STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly-situated,

Plaintiffs,

v.

Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc.,

Defendants.

C.A. No. 2017-CP-42-00219

AMENDED SUMMONS

TO THE ABOVE-NAMED DEFENDANTS:

You are hereby summoned and required to answer the Amended Class Action Complaint in this action, a copy of which is attached hereto and herewith served upon you, and to serve a copy of your answer to same upon the subscriber at 178 West Main Street, Post Office Box 3547, Spartanburg, South Carolina 29304, within thirty (30) days after the service of same, exclusive of the day of such service. If you fail to answer same within thirty (30) day period, the Plaintiff will apply to the Court for the relief demanded therein and judgment will be taken against you be default.

HARRISON WHITE, P.C.

s/John B. White, Jr.
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Spartanburg, South Carolina

April 24, 2020

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AMENDED CLASS ACTION COMPLAINT

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all persons similarly situated, by and through the undersigned counsel of record, state and allege as follows:

INTRODUCTION AND BACKGROUND

1. Plaintiffs bring this action on behalf of themselves and others similarly situated to remedy Defendants' unlawful, unfair, and predatory service and billing practices.

2. At all times relevant to this Complaint, Defendant Mary Black Health System, LLC (referred to herein as "Mary Black") was in the business of providing healthcare services and operated Mary Black Memorial Hospital in the City of Spartanburg, Spartanburg County, South Carolina.

3. As described in more detail below, at all relevant times, Mary Black subverted the financial interests of its patients for its own benefit and profit through unlawful and predatory billing practices.

4. Upon information and belief, Mary Black had a practice of screening all patients and making an initial determination regarding the reason for treatment and whether there might be third-party recovery available to pay for such treatment. Typically, this would be where the patient presented for treatment as a result of an injury from an automobile accident.

5. If Mary Black identified the patient as one whose health expenses might be eligible for third-party recovery, Mary Black refused to submit that patient's medical bills to his or her health insurance provider.

6. The reason for this is simple. Mary Black employed this business model under the belief that if it held out on submitting an accident patient's medical bills to his or her health insurance provider, then Mary Black could receive a higher reimbursement from another source, thereby increasing its profit margin.

7. While refusing to turn over medical bills to accident patients' health insurance providers, Mary Black routinely pursued payment for the medical bills from those same patients. Mary Black did so by, among other things, demanding cash payment directly from the patients, turning over the patients to collection agencies (including, but not limited to, Defendant Professional Account Services, Inc.), and by reporting patients to credit bureaus, thereby impairing patients' credit scores.

8. Mary Black pursued such course of conduct despite the patients having health insurance and being entitled to have their healthcare expenses that were incurred at Mary Black submitted to their health insurance for payment.

9. Such patients were unable to submit their medical bills directly to their health insurance as Mary Black was the entity responsible for submitting such bills. Mary Black was the entity in possession of the information required to make such submissions, and Mary Black was the entity that contracted with patients' health insurance providers for a reduced compensation for treating patients with health insurance (i.e., provider contracts).

10. By employing such a policy and business model, Mary Black unlawfully violated the rights of Plaintiffs and the class members, as described more fully below.

11. Moreover, such conduct of Mary Black and its agents was outrageous, intentional, willful, wanton, and malicious, and otherwise showed a complete indifference to or disregard for the rights of Plaintiffs and the class members such that an award of punitive damages would be appropriate to punish and deter such wrongdoing.

PARTIES, JURISDICTION, AND VENUE

12. Plaintiff Jo Ann Blackwell ("Plaintiff Blackwell"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Blackwell was injured as the result of being struck by an automobile on December 19, 2013, and Plaintiff Blackwell was a patient of Mary Black Memorial Hospital from December 27, 2013 until January 3, 2014. Plaintiff Blackwell received medical treatment at Mary Black for injuries associated with the accident.

13. Plaintiff Michelene Brooks ("Plaintiff Brooks"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Brooks was injured in an automobile collision on February 26, 2016.

Following the collision, on February 28, 2016, Plaintiff Brooks presented to Mary Black Memorial Hospital where she received medical treatment for injuries associated with the accident.

14. Plaintiff Samuel Herbert Owens, Jr. ("Plaintiff Owens"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Owens was injured in an automobile collision on October 9, 2015. Immediately following the collision, Plaintiff Owens was transported to Mary Black Health System Emergency Department via private vehicle, where he received medical treatment for injuries associated with the accident.

15. Defendant Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, is a limited liability company organized, existing, and operating under the laws of the State of South Carolina, and at all times relevant to this Complaint, Mary Black provided healthcare services for Plaintiffs and the general public at its locations in Spartanburg County, South Carolina.

16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.

17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.

18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating

to billing and liens, and all of these entities committed the acts and omissions complained of herein jointly and in concert.

19. Defendants are referred to collectively herein as Mary Black and/or Defendants.

20. This Court has jurisdiction over the parties to and the subject matter of this action, and venue in Spartanburg County is proper.

21. Plaintiffs bring this action on behalf of themselves and all other similarly-situated individuals in the State of South Carolina as a class action.

FACTUAL ALLEGATIONS

1. Defendants' policies and practices

22. Upon admission, Defendants screen all patients and make a determination regarding the reason for treatment and whether there may be sources of payment other than health insurance available.

23. On information and belief, if Defendants identify a patient as one whose medical bills may be recoverable from a source other than the patient's health insurance, Defendants refuse to submit that patient's medical bills to his or her health insurance provider.

24. Defendants engaged in these practices even though Defendants are required to submit patients' bills to their health insurance carriers, accept payment from health insurance in satisfaction of the bill, not seek payments from additional sources, and/or hold the patient harmless from any amounts owed other than co-pays and/or deductibles.

25. While refusing to submit medical bills to patients' health insurance carriers and accept payment from health insurance carriers in satisfaction of the bills, Defendants routinely seek payment for the medical bills from those same patients, either directly or indirectly.

26. For example, Defendants seek payment for medical bills by demanding cash payment directly from the patients, placing unlawful liens on patients' third-party tort claims, seeking medical payment benefits from patients' automobile insurers, turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing patients' credit scores).

27. Defendants pursue such conduct despite the patients having health insurance and being entitled to have their medical bills submitted to their health insurance for payment.

28. Upon information and belief, Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers. Defendants were likewise required to submit the medical bills of Plaintiffs and the Class Members to their health insurance.

29. Defendants are required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in full satisfaction of the patients' debts.

30. Defendants fail to inform patients at the time of treatment that they will not submit medical bills to the patients' health insurance if the circumstances create the possibility of another source of recovery.

31. Patients are unable to submit their medical bills directly to their health insurance. Defendants are the entities responsible for such submissions and are the only entities in possession of the information required to make such submissions. Further, Defendants have contracts with health insurance providers and health plans for reduced compensation for treating patients who have health insurance.

32. Through Defendants' bill collection practices, they attempt to maximize the amount they receive for services rendered by attempting to recover amounts billed from patients rather than accepting the discounted amount they agreed to accept from patients' health insurance.

33. By employing such policies and practices, Defendants have violated the rights of Plaintiffs and the Class Members as described herein.

34. Further, such conduct of Defendants and their agents, for which they are directly and indirectly responsible, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiffs and the Class Members such that punitive damages are appropriate and warranted under the circumstances.

2. Plaintiff Blackwell

35. On December 19, 2013, at approximately 8:28 a.m., Plaintiff Blackwell was walking across Daniel Morgan Avenue in Spartanburg, South Carolina, when she was struck by a vehicle. Initially, Plaintiff Blackwell was taken to the trauma department of Spartanburg Regional Medical Center, but she was transferred to Mary Black Memorial Hospital on December 27, 2013. Plaintiff Blackwell remained at Mary Black until January 3, 2014, when she was discharged.

36. At the time of her treatment, Plaintiff Blackwell had valid health insurance coverage with her health plan, which is self-insured through her employer, QS-1. Mary Black knew or should have known that Plaintiff Blackwell had valid health insurance coverage.

37. Plaintiff Blackwell's treatment at Mary Black resulted in medical charges in the amount of $33,093.65. Defendants refused to submit Plaintiff Blackwell's bills for medical services to her health insurance for payment.

38. At the time of her treatment, Defendants did not inform Plaintiff Blackwell that Defendants would not accept her health insurance, nor did they explain that they would be seeking

the balance of Plaintiff Blackwell's medical bills from her directly and/or by pursuing a third-party lien against her personal injury recovery.

39. Upon information and belief, Plaintiff Blackwell's medical bills would have been paid had they been submitted to her health insurance for payment.

40. However, instead of turning over Plaintiff Blackwell's medical bills to her health insurance provider for payment, Defendants sought collection of Plaintiff Blackwell's account by asserting liens against Plaintiff's potential third party automobile accident claim.

3. Plaintiff Brooks

41. On February 26, 2016, Plaintiff Brooks was a passenger in a vehicle that was hit by another automobile. Plaintiff Brooks presented to the emergency room at Mary Black Hospital two days later, on February 28, 2016, complaining of injuries associated with the accident.

42. At the time of her medical treatment, Plaintiff Brooks had valid health insurance coverage through Medicare. Mary Black knew or should have known that Plaintiff Brooks had valid health insurance coverage.

43. Plaintiff Brooks's treatment at the Mary Black ER resulted in medical charges totaling $9,982.44. Defendants refused to submit those bills for medical services to Plaintiff Brooks's health insurance for payment.

44. Upon information and belief, Plaintiff Brooks's medical bills would have been paid had they been submitted to her health insurance for payment.

45. However, instead of turning over Plaintiff Brooks's medical bills to her health insurance for payment, Defendants sought collection of Plaintiff Brooks's account by asserting liens against her third-party automobile accident claim.

46. On or about September 26, 2017, Defendants agreed to accept a 50% reduction on Plaintiff Brooks's account and settle for $4,991.22. Defendants agreed to this reduction only after asserting a lien against Plaintiff Brooks's third-party recovery in her personal injury case and after reviewing the settlement offer for that case.

4. Plaintiff Owens

47. On October 9, 2015, Plaintiff Owens was driving his vehicle when he was rear-ended by another automobile. Plaintiff Owens was transported to the emergency department at Mary Black Hospital via private vehicle following the accident, and he received medical treatment at Mary Black for injuries associated with the accident.

48. At the time of his medical treatment, Plaintiff Owens had valid health insurance coverage through Cigna. Mary Black knew or should have known that Plaintiff Owens had valid health insurance coverage.

49. Plaintiff Owens's treatment at the Mary Black ER resulted in medical charges totaling $9,086.75. Defendants refused to submit those bills for medical services to Plaintiff Owens's health insurance for payment.

50. Upon information and belief, Plaintiff Owens's medical bills would have been paid had they been submitted to his health insurance for payment.

51. However, instead of turning over Plaintiff Owens's medical bills to his health insurance for payment, Defendants sought collection of Plaintiff Owens's account by asserting a lien against his third-party automobile accident claim.

52. On or about October 14, 2016, Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for $4,543.38. Defendants agreed to this reduction only after

asserting a lien against Plaintiff Owens's third-party recovery in his personal injury case and after reviewing the settlement offer for that case.

CLASS ACTION ALLEGATIONS

53. This action is brought as a class action pursuant to Rule 23 of the South Carolina Rules of Civil Procedure. Plaintiffs bring this action on their own behalf and on behalf of all others similarly situated as representatives of the following Class:

> All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.

54. The particular members of the Class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of Defendants.

55. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

56. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class Members. The only material difference between the Class Members' claims is the exact monetary amount to which each member of the Class is entitled.

57. The principal common issues include, but are not limited to, the following:

a) Whether Defendants entered into express and/or implied agreements with various health insurance carriers providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;

b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;

c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;

d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;

e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;

f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;

g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;

h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;

i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and

k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

58. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories as outlined herein.

59. Plaintiff and her counsel will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel who have prosecuted numerous complex actions within the State of South Carolina and across the nation. Undersigned counsel is committed to the vigorous prosecution of this action.

60. Certification of a class is appropriate in that Plaintiff and the Class Members are seeking monetary damages, common questions predominate over any individual questions, and a class action is a superior method for the fair and efficient adjudication of this controversy. A class action will cause an orderly and expeditious administration of the claims of the Class Members. Economies of time, effort, and expense, will be promoted and uniformity of decisions will be promoted by certification of the class. Additionally, the individual Class Members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against Defendants and Defendants' vast resources.

61. Certification of a class action is likewise appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for Defendants. In addition, as a practical matter, adjudications with respect to individual members of the class would be dispositive of the interests of the other members not

parties to the adjudications or would, at the very least, substantially impair or impede their ability to protect their interests.

62. Defendants have acted or refused to act on grounds generally applicable to the Class as a whole, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole.

COUNT I
TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP

63. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

64. Plaintiffs and the Class Members had a valid business expectancy and/or contractual relationship with their own health insurance providers by virtue of an express or implied contract that Plaintiffs and each individual Class Member had with their health insurance carrier.

65. Defendants knew or should have known of the business expectancies and/or contractual relationships involving Plaintiffs, the Class Members, and their respective health insurance carriers.

66. Defendants intentionally and improperly inferred with and caused a disruption of the business expectancies and/or contractual relationships of Plaintiffs and the Class Members by preventing them from receiving the benefit of their relationships with their respective health insurance carriers. Defendants did so without justification or privilege in a malicious attempt to obtain additional monies to which Defendants were not entitled and with reckless disregard for the damage and harm such action would have on Plaintiffs and the Class Members.

67. Defendants' actions resulted in Plaintiffs and the Class Members having paid premiums but receiving no or little benefit. Defendants' actions thus proximately caused Plaintiffs and the Class Members damages.

68. Plaintiffs and the Class Members are entitled to compensatory damages, punitive damages, and interest in amounts to be determined at trial.

COUNT II
UNJUST ENRICHMENT

69. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

70. As alleged above, Defendants have engaged in a pattern of subverting the financial interests and contractual agreements of Plaintiffs and the Class Members—patients of Defendants' hospitals—for their own pecuniary gain.

71. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled and which they received in violation of South Carolina law.

72. Said benefits were conferred on Defendants by Plaintiffs and the Class Members and were unlawfully obtained to the detriment of Plaintiffs and the Class Members.

73. It would be unjust for Defendants to retain these funds because payment for the services provided should have come from the health insurance carriers of Plaintiffs and the Class Members, with the amount to be paid for services provided determined by the contracts between Defendants and patients' health insurance carriers.

74. Allowing Defendants to retain these benefits would violate fundamental principles of justice, equity, and good conscience.

COUNT III
INJUNCTIVE RELIEF

75. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

76. On information and belief, Defendants were required to submit the medical bills of Plaintiffs and the proposed Class Members directly to their health insurance for payment.

77. On information and belief, Defendants were also required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in satisfaction of the patients' bills.

78. Nevertheless, on information and belief, Defendants failed to honor contractually agreed-upon discounts regarding Plaintiffs' medical bills and those of the proposed Class Members. Defendants likewise failed to honor their contractual commitment to submit the medical bills of insured patients to those patients' insurance.

79. Defendants are, on information and belief, precluded from seeking payment for covered services from other sources, including from the patient directly, medical payment benefits from the patient's auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

80. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than they are entitled to for the covered treatment), rather than accepting the discounted amount they have agreed to accept from the patient's health insurance carrier.

81. By employing such a policy and business model, Defendants are violating the terms of their health insurance provider agreements and have unlawfully violated the rights of Plaintiffs and the Class Members.

82. A real and subsisting controversy exists between the parties hereto concerning the validity of Defendants' policies and procedures.

83. Plaintiff requests that this Court declare that Defendants, through their actions, policies, procedures, and misconduct as alleged herein, have violated the terms of their agreements with the various health insurance providers and said policies and procedures should be declared invalid and void as a matter of law. Further, this Court should enter a permanent injunction enjoining Defendants from engaging in their unlawful billing practices as described herein and for such other and further relief as the Court deems just and proper under the circumstances.

JURY DEMAND

84. Plaintiffs, on behalf of themselves and the Class Members, demands a jury trial on all issues so triable.

PRAYER FOR RELIEF

Wherefore, Plaintiffs, on behalf of themselves and all Class Members, respectfully pray for judgment against the Defendants as follows:

(a) For an Order pursuant to S.C.R.C.P. 23 certifying that this action may be maintained as a class action and appointing Plaintiffs and their counsel to represent the class;

(b) For a declaration that Defendants' actions violated the rights of Plaintiffs and the Class Members under South Carolina law;

(c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of the rights of Plaintiffs and the Class Members under South Carolina law;

(d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order requiring Defendants to disgorge any unlawfully gained proceeds;

(e) For pre-judgment interest as provided by law;

(f) For post-judgment interest as provided by law;

(g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;

(h) For an award to Plaintiffs and the Class Members of their reasonable attorneys' fees;

(i) For an award to Plaintiffs and the Class Members of their costs and expenses of this action; and

(j) For such other and further relief as this Court may deem necessary and proper.

Signature Page Follows

Respectfully submitted,

s/John B. White, Jr.

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