim for breach of contract.

A. The Court improperly interpreted the plain and unambiguous language of the Institutional Agreement to find that Beverly is an intended and direct third-party beneficiary of the Institutional Agreement.

The language of the Institutional Agreement is plain and unambiguous. Grand Strand and BCBS do not intend for third-parties to enjoy legal status as third-party beneficiaries able to enforce the terms of their contract. The Court erred in ignoring this clear unambiguous declaration of the parties' intent and in interpreting the Institutional Agreement to find otherwise.

In South Carolina, it is fundamental that there is a presumption that a contract is not enforceable by a person who is not a party to the contract. *See Touchberry v. City of Florence*, 295 S.C. 47, 48-49, 367 S.E.2d 149, 150 (1988). This is true because it is well settled that the law presumes that parties contract exclusively for their own benefit. *See Ancrum v. Camden Water, Light & Ice Co.*, 82 S.C. 284, 295, 64 S.E. 151, 155 (1909). In order to overcome this presumption, the non-party may show that the parties to the contract intended the third-party to be a direct beneficiary of the contract. *Touchberry*, 295 S.C. at 48-49, 367 S.E.2d at 150. "No third-party beneficiary status is created absent an intent by the parties to confer a substantial benefit on [the plaintiff]." *Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 19, 605 S.E.2d 750, 753 (Ct. App. 2004).

The line between a direct intended third-party beneficiary of the contract and an incidental or consequential third-party beneficiary is first drawn by examining the clear intent of the actual parties to the contract. Absent an expression of clear intent of the actual contracting parties to directly benefit the third-party, that third-party is merely an incidental beneficiary with no right to

enforce the contract. See *TC X, Inc. v. Commonwealth Land Title Ins. Co.*, 928 F. Supp. 618, 623 (D.S.C. 1995), *aff'd*, 86 F.3d 1152 (4th Cir. 1996). Therefore, the necessary first step in determining whether a party is an intended direct third-beneficiary of a contract is to ascertain and give legal effect to the language of the contract on the issue of intent. *Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012) (“The cardinal rule of contract interpretation is to ascertain and give legal effect to the parties’ intentions as determined by the contract language.” (citation omitted)).

Grand Strand and BCBS did not intend for third-parties to be able to enforce the Institutional Agreement, and they said so plainly and directly. This intent is evidenced by Section 16.16 of the Institutional Agreement which expressly, definitively, and unequivocally states Grand Strand and BCBS’s intention that the contract was not to be construed to have any third-party beneficiaries:

This Agreement is not intended to be, and shall not be construed to make any person or entity a third party beneficiary.

(R. 123). However, despite observing that the actual parties to the Institutional Agreement plainly stated their intention, the Court impermissibly proceeded to ignore that direct statement of the intent of the parties and to rewrite the Agreement to create a contrary outcome.

When the parties to a contract include an express third-party beneficiary disclaimer, the Court is bound to find the parties did not intend to convey a direct benefit to third parties or to create a right for such third parties to enforce or sue upon the contract. See *Lightsey v. Toshiba Corp.*, No. 9:18-CV-190, 2019 WL 5872168, at *3 (D.S.C. Mar. 4, 2019) (applying New York law and finding that “[d]ismissal of a third-party-beneficiary claim is appropriate where the contract rules out any intent to benefit the claimant. . . .”); see also *Atherton v. Tenet Healthcare Corp.*, No. 2005-UP-362, 2005 WL 7084013, at *4 (Ct. App. May 25, 2005 (holding the contract’s

third-party disclaimer conveyed an unambiguous expression of the parties' intent to exclude third-parties from being able to enforce its terms).

Moreover, rather than accepting and enforcing the plain and unambiguous language of the contract, and its express disclaimer of third-party beneficiaries, the Court improperly chose to search for and give greater weight to other jurisdictions' interpretations of other contracts to find a basis to interpret the unspoken and contrary intent of Grand Strand and BCBS at the time the Institutional Agreement was drafted.¹ The Court's determinative step in reviewing the Institutional Agreement should have been to review its plain and unambiguous language. Review of the plain and unambiguous language must result in a finding that Grand Strand and BCBS did not express an intent to allow Beverly to enforce the contract as a third-party beneficiary. This intent was directly expressed, and the Court ignored this intention in finding otherwise. Such action by the Court is improper, and violates the undeniable legal tenets of contract interpretation in South Carolina. Accordingly, the Court should alter or amend its order and affirm the circuit court's dismissal of Beverly's breach of contract claim on the grounds that Beverly is not a third-party beneficiary with standing to pursue a claim for breach of the Institutional Agreement.

B. The Court erred in its interpretation of the Institutional Agreement by concluding that the second sentence of the Institutional Agreement's third-party beneficiary disclaimer creates an exception to the clear and unambiguous disclaimer of third-party beneficiaries.

The second sentence of the Institutional Agreement's third-party beneficiary disclaimer (Section 16.16) does not alter the direct expression of the parties' intent that there be no third-party

¹ The Court's order relies upon the Pennsylvania District Court's holding in *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Center*, Civil Action No. 13-03101, 2015 WL 1954287 (E.D. Pa. Apr. 30, 2015) which was dependent upon a finding that the institutional agreement at issue in that case was ambiguous. Such reliance by the Court is misplaced, because the circuit court in the present case held that "[t]he language of the Institutional Agreement is clear, explicit, and unambiguous" and this finding was not appealed by Beverly.

beneficiaries. The second sentence of the Institutional Agreement's third-party beneficiary disclaimer states:

Notwithstanding the preceding, nothing in this section shall affect Plan's rights under Article XV, or a Member's right to receive Covered Services pursuant to the Terms of this Agreement.

(R. 123).

The second sentence does not provide third-parties, like Beverly, the right to enforce the terms of the Institutional Agreement. This sentence simply serves to clarify that while the contracting parties' intent was to exclude third-party beneficiaries that intent does not otherwise alter the right of a BCBS policyholder to receive services that are covered by their BCBS policies. Nevertheless, the Court incorrectly construed this provision in the second sentence of Section 16.16 to utterly and totally eviscerate the third-party beneficiary exclusion of the first sentence. The Court completely read the third-party beneficiary exclusion out of the Institutional Agreement and from whole cloth created the ability to bring an action to enforce the Institutional Agreement as a direct and intended third-party beneficiary.

The Court's improper interpretation of the second sentence of Section 16.16, renders the first sentence—which unambiguously states that Grand Strand and BCBS did not intend for the Institutional Agreement to have third-party beneficiaries—moot. Such an interpretation of the contract in this manner violates a cardinal rule of contract interpretation: a court should interpret an agreement so as to give effect to all of its provisions. *See Ecclesiastes Prod. Ministries v. Outparcel Assocs., LLC*, 374 S.C. 483, 498, 649 S.E.2d 494, 502 (Ct. App. 2007). The Court must enforce a contract as written and the Court has no authority to rewrite the contract and impose unwanted obligations and terms. *Lowcountry Open Land Tr. v. Charleston Southern Univ.*, 376 S.C. 399, 656 S.E.2d 775, 781 (2008). Thus, the Court erred in finding the second sentence of Section 16.16 reestablishes an unspoken intent of the parties and permits third-parties, like

Beverly, to sue to enforce the Institutional Agreement. Accordingly, the Court should alter its prior order and affirm the circuit court's finding that the Institutional Agreement does not contain a carve out provision that would allow Beverly to circumvent the Institutional Agreement's express third-party beneficiary disclaimer.

C. The Court erroneously concluded that Beverly is a direct and intended third-party beneficiary of the Institutional Agreement.

The Court's order fails to recognize the distinction between an intended and direct benefit and incidental or consequential benefit. The primary distinguishing factor between an intended and direct benefit and incidental or consequential benefit is the intent of the contracting parties. *See Pearson v. Gardere Wynne Sewell LLP*, 814 F. Supp. 2d 592, 601 (M.D.N.C. 2011) ("A person is a direct beneficiary of the contract if the contracting parties intended to confer a legally enforceable benefit on that person. It is not enough that the contract, in fact, benefits the plaintiff, if, when the contract was made, the contracting parties did not intend it to benefit the plaintiff directly." (internal citations and quotation marks omitted)). A third-party is an intended direct beneficiary of a contract when the contract contains a clear expression of the contracting parties' intent that the contract is for the direct benefit of a third-party. *See Cothran v. Rock Hill*, 211 S.C. 17, 20, 43 S.E.2d 615, 616-17 (1947) (stating that to overcome the general presumption that parties contract exclusively for their own benefit it must appear that the contracting parties intended (contrary to the presumption) to create a direct, not incidental or consequential, benefit to the third party). All other benefits should be considered indirect, incidental, or consequential. *See United States v. Chester Heights Assocs.*, 406 F.Supp. 600, 604 (D.S.C. 1975) ("It is not sufficient to show that one is only an incidental beneficiary under such an agreement or that one benefits through the mere operation of the contract.").

The Court's order contains a conclusory statement that "the remaining twenty pages of the Agreement impose requirements on Grand Strand specifically intended to benefit Beverly and

other Members.” The Court’s order fails to identify where in those “remaining twenty pages” Grand Strand and Beverly intended to convey a direct benefit to Beverly, because such provisions are not in the Institutional Agreement. Any such benefits that are conveyed are merely incidental or consequential benefits—not intended and direct benefits. Beverly derives benefit from the Institutional Agreement by the mere operation of the contract. The incidental or consequential benefits that she derives from the operation of the contract do not make her an intended direct beneficiary of the contract. To be an intended direct beneficiary of the contract Grand Strand and BCBS needed to include a direct expression of their intent for the contract to be for the direct benefit of Beverly. Grand Strand and BCBS’s contract states the opposite, and the Court’s analysis of the Institutional Agreement fails in that it ignores the express intent of the contracting parties in favor of elevating incidental and consequential benefits to intended and direct benefits.

In *Windsor Green Owners Association, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 20, 605 S.E.2d 750, 754 (Ct. App. 2004) a condominium homeowners’ association (“Windsor”) sued to enforce a provision of the rental agreement between a tenant and the owner of the condominium that obligated the tenant to pay for damage to the property after the tenant’s son burned down the condominium and damaged the common area of the condominium complex. Windsor argued that it was a third-party beneficiary with the right to enforce the rental agreement between the condominium owner and the tenant because it was an intended and direct beneficiary of the rental agreement’s provision obligating the tenant to pay for damage to the “Property.” The circuit court found that “Property” included the common areas that were damaged by the fire. The circuit court held that Windsor was a third-party beneficiary to the contract because Windsor “is the entity which maintains and controls the ownership interests of the common elements and because [the tenant] agreed to be financially responsible for damage to the property caused by it or its guests, with the term ‘property’ encompassing the common elements.” *Windsor*, 362 S.C. at 18, 605

S.E.2d at 753 (internal quotation marks omitted). On appeal, the Court of Appeals reversed the circuit court's finding that Windsor was an intended and direct third-party beneficiary to the rental agreement. *Id.* at 20, 605 S.E.2d at 754. In analyzing the issue of whether Windsor was a third-party beneficiary with the right to enforce the rental agreement the court stated:

We do not think a rental agreement between a condominium owner and the owner's tenant by which the tenant voluntarily agreed to pay *the owner* for any property damage caused by the tenant, his family, or guests, goes so far as to make the homeowners association a third-party beneficiary of the contract, notwithstanding the fact that, by law, the tenant has the right to use the common areas. Under this rationale, a homeowners' association could directly hold a tenant contractually responsible for assessments, association dues, or any other expenses even though the parties did not intend this result by virtue of entering into a rental agreement.

Id. (emphasis in original).

The rationale applied by the court in *Windsor* is applicable to the present case. Like the agreement in *Windsor*, the Institutional Agreement provides indirect, incidental, or consequential benefits to third-parties, including Beverly. However, those indirect, incidental, or consequential benefits do not provide Beverly with the right independently to enforce the Institutional Agreement as a third-party beneficiary because the Institutional Agreement lacks a clear expression of Grand Strand and BCBS's intent to provide such rights to Beverly. Accordingly, the Court erred in finding Beverly is an intended and direct third-party beneficiary of the Institutional Agreement with standing to pursue a claim for breach of contract.

II. The Court erred in reversing the circuit court's dismissal of Beverly's claim for unjust enrichment/*quantum meruit*.

The Court's ruling that Beverly is a third-party beneficiary with the right to enforce the terms of the Institutional Agreement affirmatively determines that a contract governs the rights that Beverly is seeking to enforce. Therefore, the Court erred in concluding that Beverly may also pursue a claim for unjust enrichment/*quantum meruit*.

It is axiomatic under South Carolina law that “[i]f the tasks the plaintiff is seeking compensation for under a *quantum meruit* theory are encompassed within the terms of an express contract which has not been abandoned or rescinded, the plaintiff may not recover under *quantum meruit*.” See *Swanson v. Stratos*, 350 S.C. 116, 122, 564 S.E.2d 117, 120 (Ct. App. 2002); see also 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.”).

In its order, the Court expressly recognized that the facts upon which an alleged unjust enrichment claim might arise are the very same facts upon which the breach of contract claim was purportedly based. The Court stated that the basis of an unjust enrichment claim was that Grand Strand “is not permitted to bill a Member for its services at a higher payment rate than it contractually agreed to accept.” (emphasis added). Additionally, the Court based its conclusion that it was error to dismiss the *quantum meruit* claim on the grounds that when Grand Strand billed Beverly for covered services “it declined to bill her at the contracted for rate, and it sent her a bill in violation of its contract with BCBS.” (emphasis added). Thus, it could not be more clear that the Court seeks to allow Beverly to pursue a contract claim and an unjust enrichment/*quantum meruit* claim for exactly the same alleged conduct and damages. Furthermore, it could not be more clear that the Court recognizes that the purported foundation of the equitable claim is the terms of the express contract (a contract which the Court already declared to be applicable and enforceable).

South Carolina law does not permit both claims to proceed. A careful exposition and summary of South Carolina law on this point was even discussed in recent consolidated multidistrict litigation in, *In re General Motors LLC Ignition Switch Litigation*, 399 F.Supp3d 262, 340 (2018). In that case, the United States District Court for the Southern District of New York correctly analyzed and applied South Carolina law to find that a plaintiff is only permitted to pursue

a claim for unjust enrichment as an alternative to a claim for breach of contract “where it is uncertain whether a valid and enforceable contract exists.” *General Motors*, 399 F.Supp3d at 340. When the existence and applicability of an express contract is not in question, or has already been determined the equitable claim may not continue—even in the alternative. In reaching this conclusion, the court recognized that under South Carolina law a claim for unjust enrichment is an equitable claim and “that ‘equity will not intervene’ where a plaintiff ‘possesses an adequate remedy at law.’” *Id.* at 341 (quoting *Dema v. Tenet Physician Servs.-Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430 (2009); *Van Robinson Ins. Agency, Inc. v. Harleysville Mut. Ins. Co.*, 272 S.C. 127, 128-29, 249 S.E.2d 744 (1978)). The court noted that in South Carolina “to be adequate, a legal remedy need not guarantee success.” *Id.* (quoting *EllisDon Constr., Inc. v. Clemson Univ.*, 391 S.C. 552, 555, 707 S.E.2d 399 (2011)). Ultimately, the court held that under South Carolina law the plaintiffs had an adequate remedy at law and, therefore, the plaintiffs could not maintain a claim for unjust enrichment—even in the alternative. *Id.* at 342.

In *Charleston County School District v. Laidlaw Transit, Inc.*, 348 S.C. 420, 422-23, 559 S.E.2d 362, 363 (Ct. App. 2001), the Charleston County School District sought to recover alleged overpayments to a bus company under a transportation contract. The bus company counterclaimed under a *quantum meruit* theory for set-off and payment for extra services rendered. *Id.* at 423-24, 559 S.E.2d at 364. The circuit court dismissed the *quantum meruit* counterclaim and the court of appeals affirmed, agreeing that “there was a specific contract between the parties and they were limited to that contract.” *Id.* at 424-26, 559 S.E.2d at 364. The court explained:

By admitting the contract and its terms, . . . the parties have defined their relationship, and their rights and obligations are governed solely by the contract terms.

Id. at 425, 559 S.E.2d at 364.

Similarly, in *Swanson*, 350 S.C. at 118-21, 564 S.E.2d at 118-20, the court was asked to determine whether a forester was entitled to recover under *quantum meruit* against a property owner when the forester had an express written contract with the property owner. *Id.* at 119, 564 S.E.2d at 118. The court held that the forester was not entitled to the recover under *quantum meruit* because the work performed by the forester was within his obligations under the express contract. *Id.* at 123, 564 S.E.2d at 120. The court explained that a claim for *quantum meruit* fails in the face of an enforceable contract governing the relationship between the parties. *Id.*

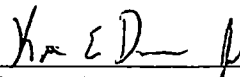
In this case, the Court resolved the question of an enforceable contract existing and applying between the litigants. Having done that, the Court may not also sanction an alternative equitable claim (unjust enrichment/*quantum meruit*) to continue as well. If left unaltered, the Court's order is in conflict with established South Carolina law, and is error. Beverly seeks to recover under a theory of unjust enrichment/*quantum meruit* despite her claim, and the Court's finding, that an express contract (the Institutional Agreement) exists which governs the rights and obligations of the parties. The Court held that Beverly is a third-party beneficiary under the Institutional Agreement and that she has the right to sue Grand Strand for breach of that express contract. Thus, following the Court's ruling on the breach of contract claim, there is no dispute as to the existence of the express contract or its application to the current dispute.

Because the Court's order validated the breach of contract claim and ends any dispute as to the existence or application of the express contract to the claims in issue, the unjust enrichment/*quantum meruit* claim must be dismissed as a matter of law. See *Charleston County School District*, 348 S.C. at 422-23, 559 S.E.2d at 363; *Swanson*, 350 S.C. at 118-21, 564 S.E.2d at 118-20. Beverly's ability to pursue the claims in the alternative only existed when the existence of the express contract, or its applicability to the claims in issue, was in dispute. See *Boldt Co. v. Thomason Elec. & Am. Contractors Indem. Co.*, 820 F. Supp. 2d 703, 707 (D.S.C. 2007); *United*

States v. Savannah River Nuclear Sols., LLC, No. 1:16-CV-00825-JMC, 2016 WL 7104823, at *26 (D.S.C. Dec. 6, 2016). When no such dispute remains, Beverly's ability to maintain even an alternative claim based on a theory of *quantum meruit* or quasi-contract ends. Moreover, Beverly's inability to maintain a claim for *quantum meruit* cannot be remedied if she elects to drop her claim for breach of contract. If the Court finds she is entitled to enforce the agreement as a direct third-party beneficiary, then her claim will always be controlled by the express terms of the Institutional Agreement. Therefore, upon the Court's finding and conclusion that Beverly is a third-party beneficiary with the right to pursue a claim for breach of an express contract, Beverly is foreclosed from pursuing an alternative claim for *quantum meruit*. Accordingly, the Court erred in finding that Beverly may continue to pursue her claim for *quantum meruit*.

CONCLUSION

Based on the foregoing, Grand Strand respectfully requests the Court alter or amend its order to find that Beverly is not an intended and direct third-party beneficiary of the Institutional Agreement and affirm the circuit court's dismissal of Beverly's breach of contract claim. Additionally, Grand Strand requests the Court alter or amend its order to affirm the circuit court's dismissal of Beverly's unjust enrichment claim on the grounds that Beverly may not continue to pursue a claim for unjust enrichment/*quantum meruit* after the Court has found that a valid and enforceable contract governs the rights and obligations Beverly is seeking to enforce.



James Lynn Werner; SC Bar-No. 6029
William R. Thomas; SC Bar No. 16348
Katon E. Dawson Jr.; SC Bar No. 101167
PARKER POE ADAMS & BERNSTEIN LLP
1221 Main Street, Suite 1100
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 Respondent
Grand Strand Regional Medical Center, LLC

February 14, 2020
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED

FEB 14 2020

APPEAL FROM HORRY COUNTY
Court of Common Pleas

SC Court of Appeals

Benjamin H. Culbertson, Circuit Court Judge

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

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

v.

Grand Strand Regional Medical Center, LLC Respondent.

PROOF OF SERVICE

The undersigned hereby certifies that on February 14, 2020, he served the foregoing **RESPONDENT GRAND STRAND REGIONAL MEDICAL CENTER, LLC's PETITION FOR REHEARING** on all parties listed below by placing a copy of it in the United States Mail, first class postage prepaid, addressed as follows:

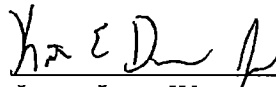
John G. Felder, Jr.
McGowan, Hood & Felder, LLC
1517 Hampton Street
Columbia, SC 29201

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

Roy Harmon
Sidney L. Major, Jr.
Harmon & Major, P.A.
PO Box 8954
Greenville, SC 29604

Jeff C. Chandler
The Chandler Law Firm
Bank of America Building
2501 Oak Street
Myrtle Beach, South Carolina 29577

Attorneys for Appellant Jeanne Beverly



James Lynn Werner; SC Bar No. 6029
William R. Thomas; SC Bar No. 16348
Katon E. Dawson Jr.; SC Bar No. 101167
PARKER POE ADAMS & BERNSTEIN LLP
1221 Main Street, Suite 1100
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 Respondent
Grand Strand Regional Medical Center, LLC

February 14, 2020
Columbia, South Carolina



Katon E. Dawson, Jr.
Associate
Telephone: 803.253.6854
Direct Fax: 803.255.8017
katondawson@parkerpoe.com

Atlanta, GA
Charleston, SC
Charlotte, NC
Columbia, SC
Greenville, SC
Raleigh, NC
Spartanburg, SC

February 14, 2020

Via Hand Delivery

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
1015 Sumter Street
Columbia, SC 29211

**Re: *Jeanne Beverly Individually and on behalf of other similarly situated v. Grand Strand Regional Medical Center, LLC*; Civil Action No. 2016-CP-26-0116
Respondent's Petition for Rehearing**

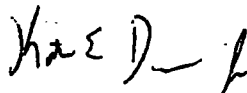
Dear Mrs. Kitchings:

Enclosed are an original and one (1) copy of Respondent Grand Strand Regional Medical Center, LLC's Petition for Rehearing and Proof of Service, and our firm check in the amount of \$50.00 in the above-referenced lawsuit. Please return a file-stamped copy of the Respondent's Petition for Rehearing and Proof of Service with my courier.

By copy of this letter, I am serving counsel for Appellant Jeanne Beverly with a copy of the Respondent's Petition for Rehearing.

Thank you for your attention to this request.

Sincerely,


Katon E. Dawson, Jr.

KED:bg
Enclosures

cc: John G. Felder, Jr.
Chad A. McGowan
Jordan C. Calloway
Roy Harmon
Sidney L. Major, Jr.
Jeff C. Chandler

RECEIVED

FEB 14 2020

SC Court of Appeals

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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 4(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

SCRPC Form 4C (03/2013)

2148
Judge Code

April 27, 2016
Date

Page 1 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

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.

[illegible]

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

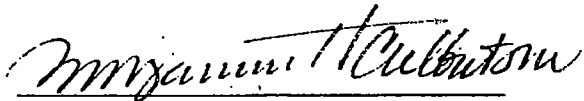
claim for unjust enrichment based on the allegation that the company failed to issue a preferred policy instead of a standard policy for his daughter, while the preferred policy would have charged lower premiums than the standard policy of equal face value. After reciting the same essential elements 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

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.

RECEIVED
JUL 19 2016
SC Court of Appeals

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 :

HORRY COUNTY
2016 JUN 29 PM 2:44
CLERK OF COURT

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

June 22, 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, 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-

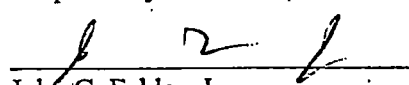
SUMMONS

RECEIVED COUNTY
2016 JAN 11 PM 2:40

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 JAN 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, SCRCPP, 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.

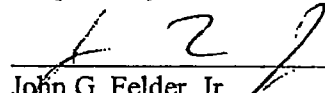
COUNT III
UNJUST ENRICHMENT

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

COUNTY OF HORRY

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

Plaintiffs,

vs.

Grand Strand Regional Medical Center, LLC,

Defendants.

IN THE COURT OF COMMON PLEAS

FIFTEENTH JUDICIAL CIRCUIT

C.A. No. 2016-CP-26-0166

MOTION TO DISMISS

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:

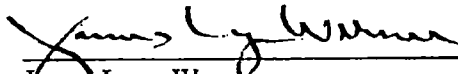
1. Plaintiff asserts a claim for breach of a contract to which she is not a party and which expressly provides that the parties thereto do not intend to make any person or entity a third-party beneficiary thereof. As a matter of law, Plaintiff's First Cause of Action for breach of contract based on a 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

COUNTY OF HORRY

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

Plaintiffs,

vs.

Grand Strand Regional Medical Center, LLC,

Defendant.

IN THE COURT OF COMMON PLEAS

FIFTEENTH JUDICIAL CIRCUIT

C.A. No. 2016-CP-26-0166

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

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), SCRCP, 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).

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-Coöper 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

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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

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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-WALKER
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), SCRCP. 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".

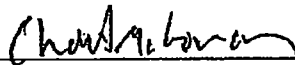
It would be unconscionable and unforeseeable by the consumer that an undisclosed, confidential provision in the agreement would foreclose suit when A hospital violates the published facts of agreement to consumers and then bills patients in excess of the rate agreed upon by member's insurance plan (BCBS). 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**

16 MAY 13 PM 2:17

Pursuant to Rule 59, SCRCF, 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.

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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.

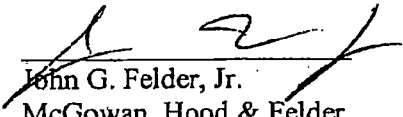
Finally, the Court should reconsider its ruling because it places the pernicious behavior alleged in the Complaint beyond any form of judicial review. If Plaintiff is unable to enforce a contract drafted with her in mind and that articulates tangible benefits for her, then no BCBSSC member has legal 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 others similarly situated,	)	C.A. No. 2016-CP-26-0166
	)	
Plaintiffs,	)	
	)	
vs.	)	DEFENDANT GRAND STRAND REGIONAL MEDICAL CENTER, LLC'S MEMORANDUM OF LAW IN OPPOSITION TO PLAINTIFF'S MOTION TO ALTER OR AMEND JUDGMENT
	)	
Grand Strand Regional Medical Center, LLC,	)	
	)	
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), SCRPC 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. Abstract 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

katedawson@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

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2
3 I, the undersigned, Grace L. Hurley, Official Court
4 Reporter for the State of South Carolina, do hereby certify
5 that the foregoing is a true, accurate and complete Transcript
6 of Record of the Hearing held in the case of Jeanne Beverly,
7 individually and on behalf of others similarly situated versus
8 Grand Strand Regional Medical Center, LLC, held in the Court
9 of Common Pleas for Horry County, Horry County Courthouse,
10 Conway, South Carolina, on April 26, 2016.

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

13
14
15
16
17 _____
18 Grace L. Hurley, CVR-CM-M
19 Official Reporter
20
21
22
23
24

25 August 4, 2016.

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SC Court of Appeals

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

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

Appellant

v.

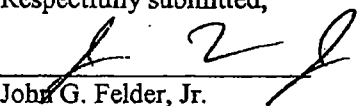
Grand Strand Regional,
Medical Center, LLC

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), SCRCF 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

RECEIVED

MAR 31 2017

SC Court of Appeals

Jeanné Beverly, Individually
and on behalf of others
similarly situated

.....

Appellant

v.

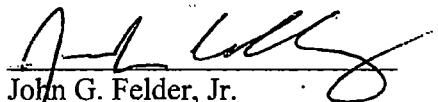
Grand Strand Regional,
Medical Center, LLC

.....

Respondent.

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

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