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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Steven H. John, Circuit Court Judge

Appellate Case No.: 2021-001342

Jessica Bennett, individually and on
behalf of those similarly situated,Respondent,

v.

ACS Primary Care Physicians-Southeast P.C.,Appellant.

APPELLANT’S MOTION TO CONSOLIDATE

Pursuant to Rule 214 SCACR, Appellant ACS Primary Care Physicians-Southeast P.C. (“ACS”) hereby requests that the Court consolidate this matter (“*Bennett*”) with another appeal currently before this Court: *Thuy N. Gasser, individual and on behalf of those similarly situated v. ACS Primary Care Physicians-Southeast P.C.*, Appellate Case No. 2021-001411 (“*Gasser*”). The Court should consolidate these appeals because the appeals involve the same legal question decided based on the same erroneous reasoning by the trial court. Furthermore, the Complaints in both matters purport to allege very similar classes, each of which includes the other named Respondent and many other overlapping members of the other class.

DISCUSSION

These two matters should be consolidated because they involve the same legal question and essentially the same parties. Rule 214 SCACR provides in relevant part that, “where the same question is involved in two or more appeals in different cases, the appellate court may, in

its discretion, order the appeal to be consolidated.” Here, both the *Bennett* and *Gasser* appeals turn on the same legal question: whether the trial court erred in finding that a non-signatory alleging breach of contract as a third party beneficiary is equitably estopped from avoiding an arbitration provision in the same contract.

First, both of these matters involve the same legal question of whether a non-signatory can be compelled to arbitration based on an arbitration clause in the contract they seek to enforce as third-party beneficiaries. In fact, the arbitration clauses in both agreements are virtually identical. In both cases, Respondents allege that they are third-party beneficiaries of a Provider Agreement between ACS and Blue Cross Blue Shield (“BCBS”). Both provider agreements contain arbitration clauses that cover these disputes, and ACS moved to compel arbitration and dismiss the claims. Judge Steven H. John denied both motions in orders that are also virtually identical.¹ In both cases, the trial court erroneously denied ACS’s motions to compel arbitration and dismiss because the court found that Respondents were unaware of and did not exploit the relevant provider agreement. (*See Bennett* Order at 4, attached hereto as Ex. A; *Gasser* Order at 4, attached hereto as Ex. B.)

Second, both matters involve the same parties. ACS is the sole Defendant in both cases. Each Respondent purports to allege claims on behalf of a class that would include the other named Respondent. As such, Respondents and putative plaintiffs overlap significantly. First, in the *Bennett* matter, Respondent purports to represent the following class:

All persons in South Carolina having an insurance policy with Blue Cross Blue Shield of South Carolina, who received services from Defendant from March 17, 2017 to May 17, 2020, where Defendant billed the persons directly at a higher price for services than the Blue Cross Blue Shield negotiated rates.

¹ There are slight differences in the fact patterns, but the differences are unrelated to the trial court’s reasoning.

(*Bennett* Compl. ¶ 43, attached hereto as Ex. C.) In *Gasser*, Respondent alleges that she is a resident of South Carolina and in December 2019, she had health insurance with BCBS when she received services from ACS, and that ACS billed her directly for more than the negotiated amount between ACS and BCBS. (*Gasser* Compl. ¶¶ 7, 13, 15, 19, 21, and 22, attached hereto as Ex. D.) Thus, the *Gasser* Respondent is included in the *Bennett* class. Similarly, Respondent in the *Bennett* matter is included in the class proposed in *Gasser*. In the *Gasser* Complaint, Respondent alleges the following class:

All persons (or estates of persons) in South Carolina or persons (or estates of persons) who have jurisdiction with a South Carolina Court under the Door Closing Statute) insured by BCBS receiving services from Defendant in any medical facility from December 9, 2016 to present for whom Defendant failed to submit the bill for medical services to BCBS and instead obtained recovery from the person.

(*Gasser* Compl. ¶ 28.) In the *Bennett* Complaint, Respondent alleges that she is a resident of South Carolina, with a health insurance policy through BCBS in December 2018, when she received services from ACS, and ACS billed her directly for sums greater than those which would have been charged to BCBS. (*Bennett* Comp. ¶¶ 6, 12, 21, 24, 25, 27, and 29.) Thus, the named Respondent in *Bennett* would also be included in the class set forth in the *Gasser* Complaint. Furthermore, the classes would overlap significantly. Accordingly, the parties are virtually the same for the purposes of this appeal and should be consolidated.

CONCLUSION

For all of these reasons as well as any set forth in any future briefing or hearing on the matter, if any, ACS respectfully requests that the Court issue an Order consolidating these matters for the remainder of the appeal.

Dated: January 12, 2022

GORDON REES SCULLY MANSUKHANI

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EXHIBIT A

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF HORRY

C/A no. 2020-CP-26-01982

Jessica Bennett, individually and on behalf of those similarly situated,

Plaintiff,

ORDER

v.

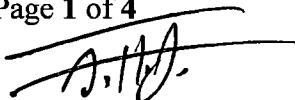
ACS Primary Care Physicians-Southeast P.C.,

Defendant.

Defendant, ACS Primary Care Physicians-Southeast P.C. (ACS), filed a Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion. The parties submitted initial briefs. The court then granted leave for the filing of supplemental briefs in lieu of a hearing. The parties submitted those briefs as well. Having fully reviewed the parties' positions, the court denies ACS's motion.

I. Introduction.

Plaintiff alleges the following facts: Plaintiff was injured in a car crash. Plaintiff alleges that she went to the emergency department at a Spartanburg hospital, staffed with ACS physicians, to receive treatment for those injuries. Plaintiff alleges that she informed ACS that she was an insured member and beneficiary under a Blue Cross Blue Shield of South Carolina (BCBS) health insurance plan. ACS, a Georgia corporation, is an in-network provider for BCBS under the terms of a preferred provider organization (PPO) agreement. Under that agreement, ACS is held out as an in-network or preferred provider for BCBS patients. The Plaintiff alleges that the agreement requires ACS to bill BCBS directly for covered medical services ACS provides to BCBS health plan



members.¹ The Plaintiff alleges that the agreement also provides that ACS will accept a discounted rate (the Fee Allowance amount) for services provided to BCBS's members.² Last, the agreement requires ACS to "[a]ccept payment of [BCBS's] Fee Allowance amount plus any Patient Pay Amounts as payment in full for Covered Services rendered to Members."³

Plaintiff alleges ACS did not bill BCBS for the services that ACS provided her, but instead billed her directly for an amount in excess of the BCBS fee allowance. Plaintiff further alleges that ACS has a common practice of identifying car crash victims and not submitting their bills to insurance in order to get a higher rate directly from the patients. As a result, plaintiff filed this action on behalf of herself and all others similarly situated.

Plaintiff alleges two causes of action. First, she alleges ACS is in breach of its agreement with BCBS to accept her health insurance benefits for services provided to her. Second, plaintiff alleges unjust enrichment and equity as a result of ACS's alleged scheme to circumvent her health insurance. After being served, ACS filed their Motion to Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion, arguing that she is not bound by the arbitration provision.

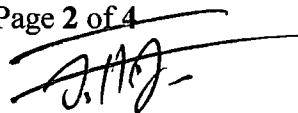
II. Legal analysis.

The PPO agreement between ACS and BCBS provides the framework for how ACS is to administer billing to BCBS's insured members. The PPO agreement between ACS and BCBS contains an arbitration agreement. It provides:

¹ See PPO agreement at p.5, § IV(A)(11) [Ex. A to plaintiff's opposition (Aug. 31, 2020)].

² *Id.* at p.4, § IV(A)(1).

³ *Id.*

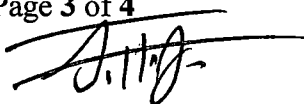


(1) Except for decisions made pursuant to the Utilization Management Program, [BCBS] and Preferred Provider [ACS] agree to meet and confer in good faith to resolve any problems or disputes that may arise under this agreement.

(2) In the event that the parties through mutual negotiation are not able to satisfactorily resolve any problem or dispute . . . [BCBS] and Preferred Provider [ACS] agree to arbitrate such problem or dispute. A single arbitrator shall conduct the arbitration (including conducting pre-hearing matters) under the then current commercial rules of the American Arbitration Association and such rules shall apply in lieu of state or federal rules of civil procedure. The American Arbitration Association shall appoint an arbitrator who is knowledgeable in the healthcare management field. The arbitration shall be held and any award shall be made in South Carolina. Subject to the terms of the Uniform Arbitration Act, the arbitrator's determination shall be final and binding upon the parties. By entering into this Agreement and selecting arbitration as a dispute resolution mechanism the parties waive any right to jury trial.⁴

Although Bennet was not a signatory to the agreement at issue, ACS argues that the mandatory arbitration agreement governs this dispute under the doctrine of equitable estoppel. Defendant claims that "a nonsignatory is estopped from refusing to comply with an arbitration clause 'when it receives a direct benefit from a contract containing an arbitration clause.'" *Pearson v. Hilton Head Hops*, 400 S.C. 281 at 290, 733 S.E. 2d 597 at 601 (Ct. App. 2012). According to Defendant, a nonsignatory seeks a direct-benefit when they assert a claim based upon the contract at issue. As a result, Defendant asserts that "because Plaintiff is relying on [the contract] as the foundation for her breach of contract claim, she is estopped from denying she is not a signatory to that agreement" *Def. Motion to Compel Arbitration and Dismiss or Stay*, at 6.

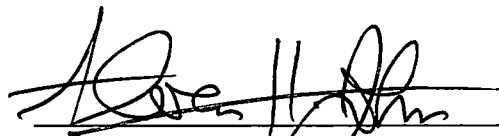
⁴ PPO agreement at p.11, § IX(M) (emphasis added).



However, South Carolina Courts have repeatedly held that "direct benefits estoppel is not implicated simply because a claim relates to or would not have arisen 'but for' a contract's existence". Weaver v. Brookdale Senior Living, 431 S.C. 223 at 231, 847 S.E. 2d 268 at 272 (Ct. App. 2020) (Citing Wilson v. Willis, 426 S.C. 326 at 343, 827 S.E.2d 167 at 176 (Supreme Court 2019)). Instead, equitable estoppel is "a theory designed to prevent injustice, and it should be used sparingly". *Id.* at 233, 274. The doctrine of equitable estoppel is reserved for instances where a beneficiary of a contract "actively exploits" the agreement or "mislead[s] [the other party] to his injury". *Id.*

In this case, the Plaintiff was completely unaware that the PPO contract existed when she received her medical treatment. Plaintiff underwent medical treatment with the understanding that she would not bear the full responsibility of paying her medical bills given her valid health insurance. Plaintiff was not aware of, nor did she actively exploit, the PPO agreement between ACS and BCBS. Therefore, Defendant's Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims is DENIED.

IT IS ORDERED.



The Honorable Steven H. John
Resident Judge
Fifteenth Judicial Circuit

Dated: 6/18/21
Conway, South Carolina.

EXHIBIT B

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF HORRY

C/A no. 2020-CP-26-03169

Thuy N. Gasser, individually and on behalf of those similarly situated,

Plaintiff,

ORDER

v.

ACS Primary Care Physicians-Southeast P.C.,

Defendant.

Defendant, ACS Primary Care Physicians-Southeast P.C. (ACS), filed a Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion. The parties submitted briefs and agreed to a ruling on the briefs without a hearing. Having fully reviewed the parties' positions, the court denies ACS's motion.

I. Introduction.

Plaintiff alleges the following facts: Plaintiff was injured in a car crash. Plaintiff went to the emergency department at Grand Strand Regional Medical Center, a hospital staffed with ACS physicians, to receive treatment for those injuries. Plaintiff alleges that she informed ACS that she was an insured member and beneficiary under a Blue Cross Blue Shield of South Carolina (BCBS) health insurance plan. ACS, a Georgia corporation, is an in-network provider for BCBS under the terms of a preferred provider organization ("PPO") agreement. Under that agreement, ACS is held out as an in-network or preferred provider for BCBS patients. The plaintiff alleges that the agreement requires ACS to bill BCBS directly for covered medical services ACS

provides to BCBS health plan members.¹ The Plaintiff alleges that the agreement also provides that ACS will accept a discounted rate (the Fee Allowance amount) for services provided to BCBS's members.² Last, the agreement requires ACS to "[a]ccept payment of [BCBS's] Fee Allowance amount plus any Patient Pay Amounts as payment in full for Covered Services rendered to Members."³

Plaintiff alleges ACS did not bill BCBS for the services that ACS provided her, but instead billed her directly for an amount in excess of the BCBS fee allowance. Plaintiff further alleges that ACS has a common practice of identifying car crash victims and not submitting their bills to insurance in order to get a higher rate directly from the patients. As a result, plaintiff filed this action on behalf of herself and all others similarly situated.

Plaintiff alleges two causes of action. First, she alleges ACS is in breach of its agreement with BCBS to accept her health insurance benefits for services provided to her. Second, plaintiff alleges unjust enrichment and equity as a result of ACS's alleged scheme to circumvent her health insurance. After being served, ACS filed their motion to Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion, arguing that she is not bound by the arbitration provision.

II. Legal Analysis.

The PPO agreement between ACS and BCBS provides the framework for how ACS is to administer billing to BCBS's insured members. The PPO agreement between ACS and BCBS contains an arbitration agreement. It provides:

¹ See PPO agreement at p.5, § IV(A)(11) [Ex. 1 to Defendant's Motion to Stay/Dismiss and Compel Arbitration of Plaintiff's claims (Aug. 31, 2020)].

² *Id.* at p.4, § IV(A)(1).

³ *Id.*

- (1) Except for decisions made pursuant to the Utilization Management Program, [BCBS] and Preferred Provider [ACS] agree to meet and confer in good faith to resolve any problems or disputes that may arise under this agreement.
- (2) In the event that the parties through mutual negotiation are not able to satisfactorily resolve any problem or dispute... [BCBS] and Preferred Provider [ACS] agree to arbitrate such problem or dispute. A single arbitrator shall conduct the arbitration (including conducting pre-hearing matters) under the then current commercial rules of the American Arbitration Association and such rules shall apply in lieu of state or federal rules of civil procedure. The American Arbitration Association shall appoint an arbitrator who is knowledgeable in the healthcare management field. The arbitration shall be held and any award shall be made in South Carolina. Subject to the terms of the Uniform Arbitration Act, the arbitrator's determination shall be final and binding upon the parties. By entering into this Agreement and selecting arbitration as a dispute resolution mechanism the parties waive any right to jury trial.⁴

Although Gasser was not a signatory to the agreement at issue, ACS argues that the mandatory arbitration agreement governs this dispute under the doctrine of equitable estoppel. ACS claims, that a “nonsignatory is estopped from refusing to comply with an arbitration clause ‘when it receives a direct benefit from a contract containing an arbitration clause.’” Pearson v. Hilton Head Hops, 400 S.C. 281 at 290, 733 S.E. 2d 597 at 601 (Ct. App. 2012). According to Defendant, a nonsignatory seeks a direct-benefit when they assert a claim based upon the contract at issue. As a result, Defendant asserts that “because Plaintiff is relying on the [contract] as the foundation for her breach of contract claim, she is estopped from denying she is not a signatory to the agreement.” *Def. Motion to Compel Arbitration and Dismiss or Stay*, at 6.

However, South Carolina Courts have repeatedly held that “direct benefits estoppel is not implicated simply because a claim relates to or would not have arisen

⁴ PPO agreement at p.10, § IX(M) (emphasis added)

'but for' a contract's existence". Weaver v. Brookdale Senior Living, 431 S.C. 223 at 231, 847 S.E. 2d 268 at 272 (Ct. App. 2020) (Citing Wilson v. Willis, 426 S.C. 326 at 343, 827 S.E. 2d 167 at 176 (Supreme Court 2019)). Instead, equitable estoppel is "a theory designed to prevent injustice, and it should be used sparingly." *Id.* at 233, 274. The doctrine of equitable estoppel is reserved for instances where a beneficiary of a contract "actively exploits" the agreement or "mislead[s] [the other party] to his injury." *Id.*

In this case, the Plaintiff was completely unaware that the PPO contract existed when she received her medical treatment. Plaintiff underwent medical treatment with the understanding that she would not bear the full responsibility of paying her medical bills given her valid health insurance. Plaintiff was not aware of, nor did she actively exploit the PPO agreement between ACS and BCBS. Therefore, Defendant's motion to Stay/Dismiss and Compel Arbitration of Plaintiff's Claims is DENIED.

IT IS ORDERED.

The Honorable Steven H. John
Resident Judge
Fifteenth Judicial Circuit

Dated: _____
Conway, South Carolina



Horry Common Pleas

Case Caption: Thuy N Gasser VS ACS Primary Care Physicians Southeast PC

Case Number: 2020CP2603169

Type: Order/Other

So Ordered

s/ Steven H. John, Resident Circuit Judge, #129

EXHIBIT C

STATE OF SOUTH CAROLINA)
)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT

Case No.: 2019-CP-26-_____

Jessica Bennett, individually and on)
behalf of all those similarly situated)

Plaintiff,)

v.)

ACS Primary Care)
Physicians-Southeast P.C.)

Defendant.)
_____)

COMPLAINT

JURY TRIAL DEMANDED

Plaintiff, Jessica Bennett, (hereinafter “Plaintiff”), individually and on behalf of all others similarly situated, files this Class Action Complaint against ACS Primary Care Physicians-Southeast P.C. (“Defendant”), and respectfully shows the following:

INTRODUCTION

1. Plaintiff and those similarly situated received healthcare services provided by Defendant, while insured through Blue Cross Blue Shield (hereinafter “BCBS”).
2. Upon information and belief, Defendant entered into a contract with BCBS to be an in-network provider (agreement referred to herein as “Provider Agreement”). Under the Provider Agreement, Defendant agreed to bill BCBS directly for services rendered to patients insured through BCBS (“Insureds”).
3. Upon information and belief, under the Provider Agreement, Defendant agreed to accept payment from BCBS at a negotiated rate for services rendered to Insureds.

4. Despite this obligation, upon information and belief, Defendant refused to bill BCBS for services rendered to Insureds. Instead, Defendant would bill Insureds directly at a rate higher than the negotiated BCBS rate, resulting in an increase in healthcare costs to Insureds.

5. Plaintiff and those similarly situated paid premiums to BCBS in order to receive certain benefits, including but not limited to, lower costs of healthcare obtained through BCBS's negotiated rates with providers. Plaintiff and those similarly situated were directly deprived of this benefit through Defendant's unlawful actions in breach of the Provider Agreement.

THE PARTIES

6. Plaintiff, Jessica Bennett, was at all times relevant a resident of Spartanburg County and insured by BCBS.

7. Defendant, ACS Primary Care Physicians-Southeast, is a professional corporation incorporated in the State of Georgia. Defendant operates throughout the State of South Carolina, with a principal place of business in Horry County, South Carolina. Defendant maintains a registered agent at 1703 Laurel Street, Columbia SC 29201.

8. As part of Defendant's business, Defendant contracts with certain hospitals throughout South Carolina to staff hospitals' emergency rooms with doctors and other staff in order to provide emergency medicine services.

JURISDICTION AND VENUE

9. This Court has jurisdiction under S.C. Const. art. V § 11, granting circuit court jurisdiction over civil actions.

10. Venue is proper as Defendant's principal place of business is Horry County.

FACTUAL ALLEGATIONS SPECIFIC TO THE NAMED PLAINTIFF

11. Plaintiff incorporates the foregoing allegations as if fully set forth herein.
12. At all times relevant hereto, Plaintiff was covered under a health insurance policy issued by BCBS through her employer.
13. Plaintiff timely paid her premiums for the coverage provided by her BCBS policy.
14. In consideration for Plaintiff's payment of premiums, Plaintiff received certain benefits under her policy, including lower costs of health care through BCBS's negotiated rates with Providers who are in BCBS's provider network.
15. Upon information and belief, at all times relevant hereto, Defendant, acting as an in-network provider, accepted insurance provided through BCBS.
16. Upon information and belief, to become an in-network provider, Defendant entered into the Provider Agreement with BCBS.
17. Upon information and belief, under the Provider Agreement, Defendant agreed to bill BCBS directly for services rendered by Defendant to a BCBS Insured, like Plaintiff.
18. Upon information and belief, under the Provider Agreement, Defendant agreed to not bill a BCBS insured directly for services rendered to a BCBS Insured, like Plaintiff.
19. Upon information and belief, under the Provider Agreement, Defendant agreed to accept a negotiated rate for services rendered to an Insured, like Plaintiff, as full payment for those services.
20. Upon information and belief, Insureds, like Plaintiff, receive direct benefits from the Provider Agreement, including but not limited to: not receiving bills directly from an in-network provider, and the costs of the services by an in-network provider being limited to BCBS's negotiated rates.

21. On December 14, 2018, Plaintiff was in a car wreck resulting in injuries to her person.

22. On December 16, 2018, Plaintiff went to the emergency room at the Mary Black Memorial Hospital, 1700 Skylyn Drive, Spartanburg SC.

23. Upon information and belief, Mary Black Memorial Hospital contracts with Defendant to provide emergency medicine services at Mary Black.

24. On December 16, 2018, Plaintiff received treatment for her injuries from medical professionals working for Defendant.

25. At the time of the treatment, Plaintiff was insured through BCBS.

26. Despite this fact, Defendant did not submit any claim to BCBS for services rendered to Plaintiff.

27. Instead, Defendant billed Plaintiff directly for her emergency room visit.

28. Defendant has charged Plaintiff \$1,050.00 for her emergency room visit.

29. Upon information and belief, this charge is significantly higher than what Defendant is required to accept from BCBS, for the type of services rendered to Plaintiff under the Provider Agreement.

30. At all times relevant hereto, Defendant had a duty to place the interests of Plaintiff above its own financial interests.

31. At all times relevant hereto, Defendant had a duty of care to accurately bill Plaintiff for the services rendered.

32. Through its bills to Plaintiff, Defendant misrepresented that it was entitled to the \$1050.00 for these services, despite Defendant's contractual obligations and duties under the Provider Agreement.

33. Upon information and belief, Defendant ignored, breached, and violated the Provider Agreement, in an attempt to increase revenue.

34. Defendant's breach of the Provider Agreement directly harmed Plaintiff.

CLASS ALLEGATIONS

35. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

36. Plaintiff brings this action on behalf of herself and other similarly situated persons who were covered by BCBS and received services from Defendant.

37. Defendant has provided services to Insureds throughout South Carolina.

38. Upon information and belief, Defendant has repeatedly refused to bill BCBS for services rendered to Insureds, in violation of the Provider Agreement.

39. At all times relevant hereto, Defendant was a fiduciary to Insureds through the provider-patient relationship. This duty and Defendant's ethical obligations required Defendant to place its patients' interests above its own financial interests.

40. Defendant's failure to consistently honor the terms of the Provider Agreement has resulted in systematic breaches and acts of bad faith by Defendant.

41. By billing Insureds directly, at a rate higher than the BCBS negotiated rate, Defendant's conduct has been, and continues to be, in violation of South Carolina law and contrary to the terms, conditions, and obligations of the Provider Agreement.

42. Defendant's actions, in violation of South Carolina law and Defendant's express contractual obligations, have directly and proximately resulted in damages to Plaintiff and other similarly situated persons.

43. Specifically, pursuant to Rule 23 of the South Carolina Rules of Civil Procedure, Plaintiff brings this action on behalf of herself and all others similarly situated, as a representative of the following class (the “Class”):

All persons in South Carolina having an insurance policy with Blue Cross Blue Shield of South Carolina, who received services from Defendant from March 17, 2017 to March 17, 2020, where Defendant billed the persons directly at a higher price for services than the Blue Cross Blue Shield negotiated rates.

44. Excluded from the Class are Defendant, the officers and directors of Defendant, members of their immediate families and their legal representatives, heirs, successors or assigns, and any entity in which Defendant has or had a controlling interest.

45. Defendant had a pecuniary interest in billing Class members directly at a rate higher than the Blue Cross Blue Shield negotiated rate.

46. Defendant’s continued and systematic breaches of the Provider agreement shows that Defendant placed its pecuniary interests over the interests of Class members. These breaches deprived Class members of the benefits conferred them through the Provider Agreement.

47. Defendant’s breaches of the Provider Agreement directly and proximately resulted in damages to Class members.

THE CLASS MEETS THE REQUIREMENTS OF SOUTH CAROLINA RULE OF CIVIL PROCEDURE 23

48. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

49. The Class is properly brought and should be maintained as a class action under Rule 23(a) of the South Carolina Rules of Civil Procedure because it satisfies the prerequisites of numerosity, commonality, typicality, and adequacy.

50. On information and belief, the members of the Class are so numerous that joinder of all members is impracticable. The exact number of Class members is unknown to Plaintiff at this time and can only be ascertained through appropriate discovery.

51. The claims of Plaintiff and the members of the Class involve common questions of law and fact, which predominate over questions affecting only individual members of the Class and which can be answered with common proof, including, *inter alia*, the following: (1) whether members were third-party beneficiaries of the Provider Agreement; (2) whether Defendant, in failing to bill BCBS directly, violated South Carolina law and/or breached the terms of the Provider Agreement; (3); whether Defendant acted in good faith in billing members directly at a higher rate than what it would receive from BCBS for the same service; and (4) whether Plaintiff and Class members are entitled to damages as a result of Defendant's breaches of its contractual obligations and acts of bad faith.

52. Plaintiff's claim is typical of those of the members of the Class because her claim has the same essential characteristics as the claims of the Class members, and their claims arise from the same course of conduct by Defendant. Plaintiff and all of the members of the Class maintain, or have maintained, health insurance coverage through BCBS. Plaintiff's action arises out of a standard form Provider Agreement that has not been followed due to the policies, practices, and procedures of Defendant that omit or conceal Defendant's obligation to bill BCBS directly and accept reimbursement at the pre-negotiated rate for services. Upon information and belief, Defendant applies these policies, practices, and procedures in a similar fashion to Plaintiff and all other Class members. Plaintiff and Class members were all direct beneficiaries of the Provider Agreement's provision requiring Defendant to bill BCBS and accept a negotiated rate for services rendered to Plaintiff and Class members. The Provider Agreement directly confers these and other

benefits to Plaintiff and Class members, and as third-party beneficiaries, Plaintiff and Class Members have standing to enforce the Provider Agreement. As to Plaintiff and all Class members, Defendant breached the Provider Agreement in a substantially similar manner, *i.e.*, by Defendant billing Class members directly for services at a higher rate, contrary to the terms of the Provider Agreement requiring Provider to bill BCBS directly and accept payment at lower negotiated rate.

53. Moreover, a class action is superior to other available methods for the fair and efficient adjudication of this controversy in that, among other factors:

(a) The interests of the Plaintiff and Class Members in individually controlling the prosecution of separate actions are outweighed by the advantages of adjudicating the common issues of fact and law by means of a class action;

(b) The expense of prosecuting Plaintiff's and Class Members' claims individually would significantly exceed any economic benefit Plaintiff or Class members could realize individually, and individual litigation would overload court dockets and magnify the delay and expense to all parties, making individual litigation of liability and damages economically impractical and infeasible;

(c) It is desirable that litigation of the claims occur for the Class in this forum to preserve the resources of both the courts and the litigants, and to reduce the risk of varying and inconsistent adjudications that could occur in individual adjudications; and

(d) Little, if any, difficulty is likely to be encountered in management of this class action because applicable law and contract terms will uniformly apply to the claims of the Class.

54. Plaintiff will fairly and adequately represent the interests of all members of the Class. Plaintiff's claims are common to all members of the Class, and Plaintiff has strong interests in vindicating their rights. Plaintiff is represented by counsel experienced in complex, class action

litigation. Neither Plaintiff nor Plaintiff's counsel has any interests adverse to, or in conflict with, any absent class member.

55. The amount in controversy for all Class members exceeds one hundred dollars.

FOR A FIRST CAUSE OF ACTION
Breach of Contract or Breach of Implied Contract

56. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

57. During the relevant class period, Plaintiff and all Class members entered into a contractual agreement with BCBS. Under this contractual agreement, Plaintiff and Class members agreed to pay monthly premiums to BCBS.

58. BCBS contracted with Defendant through the Provider Agreement. Under the Provider Agreement, Defendant agreed to certain conditions to be an in-network provider. Under this agreement and as an in-network provider, Defendant agreed to bill BCBS for services rendered to individuals insured by BCBS. Additionally, Defendant agreed to accept a lower pre-negotiated rate as full payment for the services rendered to individuals insured by BCBS.

59. During the relevant class period, Plaintiff and Class members received services from Defendant.

60. Defendant failed to bill these services to BCBS.

61. Despite the contractual terms to the contrary, Defendant billed Plaintiff and Class members directly, demanding a price higher than what it would have received from BCBS for the same services.

62. By failing to bill Blue Cross Blue Shield directly, Defendant breached its Provider Agreement with BCBS, including the covenant of good faith and fair dealing.

63. Plaintiff and members of the class are third-party beneficiaries of the breached Provider Agreement.

64. This breach allowed Defendant to receive more money that it would have been entitled to had it complied with the Provider Agreement.

65. Defendant's breaches have proximately caused Plaintiff and Class members to incur damages, which include all payments collected by Defendant from Plaintiff and/or Class members and all damages which may be shown through discovery.

66. Defendant's breaches have deprived Plaintiff and Class members of benefits they paid for through their health insurance with BCBS.

67. Plaintiff and the Class members are entitled to recover damages from Defendant for breach of contract arising from Defendant's breaches.

68. Alternatively, Plaintiff seeks specific performance and/or a declaration and an order enjoining Defendant's nonperformance to prevent irreparable harm to Plaintiff and the Class Members which requires Defendant to comply with its contractual obligations.

FOR A SECOND CAUSE OF ACTION
Unjust Enrichment

69. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

70. Plaintiff and Class Members conferred a non-gratuitous benefit by paying for health care services administered by Defendant.

71. These benefits were realized by Defendant through the billing of Class members directly at a rate for services that was higher than the agreed upon BCBS rate.

72. Defendant realized the value of payments from Class members through this improper billing.

73. Had Defendant followed the terms of the Provider Agreement, it would have received less money for these services.

74. Defendant has retained these improperly obtained benefits from the Class members, none of which has been disgorged.

75. Plaintiff and Class members are entitled, as a matter of equity, to recover the increased rates associated with the Project and other relief deemed reasonable and appropriate by the Court.

FOR A THIRD CAUSE OF ACTION

Equity

76. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

77. “Courts have the inherent power to do all things reasonably necessary to insure that just results are reached to the fullest extent possible.” *Ex Parte Dibble*, 279 S.C. 592, 595–96, 310 S.E.2d 440, 442 (Ct. App. 1983).

78. Defendant thwarted contractual obligations to take advantage of individuals coming to them for medical emergencies. In doing so, Defendant chose its financial interest over that of its patients, resulting in financial harm to Plaintiff and the Class.

79. Given the foregoing, this Court should employ its inherent equitable powers to right past wrongs and fashion a just and appropriate remedy for Plaintiffs and the Class.

JURY TRIAL DEMANDED AND PRAYER FOR RELIEF

80. **WHEREFORE**, Plaintiff demands a jury trial and pray for judgment against the Defendant and that:

- a. that summons and process issue to the Defendant as required by law;
- b. that Plaintiff, individually, recover compensatory damages for the injuries and damages she has incurred in an amount proven at trial;
- c. that the Court certify the Class requested herein and find that that Plaintiff is an appropriate representative of the Class;

- d. that the Court find that the undersigned counsel fairly and adequately represents and protects the interests of the Class, and certify the undersigned counsel to act as counsel for the Class;
- e. that judgment be entered against Defendant finding that it breached the Provider Agreement by billing Plaintiff and Class members directly;
- f. that judgement be entered against Defendant finding that it breached the Provider Agreement by requesting Plaintiff and Class members pay more than the BCBS negotiated rate for services rendered by Defendant;
- g. that judgment be entered against Defendant in such amount as will fully and adequately compensate Plaintiff and the other Class members;
- h. that the Court issue an order requiring that Defendant specifically perform its obligations under the Provider Agreement in effect and/or enjoining any non-performance by Defendant;
- i. that Plaintiff and the class be awarded the just and proper equitable relief requested;
- j. that the Court award Plaintiff and members of the Class their costs;
- k. that Plaintiff have a trial by jury with respect to her legal claims; and
- l. that the Court grant such other and further relief as it deems just and proper under the premises.

Respectfully submitted,

RICHARDSON, PATRICK, WESTBROOK
& BRICKMAN, LLC

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Dated: March 17, 2020

ATTORNEYS FOR PLAINTIFF

EXHIBIT D

STATE OF SOUTH CAROLINA)
)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
FOR THE FIFTEENTH JUDICIAL CIRCUIT

Thuy N. Gasser, individually and)
on behalf of other similarly)
situated,)

Plaintiffs,)

v.)

CLASS ACTION COMPLAINT
(Jury Trial Demanded)

ACS Primary Care Physicians -)
Southeast, P.C.,)

Defendant.)

_____)

Plaintiff Thuy N. Gasser, individually and on behalf of others similarly situated, alleges and states the following claims for relief against Defendant ACS Primary Care Physicians – Southeast, P.C.

NATURE OF THE ACTION

1. Plaintiff Thuy N. Gasser, and those similarly situated, were patients who received medical services from Defendant arising from motor vehicle accidents. At the time of treatment, Defendant refused to process or submit bills to Plaintiffs’ health insurance provider and rather required or demanded Plaintiffs to pay medical bills out of pocket.

2. Ms. Gasser and the class she seeks to represent were named "insureds" or “Members” under existing insurance policies with Blue Cross Blue Shield Insurance Company (hereinafter "BCBS").

3. Defendant is a preferred provider in the BCBS network and previously agreed, pursuant to a contract, to accept scheduled rates of payment for BCBS's insureds

or Members as a condition of being a preferred provider.

4. Ms. Gasser and the class she seeks to represent are third-party beneficiaries to the preferred provider contract between Defendant and BCBS, and therefore have a right to enforce the contract between Defendant and BCBS.

5. Defendant's decision to refuse to submit claims to BCBS 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 the contracted price previously negotiated with BCBS for BCBS's insureds and Members. Defendant's actions ignored its contractual obligations to both BCBS, Plaintiff, and other class members.

6. Defendant's conduct deprived Ms. Gasser and other class members of the benefit of their insurance coverage and premiums.

PARTIES AND JURISDICTION

7. Plaintiff Thuy N. Gasser is a citizen and resident of Myrtle Beach, South Carolina. Plaintiff was a patient of Defendant ACS Primary Care Physicians – Southeast, P.C. who, like the class members she seeks to represent, was denied the right to have her medical claims processed and submitted to her insurance carrier for payment at the agreed upon rate by Defendant.

8. Defendant ACS Primary Care Physicians-Southeast, P.C. is a professional corporation organized under the laws of the state of Georgia that provides medical services in South Carolina, maintains a registered agent in Richland County, South Carolina, and transacts significant business in South Carolina.

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 as amended.

11. Venue in this Court is proper pursuant to the Rules of the South Carolina Supreme Court and the South Carolina Code.

12. Plaintiff and all class members have suffered damages in an amount of at least \$100.

GENERAL FACTUAL ALLEGATIONS APPLICABLE TO ALL CLAIMS

13. Upon information and belief, Ms. Gasser was involved in a motor vehicle collision on December 9, 2019, in which she sustained serious injuries.

14. Ms. Gasser received treatment at Grand Strand Regional Medical Center where a physician employee of Defendant provided medical services for her injuries.

15. At the time of the collision and treatment, Ms. Gasser was covered by a health insurance policy issued by BCBS. Ms. Gasser obtained this health insurance coverage for the purpose of defraying medical expenses.

16. Ms. Gasser's insurance information was provided to Defendant at the time of her admission and treatment.

17. At all relevant times, Defendant was a preferred provider in the BCBS network.

18. As a preferred provider, Defendant agreed to accept BCBS insurance and provide services for BCBS's insureds at reduced cost.

19. Despite these contractual relationships and Ms. Gasser's presentment of her insurance coverage, Defendant and its representatives refused to submit Ms. Gasser's bills related to the vehicle collision to BCBS for payment.

20. Medical claims of motor vehicle collision victims in a hospital's emergency room represent the worst performing revenue streams for a hospital.

21. 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.

22. Defendant demanded payment in full from Ms. Gasser despite her insurance coverage.

23. Defendant claimed an amount due of \$1,622.00 for medical treatment.

24. Ms. Gasser was not aware at the time of treatment of Defendant's systematic refusal to honor its contractual obligations regarding emergency room physician bills for insured patients and did not learn of this information until a later date.

25. 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. Gasser's bills, BCBS unfairly profited from Ms. Gasser and others similarly situated.

26. Ms. Gasser is a third-party beneficiary of the agreements between Defendant and BCBS.

CLASS ACTION ALLEGATIONS

27. All above allegations are incorporated herein as if realleged and restated in full verbatim.

28. Pursuant to Rule 23, SCRPC, Plaintiff brings this action on behalf of herself and all other similarly situated persons. Plaintiff seeks 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 from Defendant in any medical facility from **December 9, 2016 to present** for whom Defendant failed to submit the bill for medical services to BCBS and instead obtained recovery from the person.

29. Upon information and belief, the class includes a substantial number of Defendant's patients and is so numerous that joinder of all members is impractical.

30. 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; and
- c. Whether Defendant's retention of money for medical expenses paid by class members is just.

31. Plaintiff's 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.

32. Plaintiff will fairly and adequately protect the interests of the other class members.

33. Plaintiff's counsel is experienced in handling class action claims. Neither Plaintiff nor Plaintiff's counsel has any interests adverse to or in conflict with the absent class members.

34. The amount in controversy for all class members exceeds one hundred dollars.

FOR A FIRST CAUSE OF ACTION
(Breach of Contract)

35. All above allegations are incorporated herein as if realleged and restated in full verbatim.

36. 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.

37. 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.

38. 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. Gasser of the benefits of the discounts and other provisions negotiated between BCBS and Defendant.

39. 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.

FOR A SECOND CAUSE OF ACTION
(Unjust Enrichment)

40. All above allegations are incorporated herein as if realleged and restated in

full verbatim.

41. 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.

42. 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.

43. 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.

44. Equity demands that Defendant be compelled to return its ill-gotten gains.

45. 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, 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.

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Attorneys for Plaintiff

Surfside Beach, South Carolina
May 21, 2020

RECEIVED

Jan 12 2022

SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Steven H. John, Circuit Court Judge

Appellate Case No.: 2021-001342

Jessica Bennett, individually and on
behalf of those similarly situated,Respondent,

v.

ACS Primary Care Physicians-Southeast P.C.,Appellant.

PROOF OF SERVICE

I certify that I have served Appellant's Motion to Consolidate on the Respondent, Jessica Bennett, individually and on behalf of those similarly situated, and Respondent Thuy Gasser, individually and on behalf of those similarly situated, via E-mail, upon their respective attorneys of record as properly addressed below this 12th day of January, 2022:

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*Attorneys for Thuy N. Gasser, individually
and on behalf of those similarly situated*

Dated: January 12, 2022

By



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January 12, 2022

VIA ELECTRONIC FILING

The Honorable Jenny Abbott Kitchings
Clerk of Court
South Carolina Court of Appeals
P.O. Box 11629
Columbia, SC 29211

RECEIVED

Jan 12 2022

SC Court of Appeals

Re: *Jessica Bennett, individually and on behalf of those similarly situated v. ACS
Primary Care Physicians-Southeast, P.C.*
Appellate Case No.: 2021-001342

*Thuy N. Gasser, individually and on behalf of those similarly situated v. ACS
Primary Care Physicians-Southeast, P.C.*
Appellate Case No.: 2021-001411

Dear Ms. Kitchings:

Please find enclosed for filing, Appellant's Motion to Consolidate with Proof of Service in regards to the above referenced matters. Please file all and forward a file-stamped copy for our records. A check to cover the requisite filing fee is being placed in the mail.

We appreciate your assistance in this matter and please do not hesitate to contact me should you need anything further.

Sincerely,

GORDON REES SCULLY MANSUKHANI, LLP



Stacey A. Smith
Paralegal

SAS:
Enclosures