IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE

Sean P. Smith,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	
TENNESSEE DEPARTMENT OF FINANCE & ADMINISTRATION, DIVISION OF TENNCARE; and	)	**Case No. 24-0074-I**
	)	
STEPHEN SMITH, DIRECTOR OF TENNCARE, in his official capacity,	)	
	)	
Respondents.	)	

AMENDED COMPLAINT AND PETITION FOR JUDICIAL REVIEW

INTRODUCTION

1. Plaintiff, Sean P. Smith is a 37 year old medically disabled adult male, filing Pro Se this Complaint and Petition for Judicial Review about a letter that served as both a complaint and a medical appeal (complaint-appeal) that he mailed on November 18th 2023 to his health insurance plans and many of their contracted partners, of which UnitedHealthcare Community Plan and TennCare are listed as secondary insurance, as well as a copy mailed directly to respondent Stephen Smith at his TennCare office address. A letter sent by TennCare Member Medical Appeals [Exhibit A] dated November 30th 2023 denied Mr. Smith's complaint-appeal.

2. My childhood development was substantially disrupted by my health issues, and I have been disabled my entire adult life. I have multiple health conditions diagnosed by doctors which are causing my medical disability and impairing my activities of daily living. My existing diagnoses include but are not limited to: Obstructive Sleep Apnea, Temporomandibular Disorder, Musculoskeletal Dysfunction, Lumbar Foraminal Stenosis, Cervical Degeneration, Chronic Pain, Dysautonomia, Mast Cell Activation Syndrome, ADHD, Major Depression, Bipolar type II. My health issues extend beyond these diagnoses some of which are not evaluated or diagnosed, examples of which include but are not limited to:

a) History of head trauma (May 2014) and cranial nerve injury (2018) causing severe neurological dysregulation.
b) Lab work from 2020-2021 indicating Multiple Metal Toxicities (Cu, Ni, Pd, Br, Tl). My doctors have been unable to provide further evaluation or suggest a treatment plan; a specialist is required. Memphis and Nashville have no practicing toxicologists. I located an MD internist in Nashville who specializes in metal toxicity but he is in private practice and out of network with health plans, which prevents me from being his patient.
c) A History of Nutritional Deficiencies: B1, B12, Mg, D3 via 2020-2021 labs; Betaine/Choline supplementation observed to provide significant symptomatic. Cause of developing nutritional deficiencies/insufficiencies undefined.
d) A History of chronic mold exposure. Point of exposure (~2012-2020) and overt symptoms identified but no medical workup; diagnosis and treatment requires specialist. Testing via online purchasable diagnostics available, but cost is prohibitive.
e) the right side of my face/mouth/head goes numb due to undefined jaw-head-neck issues.
f) I have paresthesia in my hands and feet that changes in severity. I experience ataxia in my hands regularly and periodically in my legs.
g) Sometimes I fall to the ground and my legs and arms don't work very well for a minute or two.
h) When I discontinue taking nutritional supplements I develop neurological, psychiatric, digestive issues, and my MCAS flares up; I experience unwanted weight loss, increased pain, decreased sleep quality, and have relapse symptoms of nutritional deficiency, for reasons as yet not fully understood or explained.
i) Since ~2020 I have experienced episodes of mild to severe peripheral edema in my legs and hands often coinciding with lab work abnormalities that can be indicative of acute kidney injury, which seem to occur more often when I stop taking nutritional supplements, but still occur even while taking them. Occurs for reasons not yet fully understood.
j) Since 2020 I would occasionally have instances of my nose, eyes, ears, lips, and joints (shoulders, elbows, knees, ankles) all over my body turning bright red after taking nutritional supplements in the morning.

k) I have many other health issues/complaints; my doctors and I are overwhelmed. We have been unable to list and document them in their entirety, let alone attend to them.

The impact my health issues have on me extend beyond what my diagnoses would immediately suggest, and dispose me to suffer injuries that increase the length of my list of complaints and the severity of my disability.

3. My situation is complex. Understanding my health conditions requires specialized knowledge few physicians have. Even fewer possess the expertise needed to provide assistance. There is help for people like me, but the misconduct of my health plans is limiting or preventing access to care with educated specialists possessing the necessary expertise. I have been unable to find a means by which to cause my health plans to cease in their misconduct so that I may then be afforded the opportunity to receive treatment that can resolve my medical disability such that I am no longer "alienated from "Life, Liberty, and the pursuit of happiness" by fully treatable, even curable, health conditions." [Exhibit B, Sean Smith's November 2023 Complaint-Appeal, pg 65].

JURISDICTION

4. This Court has the authority to review a Final Administrative Order made by the Tennessee Department of Finance and Administration. Tenn. Code Ann. § 4-5-322.

PARTIES

Plaintiff

5. Sean Smith is a medically disabled adult resident of Bartlett, Tennessee, filing this Pro Se petition for judicial review of TennCare's November 30th 2023 denial of his complaint-appeal dated November 18th 2023.

Defendant

6. Respondent Division of TennCare is a division of the Tennessee Department of Finance and Administration, which administers Tennessee's medicaid program, known as TennCare.

7. Respondent Stephen Smith is the Assistant Commissioner of the Tennessee Department of Finance and Administration and Director of the Division of TennCare. He is responsible for managing the Division of TennCare.

STATEMENT OF FACTS

8. Mr. Sean Smith's complaint-appeal dated Nov 18th 2023 and titled "An Example of Misconduct Committed by Plan Fiduciaries & An Appeal for Rehabilitative Treatment", was mailed via USPS priority mail with signature as a physical hard copy and as a digital file on a USB drive which also contained in total 93 digital files of references and supporting documentation [Exhibit B], and was delivered to UnitedHealthcare Community Plan Appeals & Grievances and TennCare Solutions on Nov 20th 2023. A cover sheet with a USB containing digital copies of the complaint-appeal and reference documents was mailed via USPS priority mail with signature to the UnitedHealthcare Executive Office, the UnitedHealthcare Legal Department, and TennCare Deputy Director Stephen Smith.

9. TennCare sent Mr. Smith a letter dated Nov 30th denying his complaint-appeal [Exhibit A]. TennCare's denial asserts that Mr. Smith's Nov 18th complaint-appeal was about a request for Outpatient Physical Therapy, and that Mr. Smith does not get to have a fair hearing because there was a 60 day time limit to file an appeal about the request for Outpatient Physical Therapy. In his Nov 2023 complaint-appeal *Mr. Smith did not state he was appealing a denied request for Outpatient Physical Therapy*.

10. In Mr. Smith's complaint-appeal he communicates that his health plans are engaged in misconduct that prevents him from seeing the specialists required for him to receive rehabilitative treatment for the health conditions causing his medical disabilities. And as a result, Mr. Smith has suffered numerous and significant injuries and his disabilities have become increasingly severe and impairing.

11. Mr. Smith communicates having had to endure tremendous hardship due to the misconduct and dysfunction of his health plans, at times being placed in imminent danger, and that his health and safety has been and remains compromised as a result.

12. In his Nov 2023 complaint-appeal, Mr. Smith requested (1) that he be afforded the resources and opportunity to undergo rehabilitative treatment for the health conditions causing his medical disabilities; (2) that the health plans cease their misconduct and provide full and fair review to himself and other plan beneficiaries; (3) that his health plans uphold their fiduciary duty and take action to reform their organizations and remediate the damages their misconduct has caused; (4) that the health plans enter into good faith formal discussions to seek a resolution to this dispute. [Exhibit B, Sean Smith's 2023 complaint-appeal pg 5, 7-8].

13. In his November 2023 complaint-appeal Mr. Smith presented Examples of Misconduct committed by his health plans. Those examples included evidence to substantiate his allegations of health plan misconduct and other forms of abuse, neglect, and exploitation

that have caused harm to Mr. Smith. The information related to past disputes about physical therapy was presented as Evidence of health plan misconduct.

14. The evidence Mr. Smith presents in his Nov 2023 complaint-appeal focuses on the misconduct perpetrated by his primary health insurance plan's third party administrator, Cigna Healthcare. The instances of misconduct committed by UnitedHealthcare and TennCare which he encountered and documented are described in lesser detail. Mr. Smith explained that his unmet medical needs cause him substantial impairment and it would be an undue hardship to provide in his complaint-appeal examples of misconduct committed by TennCare and UnitedHealthcare with the same level of detail as those examples of misconduct committed by Cigna Healthcare. *However;*

14a. Mr. Smith has on numerous occasions since the year 2018, both verbally and in writing, filed complaints, grievances, and appeals regarding misconduct committed by UnitedHealthcare and TennCare, and as he communicated in his 2023 complaint-appeal, Mr. Smith observes that he has not received full and fair review of those complaints, grievances, and appeals.

14b. Mr. Smith retains call recordings and other records which he can submit to the Chancellor of the Davidson County Chancery Court for review in order to substantiate his allegations that he did make multiple reports and complaints to UnitedHealthcare Community Plan and TennCare that health plan misconduct was occurring and harming Mr. Smith.

14c. Mr. Smith disclosed in his Nov 2023 complaint-appeal that there are numerous instances of misconduct that he has documented and those presented in the complaint-appeal are merely examples. At no time did Mr. Smith declare that he was presenting these examples of misconduct in order to appeal a determination related to a request for physical therapy services. Mr. Smith *would not* write 88 pages over the course of several months at great detriment to his physical and mental well-being simply to appeal for "outpatient physical therapy".

14d. Mr. Smith's 2023 complaint-appeal has given the plan administrators at UnitedHealthcare and TennCare cause to investigate his allegations. Despite having been given such cause, neither organization seems to have initiated a good faith investigation into his allegations and complaints. If investigation has occurred, investigators made no attempt to request from Mr. Smith details about the instances of misconduct he disclosed with limited detail and those he declared to have occurred but had refrained from disclosing any details about. Nor did any such hypothetical investigators request any of the evidence of misconduct he declared

to have possession of, nor indicated in any determination or other communication of having reviewed such evidence on their own internal record keeping systems.

14f. The responses to complaints and grievances that Mr. Smith has received between 2018-2024 from his health plans have repeatedly shown that almost all investigators disregard the detailed information that Mr. Smith provided verbally or in writing.

15. No attempt was made by any of Mr. Smith's health plans to seek a resolution to the disputes described in his November 2023 complaint-appeal. TennCare's denial letter is the only formal response to Mr. Smith's Nov 2023 complaint-appeal as of January 20th 2024.

16. Mr. Smith's health, safety, and ability to function remains compromised because of his inability to receive needed medical assistance with specialists containing the necessary education and expertise to fully evaluate and treat him.

17. It has been disclosed to UnitedHealthcare and TennCare that Mr. Smiths ability to function is limited and that the effort required to sit at a computer reviewing records, performing research, and writing appeals reliably results in Mr. Smith suffering injury. That such injuries further impair his ability to function. In some instances the increased impairment is such that Mr. Smith can no longer attend to tasks effectively, or at all, neither with his health plans or his doctors.

18. The task of authoring this Petition for Review has been challenging for me. As I type this sentence, now, on 1.17.2024 at 21:50, I'm struggling to type because my hands are numb and experiencing ataxia, I have a headache, my jaws hurt, my neck, shoulders, back, rib cage, hips, and legs ache or burn with pain, the burden of digestion has made it harder think and to breathe for the past five to six hours alongside persistent nausea. Eariier today when I stood up from my computer and walked into the hallway I fell to the ground due to how being at the computer for hours had provoked my TMD, MSK dysfunction, and Dysautonomia. I should probably call it an evening, which for me means I begin a 2-3 hour process of managing my health conditions in order to manage pain, reduce insomnia, and improve nasal patency so as to mitigate how much my untreated TMD and OSA injure me during my sleep. I spend a similar amount of time trying to recover in the morning while at the same time trying to get things done.

19. It is my understanding that as part of this petition for judicial review I will need to review documentation, rules, procedures, laws, and other matters in detail to create a brief/memorandum and attend to other tasks, which will require me to spend the majority of my time and energy sitting at my computer reading and writing and further expend what limited financial resources I have on expenses related to this petition. UnitedHealthcare and TennCare

have since around 2018-2019 been made aware that conditions like this are injurious to my person and further compromise my health and safety.

CAUSES OF ACTION

20. Medicaid programs were created for a purpose and given a mandate "to assist the disabled". The Social Security Administration (SSA) has reiterated this mission many times in their publications. In the SSA publication titled, "Annual Statistical Report on the Social Security Disability Insurance Program, 2021", is a quote of President Eisenhower where as he signed the Social Security Amendments of 1956 he said, "We will ... endeavor to administer the disability [program] efficiently and effectively, [and] ... to help rehabilitate the disabled so that they may return to useful employment .... I am hopeful that the new law ... will advance the economic security of the American people.".

21. SSA policies and procedures are intended to help Medicaid programs fulfill their mission to assist and rehabilitate disabled citizens who qualify for the program. The SSA's purpose and mission preempts its policies and procedures. While I understand and appreciate the Davidson County Chancery Court's review of petitions often has a focus on the policies and procedures specific to a dispute with TennCare and it's MCC's, I would submit that the mission of the Medicaid program, its purpose, should garner consideration, particularly as it pertains to deciding what is proper conduct for plan administrators.

22. During the post World War II Nuremberg trials defendants argued in their defense that they were just following orders. It is policy and procedure for military personnel to follow orders, and likewise customary for civilians during wartime to heed instructions that they are given from their government and military. The Nuremberg Courts did not find this argument of following policy and procedure adequate to absolve the defendants of responsibility for their actions. The duty of the defendants was determined not to have been to follow policy and procedure, but to have acted in accordance with recognized standards of conduct which preempted policy and procedure.

23. I would submit that President Eisenhower's statement and signing of legislation communicated and established a standard of what can be considered good conduct for medicaid plan administrators. Whether or not TennCare is in compliance with the law is a matter that I believe extends beyond evaluating if they followed policy and procedure, and should include how they are implementing policy and procedure and the impact that their implementation has upon a beneficiary, their community, our State, and our Nation. Especially so as the complaints I have made in my 2023 complaint-appeal and this 2024 petition for judicial

review describe how UnitedHealthcare Community Plan and TennCare interpret and apply policy and procedure to work against the purpose and mission of the Medicaid program.

24. In his Nov 2023 complaint-appeal, Mr. Smith requested (1) that he be afforded the resources and opportunity to undergo rehabilitative treatment for the health conditions causing his medical disabilities; (2) that the health plans cease their misconduct and provide full and fair review to himself and other plan beneficiaries; (3) that his health plans uphold their fiduciary duty and take action to reform their organizations and remediate the damages their misconduct has caused; (4) that the health plans enter into good faith formal discussions to seek a resolution to this dispute. [Exhibit B, Sean Smith's 2023 complaint-appeal pg 5, 7-8].

25. TennCare has made no effort to respond to the requests Mr. Smith made in his complaint-appeal, nor has TennCare tried to assist Mr. Smith such that he might receive rehabilitative care. Instead, TennCare plan administrators denied Mr. Smith's complaint-appeal and asserted that his appeal was about a request for outpatient physical therapy, and that because the complaint-appeal was about a request for outpatient physical therapy Mr. Smith would not get a fair hearing.

26. *Tenncare "must grant an opportunity for a hearing to the following: (1) Any individual* who requests it because he or she believes the agency has taken an action erroneously." [42 CFR § 431.220]. I submit that to engage in misconduct is to act in error. Therefore, a complaint-appeal about health plan misconduct is a document whose primary focus is upon 'erroneous actions'.

27. As part of submitting his complaint-appeal Mr. Smith filled out and submitted the TennCare Appeal Authorization Form [EXHIBIT D]. At the form's field "Yes, I would like to request a Fair Hearing from TennCare for," Mr. Smith underlined "Yes" and wrote in the provided space below "Full & Fair Review & Help Now, or Fair Hearing in Court Later. You, TennCare, Decide". TennCare was made aware Mr. Smith desired to be provided full and fair review of his complaint-appeal and receive assistance, and if TennCare refused to do so Mr. Smith requested a fair hearing.

28. TennCare must "provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly" [CFR § 431.200]. Tenncare "may not limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing" [CFR § 431.221]. TennCare is permitted to deny or dismiss Mr. Smith a fair hearing if, "The applicant or beneficiary withdraws the request.", or, "The applicant or beneficiary fails to appear at a scheduled hearing" [CFR § 431.223].

29. The complaints and requests Mr. Smith made in his complaint-appeal have not even been acknowledged by Unitedhealthcare or TennCare, let alone acted upon, which precludes the possibility of any promptness even being possible with respect to a review and determination of Mr. Smith's complaints and requests. Mr. Smith did not receive full and fair review of his complaint-appeal from UnitedHealthcare or TennCare, and compounding that offense is that TennCare acted to further deprive Mr. Smith of the full and fair review of a fair hearing. Mr. Smith submits that it would be accurate to describe TennCares actions during their review of his 2023 complaint-appeal as being that TennCare breaks rules to use rules to break more rules.

30. UnitedHealthcare and TennCare were made aware that Mr Smith's disabilities cause him substantial impairment and that having to combat his health plans misconduct has and continues to cause him injury which leads him to become more severely disabled. Engaging in actions that plan administrators know to cause their beneficiaries to become injured and experience more severe disability is the opposite of what their duties require of them [42 U.S. Code § 1396a(a)(19), 42 USC § 1986]. It is the opposite of operating a health plan which assists disabled adults such that they might receive necessary medical assistance. As evidenced by the definition of medical assistance under the Social Security Act subchapter XIX Grants To States for Medical Assistance Programs, which includes "rehabilitative services" that provide "for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level" [42 U.S.C. § 1396d(a)(13)].

31. The plan administrators of TennCare and its MCC UnitedHealthcare Community Plan are engaging in activities that undermine the mission for which they are employed to achieve. Their actions betray their position of trust as fiduciaries and as state and federal employees who took an oath to fulfill their duties and uphold the Constitution of the State of Tennessee and the United States of America [TCA § 8-18-111; TCA § 6-31-112] [Exhibit C, Stephen Smith Oath of Office].

32. U.S. Supreme Court case Goldberg v. Kelly established that welfare benefits are a form of property, and depriving a beneficiary of that property without due process would be a violation of the Fourteenth Amendment of the U.S. Constitution:

> It may be realistic today to regard welfare entitlements as more like 'property' than a 'gratuity.' Much of the existing wealth in this country takes the form of rights that do not fall within traditional common-law concepts of property. It has been aptly noted that

'(s)ociety today is built around entitlement. The automobile dealer has his franchise, the doctor and lawyer their professional licenses, the worker his union membership, contract, and pension rights, the executive his contract and stock options; all are devices to aid security and independence. Many of the most important of these entitlements now flow from government: subsidies to farmers and businessmen, routes for airlines and channels for television stations; long term contracts for defense, space, and education; social security pensions for individuals. Such sources of security, whether private or public, are no longer regarded as luxuries or gratuities; to the recipients they are essentials, fully deserved, and in no sense a form of charity. It is only the poor whose entitlements, although recognized by public policy, have not been effectively enforced. [Goldberg v. Kelly (1970)] (emphasis added).

33. For a disabled adult medicaid beneficiary one's health plan benefits are a Personal Asset intrinsic to maintaining one's health and well-being; to maintaining one's autonomy; to being 'able' to Live Life, Exercise Liberty, and Pursue Happiness; to have a chance to have Independence and Declare oneself to society as a participant of society. Qualifying Disabled Adults are entitled to participate as beneficiaries of a legally compliant good faith Medicaid program - it is their Right. Access to medical assistance is required for many disabled adults to avoid injury and death. When plan administrators engage in misconduct to withhold or obfuscate access to the welfare benefit asset that is a 'legally compliant good faith Medicaid program', it is then that the health needs of their disabled adult plan beneficiaries become Neglected, which when it causes physical or psychological injury makes the neglect then become Abuse.

34. A qualifying disabled adult's entitlement to access their medicaid health plan benefits makes the health plan benefits a form of Intangible Property for which their qualifying for the program is a form of Ownership. The TennCare health plan is fundamentally a large account of funds held in trust by plan administrators who disseminate those funds to pay claims in a fiduciary capacity. TennCare plan administrators are tasked to, "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and ***the best interests of the recipients***" [42 U.S. Code § 1396a(a)(19)] (emphasis added). The TennCare plan administrators act as trustees of this account of funds that is the collective property of the beneficiaries on behalf of plan beneficiaries in accordance with the mandate and mission for which those taxpayer funds were supplied. A mandate and mission "to help rehabilitate the disabled so that they may return to useful employment" [SSA

Annual Statistical Analysis 2021]. Federal code declares that the funds made available to TennCare are provided so that they may furnish to their beneficiaries "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care" [42 U.S.C. § 1396-1].

35. TennCare Plan administrators receive payment to perform their duties, so when they neglect their duties and opt to engage in misconduct which delays and denies disabled adult plan beneficiaries access to their health plan benefits, it is a form of Exploitation which abuses the disabled adult.

36. Weaponizing policy and procedure against disabled adult plan beneficiaries to delay and deny needed medical assistance such that it leads to the Abuse and Exploitation of disabled adult plan beneficiaries is a behavior that is not in service to a mission of assisting the disabled and providing rehabilitation to them, nor does it "advance the economic security of the American people.".

37. In the Amercians with Disabilities Act, it is declared that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, *independent living, and economic self-sufficiency for such individuals.*" [42 U.S.C. § 12101(7)]. That "the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity." [42 U.S.C. § 12101(8)].

38. If TennCare plan administrators were to act in good faith to provide full and fair review of care requests and complaints, and supply rehabilitative treatment to their disabled adult plan beneficiaries in accordance with those fully and fairly reviewed care requests, then there would be fewer denials of requests, which would result in fewer appeals and complaints, and beneficiaries could access needed care and focus their attention and resources on rehabilitation, which would then cause there to be fewer plan beneficiaries, leading to fewer requests for care and a reduced need for administrative staff, which would reduce the cost of administering the health plan, thereby reducing the amount for which Managed Care Contractors (MCCs) need to be paid to administer the plan, which would also reduce the number of persons employed at TennCare and it's MCC's. Put simply, some TennCare plan administrators have a job because they create or maintain the need for their job by not doing their job.

39. I submit to the Court that sufficient evidence has been presented to be able to investigate and identify plan administrators at the UnitedHealthcare Community Plan and at TennCare who have been and continue to engage in misconduct which leads them to unduly enrich themselves to the detriment of their disabled adult plan beneficiaries and as a result those plan administrators are actively defrauding the taxpayers of the State of Tennessee and The United States of America.

40. Official misconduct has occurred when a public servant "with intent to obtain a benefit or to harm another, intentionally or knowingly:"

"3) Refrains from performing a duty that is imposed by law or **that is clearly inherent in the nature of the public servant's office** or employment;

(4) Violates a law relating to the public servant's office or employment" (emphasis added) [TCA § 39-16-402].

41. Official oppression has occurred when a public servant, "Intentionally subjects another to mistreatment..." or; "Intentionally denies or impedes another in the exercise or enjoyment of any right, privilege, power or immunity, when the public servant knows the conduct is unlawful" [TCA § 39-16-403].

42. As fiduciaries the TennCare plan administrators are expected to act in compliance with the laws relevant to their duties. In order to do so a plan administrator must have sufficient knowledge of the law. When a person having knowledge of the law and the power to stop a wrong and the duty to prevent wrong from being done does not act, they are liable for any failure to act [42 USC § 1986].

43. In Goldberg v. Kelly it was ruled that welfare benefits are a form of property that the State cannot deprive a citizen of without due process. TennCare denied Mr. Smith's appeal based upon a false assertion that his complaint-appeal was about a request for physical therapy, and then used that false premise to deprive Mr. Smith from receiving the due process of a fair hearing, in order to deny Mr. Smith the health benefits he is entitled to receive, one such specific benefit that he explicitly requested access to being rehabilitative treatment of the health conditions causing his disabilities, which is a service that is also an inherent duty of the health plan administrators.

44. In the Supplemental Foreword of his 2023 complaint-appeal Mr. Smith communicated the tremendous burden of authoring the document and how he had become too injured in the year 2020 to finish drafting it [Exhibit B, pg 2-3]. Throughout his complaint-appeal Mr. Smith mentioned his difficulties and the injuries sustained trying to complete tasks despite those difficulties [Exhibit B, pg 36, 74]. UnitedHealthcare and TennCare have been provided an

extensive amount of information such that they would have become exceptionally aware that Mr. Smith can be injured by subjecting his person to conditions where he must fight and advocate for himself against misconduct. UnitedHealthcare and TennCare plan administrators conspired to deprive Mr. Smith of his right to the due process of a fair hearing in the knowledge that Mr. Smith is likely to be injured while attempting to file a Petition for Judicial Review, or engaging in some other form of burdensome recourse. This 'knowledge of likely injury' comes from Mr. Smith's complaint-appeal [Exhibit B, pg 6] and other past verbal and written disclosures of information he made to Unitedhealthcare and TennCare, which are Protected Health Information (PHI) [45 CFR § 160.103]. Plan administrators are not permitted to use PHI to cause harm to or deprive the rights of their plan beneficiaries [45 CFR § 164.502]. They in fact have a duty to use PHI to "to prevent or lessen a serious and imminent threat to the health or safety of a person or the public" [45 CFR § 164.512(j)(1)(i)(A), 42 U.S.C. § 1396a(a)(19)]. These and other offenses establish cause of action under 42 U.S.C § 1985(2) and 42 U.S.C. § 1983.

45. Mr. Smith sent his appeal to three separate recipients at UnitedHealthcare and two separate recipients at TennCare [Exhibit B, pg 1]. Multiple persons having a duty to prevent the wrongs from being done neglected to take action to prevent those wrongs from harming Mr. Smith. Multiple persons are involved in the review and denial of Mr. Smith's appeal. This and other offenses provide cause to suspect a conspiracy among health plan administrators to deprive Mr. Smith of his rights and cause him injury [42 U.S.C. § 1985(3)].

RELIEF REQUESTED

Petitioner Sean Smith requests the court to:

1. Issue process to the respondents and direct the respondents to file an answer, as well as provide a copy of the entire record of the proceeding to Sean Smith, pursuant to TCA § 4-5-322(d);

2. Order the respondents to pay all costs, including all costs and litigation taxes associated with these proceedings;

3. That during deliberation of my petition, the Chancellor consider how the complexity of my health issues and the difficulty of managing them with inadequate medical assistance creates an exceedingly challenging situation;

4. Provide to Mr. Smith a formal acknowledgement in writing that the misconduct of TennCare and its MCC UnitedHealthcare Community Plan (UHCCP) has occurred and has harmed Mr. Smith;

5. If it be within the Chancellors power, to convince or compel UnitedHealthcare Community Plan and TennCare to also acknowledge in writing that their misconduct has occurred and has harmed Mr. Smith and that they apologize to Mr. Smith, their disabled adult plan beneficiaries, and the citizens of Tennessee for having failed in their duties;

6. To provide relief which will grant Mr. Smith the opportunity to:

a) work with the physicians possessing the specialized education, expertise, and experience required to evaluate and treat the health conditions causing his medical disabilities;

b) be afforded protections so that the misconduct of UnitedHealthcare and TennCare cannot further impede or jeopardize Mr. Smith's rehabilitation;

c) focus his attention and limited capacity to function upon his health and salvaging what little remains of his life;

d) be provided just compensation for the physical, psychological, financial, and social damages he and his caregivers have or will sustain, in a manner that is in keeping with what Mr. Smith proposed on page 7 of his November 2023 *complaint-appeal [Exhibit B, Sean Smith's 2023 complaint-appeal pg 7] and*;

e) Award punitive damages which will set a very clear precedent which deters any further misconduct perpetrated by TennCare and its Managed Care Contractors against their disabled adult plan beneficiaries. Make the penalties of engaging in misconduct exceed any possible potential benefits.

7. Order UnitedHealthcare Community Plan and TennCare to provide full and fair review of care requests and complaints to Mr. Smith and his physicians;

8. Arrange for or declare a need for some form of oversight to ensure UnitedHealthcare Community Plan and TennCare comply with the Courts Order to provide full and fair review of Mr. Smith and his physicians care requests and complaints;

9. Report these matters to the appropriate governmental agencies. Order that a comprehensive investigation into Mr. Smiths complaints of misconduct committed by health plans and other parties be performed. Enforce whatever penalties are appropriate against organizations and individuals. Provide any such further relief as the Court deems necessary and appropriate;

10. DEFEND THE DISABLED.

Originally Dated January 23, 2024.
Amended April 7, 2024.

Sincerely,

Sean P. Smith 4.7.2024

Sean Smith, Pro Se
6402 Baird Lane
Bartlett, TN 38135
(901) 573-8610
TheLastQuery@gmail.com
DefendTheDisabled.org

List of Amendments Made:

To make it clear and easy to note what changes were made to the original pleading.

Under "CAUSES OF ACTION", an additional paragraph was added at 37. which states:

"37. In the Amercians with Disabilities Act, it is asserted that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." [42 U.S.C. § 12101(7)]. That "*the continuing existence of unfair and unnecessary discrimination and prejudice denies* people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity." [42 U.S.C. § 12101(8)]."

Under "RELIEF REQUESTED":

1. Item 8 was revised from "provide full and fair review of Mr. Smith's care requests and complaints;" to, "provide full and fair review of Mr. Smith and his physicians care requests and complaints;"
2. The following sentence was added to item 9: "Order that a comprehensive investigation into Mr. Smiths complaints of misconduct committed by health plans and other parties be performed."
3. Item 6. subsection a) was changed from, "work with the physicians possessing the specialized education and expertise required" to,
   "work with the physicians possessing the specialized education, expertise, and experience required"
4. Item 6. subsections d) and e) were added as follows: "d) be provided just compensation for the physical, psychological, financial, and social damages he and his caregiver have or will sustain, in a manner that is in keeping with what Mr. Smith proposed on page 7 of his November 2023 complaint-appeal [Exhibit B, Sean Smith's 2023 complaint-appeal pg 7]"
   "e) Award punitive damages which will set a very clear precedent which deters any further misconduct perpetrated by TennCare and its Managed Care Contractors against

their disabled adult plan beneficiaries. Make the penalties of engaging in misconduct exceed any possible potential benefits."

Certificate of Service

I Sean Smith hereby certify that a true and correct copy of the *Amended Petition for Judicial Review* and it's Exhibits A-D is being forwarded via email to the following:

Defendants Counsel
HAYLIE C. ROBBINS (BPR# 038980)
Assistant Attorney General
Office of the Tennessee Attorney General
Haylie.Robbins@ag.tn.gov

Index of EXHIBITS for Petition for Judicial Review

EXHIBIT A - TennCare Nov 30 2023 Appeal Denial Letter

EXHIBIT B - Sean Smith's November 2023 Complaint-Appeal, 88 pages. Mailed with Mr. *Smith's Petition for Judicial Review is a USB drive containing file folders holding* copies of the documentation that Mr. Smith submitted with his complaint-appeal to Unitedhealthcare Community Plan, TennCare Solutions, and TennCare director Stephen Smith. The reference documents listed in the complaint-appeal are in those file folders. Mr. Smith has redacted his Insurance ID Numbers, Social Security Number, and birthdate from documents to protect his identity.

EXHIBIT C - TennCare Deputy Director Stephen Smith's 2023 Oath of Office

EXHIBIT D - Sean Smith's filled TennCare Appeal Authorization Form dated 11.16.2023

EXHIBIT A

TennCare Nov 30 2023 Appeal Denial Letter

TN 816

OMM31151368112823N00001

State of Tennessee
Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593

November 10, 20

225372 0 1129 3038 28369 1/4 BIN:0 7-1104

SEAN P SMITH
6402 BAIRD LN
BARTLETT TN 38135-2565

We've made a change to how we send our letters. When possible, we try to put all of the letters mailing to you on the same day in one envelope.

That means there may be more than one letter in this envelope for you. Be sure to look through all of the pages so you don't miss important news!

If you have questions or need more help, please call **Member Medical Appeals** at **800-878-3192.**

This page is left blank on purpose.

State of Tennessee
Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593

November 30, 2023

SEAN P SMITH
6402 BAIRD LN
BARTLETT TN 38135

Issue / Appeal ID: M31151368

Dear: SEAN P SMITH (Age: 37 and Person ID: 535555413)

On **November 28, 2023,** we received your appeal. You told us you had a problem getting care that you need.

We're closing the request(s) below.

Why?

It's too late to appeal your request for OUTPATIENT PHYSICAL THERAPY.

You only had 60 days to appeal after you found out there was a problem. When did your 60 days start? When you got the first letter that said we won't pay for this care.

So, we can't work your request for this service.

- The federal government says Tennessee must set limits on how much time you get to appeal problems in TennCare. [42 CFR Section 431.221(d), Section 438.402(b)(2)]
- Our rules also say that you only have 60 days to appeal after you find out there's a problem. [Tenn.Comp.R&Regs. 1200 - 13 - 13; Tenn.Comp.R&Regs. 1200 - 13 - 14]

If you think we counted the 60 days wrong, call Member Medical Appeals at **800-878-3192.** Have this letter with you when you call.

Do you disagree with our decision that you can't get a fair hearing? You can file a petition for review in the Davidson County Chancery Court. You have 60 days from the date on this letter to file a petition for review. After that, it's too late. [Tenn. Code Ann. § 4 - 5 - 322]

We have worked all of the requests related to your appeal. So, **we are closing your appeal**. You won't get a hearing.

Do you have questions about this letter? You can call Member Medical Appeals for free at **800-878-3192.** Have this letter with you when you call.

If you agree that we resolved your issue, you do not need to do anything else.

What if you think that we did not fully resolve your issue? Call us at **800-878-3192** and tell us why you disagree.

If you were appealing something else, call Member Medical Appeals right away at **800-878-3192.**

Do you have questions about this letter? Call us for free at **800-878-3192.**

Do you need help with this letter because you have a health problem, learning problem or a disability? Or, do you need help in another language? If so, you have a right to get help and we can help you. See the "Do you need Special Help" page with this letter. Or call **Member Medical Appeals** for free at **800-878-3192.**

- **Do you have a mental illness and need help with this letter?**
  The TennCare Advocacy Program can help you.
  Call them for free at **800-758-1638.**

We do not allow unfair treatment in our program.
No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you've been treated unfairly? Do you have more questions? Do you need more help? You can make a **free call** to the **Member Medical Appeals** at **800-878-3192.**

TN

Do You Need Special Help?

Here are some places you can call for help.

All of these numbers are free calls.

Do you have questions or need help with TennCare? Or, do you need help because you have a health, mental health, learning problem or disability?

- Call **Member Medical Appeals** at **800-878-3192.**

Do you have a hearing or speech problem and have questions or need help?

- Call the **Tennessee Relay Services (TNRS)** at **800-848-0298.** Ask them to connect you with **Member Medical Appeals** at **800-878-3192.**

Do you need help with prescription or refills at the drug store?

- First, call **your doctor.** Then, if you still need help call **Member Medical Appeals** at **800-878-3192.**

Do you need help getting health care, mental health care or drug or alcohol treatment?

- First, call **your health plan.** If you still need help call the **TennCare Advocacy Program** at **800-758-1638.**
- Then, if you still need help, call the **Member Medical Appeals** at **800-878-3192.**

Do you need help talking with us or reading what we send you?

Do you have a disability and need help getting care?

Or do you have more questions about your health care?

Call us for free at 800-878-3192.

We can connect you with the free help or service you need. (For TTY call: 800-848-0298)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birth place, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or online. Here are two places where you can file a complaint:

Division of TennCare Office of Civil Rights Compliance
310 Great Circle Road
Nashville, Tennessee 37243
Email: HCFA.Fairtreatment@tn.gov
Phone: 855-857-1673 (TRS 711)

You can get a complaint form online at:
https://tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf

U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Ave SW, Rm 509F, HHH Bldg
Washington, DC 20201
Phone: 800-368-1019
(TDD): 800-537-7697

You can get a complaint form online at:
https://hhs.gov/ocr/office/file/index.html

Or you can file a complaint online at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

TN

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English.

Spanish: **Español**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-878-3192

Kurdish: **کوردی**

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 800-878-3192 بکە.

Arabic: **العربية**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-878-3192

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-878-3192。

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-878-3192.

Korean: 한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-878-3192 번으로 전화해 주십시오.

French: **Français**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-878-3192.

Amharic: **አማርኛ**

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ለያማዘዎት ተዘጋጀተዋል፣ ወደ ማከተለው ቁጥር ይደውሉ 800-878-3192.

Gujarati: **ગુજરાતી**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-878-3192.

Laotian: **ພາສາລາວ**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-878-3192.

German: **Deutsch**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-878-3192.

Tagalog: **Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-878-3192.

Hindi: **हिंदी**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 800-878-3192 पर कॉल करें।

Serbo-Croatian: **Srpsko-hrvatski**

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezicke pomoci dostupne su vam besplatno. Nazovite 800-878-3192.

Russian: **Русский**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-878-3192.

Nepali: **नेपाली**

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 800-878-3192 ।

Persian: **فارسی**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-878-3192 تماس بگیرید.

EXHIBIT B

Sean Smith's November 2023 Complaint-Appeal, 88 pages. Mailed with Mr. Smith's Petition for Judicial Review is a USB drive containing file folders holding copies of the documentation that Mr. Smith submitted with his complaint-appeal to Unitedhealthcare Community Plan, TennCare Solutions, and TennCare director Stephen Smith. The reference documents listed in the complaint-appeal are in those file folders. Mr. Smith has redacted his Insurance ID Numbers, Social Security Number, and birthdate from documents to protect his identity.

This is a cover sheet for Sean Smith's Legal Notice Letter titled, "An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment".
The letter and its references and supporting documents are contained on a USB drive that was taped to this cover sheet in the mailing envelope.

From: Sean Smith
UHC ID: [REDACTED]
DOB: March 27th, 1986
Home Address: 6402 Baird Lane, Bartlett TN, 38135
Phone: (901) 522-5775
November 18, 2023

To:
UnitedHealthcare Community Plan
Attention: Appeals and Grievances
Unit 2035 Lakeside Centre Way, Suite 200
Knoxville, TN 37922

Contents of USB Drive:
An Example of Misconduct & Appeal v2023F.pdf
References folder (93 items, 711MB)

This is a cover sheet for Sean Smith's Legal Notice Letter titled, "An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment".
The letter and its references and supporting documents are contained on a USB drive that was taped to this cover sheet in the mailing envelope.

From: Sean Smith
TennCare ID: [REDACTED]
DOB: March 27th, 1986
Home Address: 6402 Baird Lane, Bartlett TN, 38135
Phone: (901) 522-5775
November 18, 2023

To: TennCare, Attention: Medical Appeals
TennCare Solutions,
Attention: Medical Appeals
P.O. Box 000593
Nashville, TN, 37202-0593

Contents of USB Drive:
An Example of Misconduct & Appeal v2023F.pdf
TennCare Appeal Request Form (filled).pdf
References folder (93 items, 711MB)

This is a cover sheet for Sean Smith's Legal Notice Letter titled, "An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment".

The letter and its references and supporting documents are contained on a USB drive that was taped to this cover sheet in the mailing envelope.

From: Sean Smith
TennCare ID: [REDACTED]
DOB: [REDACTED], 1986
Home Address: 6402 Baird Lane, Bartlett TN, 38135
Phone: (901) 522-5775
November 18, 2023

To: TennCare, Attention: Deputy Director Stephen Smith
Deputy Commissioner Stephen Smith
Bureau of TennCare
310 Great Circle Rd.
Nashville, TN 37243

Contents of USB Drive:
An Example of Misconduct & Appeal v2023F.pdf
References folder (93 items, 711MB)

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

To:

Cigna Healthcare, Attention: Legal Department
Cigna Healthcare, Attention: Medical Appeals Department
Cigna Healthcare, Attention: Brad G. (Senior Operations Analyst)
CareCentrix, Attention: Legal Department
Alight Solutions (aka Consumer Medical), Attention: Legal Department
eviCore, Attention: Legal Department
Federal Express Corporation, Attention: Human Resources
Federal Express Corporation, Attention: Legal Department
UnitedHealthcare Community Plan, Attention: Appeals & Grievances
UnitedHealthcare, Attention: Executive Office, Legal Risk Management
UnitedHealthcare, Attention: Patricia Kirkpatrick
UnitedHealth Group, Attention: Legal Department
Optum, Attention: Legal Department
TennCare, Attention: Medical Appeals Department
TennCare, Attention: Deputy Director Stephen Smith

From: Sean P. Smith;
Cigna ID: [REDACTED] | UHC ID: [REDACTED] | TennCare ID: [REDACTED]
DOB: [REDACTED].1986
Address: 6402 Baird Lane, Bartlett TN, 38135
Email: TheLastQuery@gmail.com
Phone: (901) 522-5775

Warning:

Upon delivery confirmation via Certified Mail the Named Entities will be afforded six weeks to respond to this letter. In the event the Named Entities are unwilling or unable to initiate a formal discussion with Mr. Smith to seek a resolution of this dispute, Mr. Smith will engage in contingency plans as specified on pages 6-7.

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

November 2023 Supplemental Foreword:

Throughout 2020 I worked day after day, week after week, month after month, writing "An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:". For several years now I have struggled to access adequate care for the health conditions causing my medical disability. As a result I have sustained injuries that have caused my disability to become increasingly severe. The many injuries stacked up by 2018 and greatly accelerated my physical and mental deterioration. During 2020 my deterioration had become extreme and I lost the ability to finish writing this letter.

I asked for help finishing this letter and that didn't work out. I then focused on trying to prevent further injury and work on other tasks that might help me 'get help', as I had learned through direct experience that trying to work with Cigna and UnitedHealthcare leads to injuries, such as how it caused me to develop PTSD in 2019-2021 after a lifetime of being unable to understand why/how people hate or fear such that it dictates how they think and behave.

I found that my efforts to engage with Cigna, UnitedHealthcare, TennCare, and their contracted partners would trigger the PTSD and that would then cause me to sustain more

physical injuries alongside the psychological ones. By 2021 I had become physically and psychologically too fragile for further interaction with Cigna, UnitedHealthcare, and TennCare.

I have not been able to recover. I elected to avoid interactions with the Named Entities as much as possible, even though doing so meant the work that needed to be done to allow me to survive would go unattended to, with little to no progress being made, and my health deteriorating even further as I languished in these harmful circumstances.

As I reread the letter I drafted in 2020, I noted how much I have deteriorated since then; how poorly functioning I am now. I needed treatment for what is causing my medical disabilities, and I still need it, and need help getting that treatment as I am not able to complete all of the necessary tasks on my own any longer.

I very much doubt Cigna or UnitedHealthcare will cease engaging in misconduct and endeavor to provide the medical assistance that I, their disabled adult plan beneficiary, need. At this time it would seem irrational, delusional even, to expect Cigna, FedEx, UnitedHealthcare, or TennCare to uphold their fiduciary responsibility, let alone try to do that in an ethical and moral manner. Even so, it is now or never to send what I drafted in 2020.

I believe I will be killed by the misconduct of Cigna, FedEx, UnitedHealthcare, TennCare, their contracted partners, and other involved parties. I believe their organizations are incapable of acting in the best interests of their plan beneficiaries; sick patients; vulnerable citizens; disabled adults. They will cause harm, injure, and kill those they are tasked to serve so long as it profits them to do so. I expect that I will not be enabled to access appropriate treatment for my medical disabilities. Yet, I wrote this letter with the hope that maybe, somehow, someone somewhere might make something happen where I am afforded the resources needed to let me be rehabilitated.

I wanted to send this letter under more favorable conditions. I wanted to get someone to help put the finishing touches on this drafted letter. I wanted to have established care with more of the doctors I will need, with them waiting for my health plans to let them help me. I really wanted to be permitted to undergo the treatments that are able to treat and even cure my medical disabilities. Knowing such treatment exists is the reason I've bothered to work so hard to keep myself alive and functioning despite all the misconduct, abuses, and other obstacles I encountered between disabled adults and rehabilitative treatment.

A part of me still dreams it is possible. But I've come to accept that whether or not I am able to undergo rehabilitative treatment is something that other people decide. Other people decide if a disabled adult gets to live as a functional member of society or gets physically and psychologically tortured to death by treatable illnesses.

It's time for me to stop planning and dreaming and submit to the reality that the assistance I require is unlikely to be afforded to me. I must simply do what I can when I can and no longer delay matters, even if that increases the likelihood, or guarantees, that I sustain further injury and am killed. I've tried to get help. I've asked, begged, pleaded, even tried manipulation and threats a few times despite finding such tactics entirely disagreeable and generally nonproductive...I tried and tried. Sending this letter is my way to finish trying.

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

Summary

Mr. Sean Smith is a disabled adult dependent who has experienced a persistent and substantial deterioration of his health, which has reduced his capacity to function and caused him to suffer increasingly severe disability. Since 2014 Mr. Smith has devoted nearly all of his efforts to understanding, managing, and seeking assistance for the health conditions causing his medical disabilities. Around 2018 Mr. Smith was able to determine that the health conditions disabling him are fully treatable, even curable, but that he is unable to access the rehabilitative care necessary to treat his health conditions and disabilities because Cigna-FedEx, UnitedHealthcare-TennCare, and their contracted partners, collectively referred to as the Named Entities, engage in illegal activity which prevents healthcare operations from proceeding such that the health plan can fulfill their fiduciary obligation [29 U.S.C. § 1104(a)] [42 U.S.C. § 1396a(19)], provide full and fair review of care requests, appeals, complaints, and grievances [29 CFR § 2560.503-1(h)] [42 U.S.C. § 1396(a)(30)][1], defray costs [29 U.S.C. § 1104(a)(1)(A)(ii)] [42 U.S.C. § 1396(a)(30)], and thereby assure that plan beneficiaries can receive needed medical assistance pursuant to the law and the present medical knowledge. Additionally, the misconduct of the Named Entities has permitted, incentivized, and at times even coerced many of the physicians and healthcare facilities comprising their provider network to engage in activities that work against the best interests of and cause harm to their plan beneficiaries. And when made aware of this the Named Entities have failed to take action which curtails or puts a stop to the misconduct and harm that the Named Entities and their physicians and facilities in their health plan network are perpetrating against their plan beneficiaries.

As a result, Mr. Smith has sustained numerous physical, psychological, financial, and social injuries, thereby compromising his physical and mental health, increasing the severity of his disability, and reducing his quality of life. In this letter, Mr. Smith demonstrates that the Named Entities have: (1) failed to provide full and fair review of Mr. Smith's care requests, complaints, grievances, and appeals; (2) violated HIPAA health privacy protection laws; (3) breached their contractual and ethical obligations to Mr. Smith and their contracted partners; (4) discriminated against Mr. Smith based upon his disabilities; (5) engaged in actions demonstrating an intent to cause injury to Mr. Smith; (6) neglected, abused, and exploited a disabled adult plan beneficiary; (7) engaged in conspiracy to commit both civil and criminal offenses; (8) committed many other ethical and legal violations.

[1] In order to curb costs to the plan without working against the best interests of the beneficiaries the plan fiduciaries must be certain they do not deny necessary care. Determining the necessity of care can only be done by performing a full and fair review. If full and fair review does not occur then denials are not simply wrongful, but represent a breach of the fiduciary obligation, and constitute fraud for receiving funds to provide a service to the beneficiaries that they then withhold from beneficiaries through noncompliance with laws, mandates, and contractual obligations.

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

Evidence supporting Mr. Smith's assertions is provided by extensive documentation of multiple instances of the Named Entities misconduct, alongside which Mr. Smith cites and examines state and federal laws as part of explaining and demonstrating the illegal nature of the Named Entities activities.

Mr. Smith requests that the Named Entities enter into formal discussions in order to seek an expeditious resolution which will allow Mr. Smith to attend to his physical and mental health and remediate the damages he has sustained. Absent receiving needed medical care Mr. Smith can be expected to sustain further injury and eventually be killed; to be physically and psychologically tortured to death by his unmet medical needs. In the event the Named Entities will not or cannot enter into good faith discussions, Mr. Smith believes his last act in life should be to communicate to his fellow citizens why and how he has been damaged and will be killed by the Named Entities. Mr. Smith would achieve this through public disclosure of the evidence of the Named Entities misconduct - of which only a portion is presented in this letter - and a real-time documentation on social media platforms of Mr. Smith seeking justice while being killed by his unmet medical disability needs.

Introduction

For a number of years Sean P. Smith, hereafter referred to as Mr. Smith, has struggled to find a way to access needed medical care due to the misconduct of Cigna-FedEx, UnitedHealthcare-TennCare, and their respective contracted partners, hereafter referred to as the Named Entity(ies). As part of escalating his efforts to seek and receive the medical assistance which would promote his survival and well-being, Mr. Smith contacted FedEx Human Resources (FedEx HR). By phone call and email Mr. Smith supplied a copy of his medical appeal previously sent to Cigna-FedEx and UnitedHealthcare-TennCare in the winter of 2019 as well as additional information which communicated to FedEx Human Resources the undue hardships he has had to endure [Sean Smith, 2020, Email To Deirdra at FedEx HR]. In response to Mr. Smith's communications FedEx HR arranged a conference call between Cigna-FedEx and Mr. Smith and his parents, which took place on May 26th 2020[2].

During the conference call Danielle Carneson - a representative of Cigna-FedEx - called the police to the home of Mr. Smith for a welfare check. Danielle called the Police presumably with the consent and knowing cooperation of Dr. Issac Martinez and perhaps also the other representatives present on that call. Representatives of the Named Entities have called the Police to request the performance of welfare checks in times previous to May 26th 2020 and at times since then. False statements have on more than one occasion been presented to Police Dispatch by the Named Entities representatives and thereby to on-site Officers [T.C.A. §

[2] This letter and all references and records were sent via USB drive to the Named Entities. A copy of the recording and transcription of that call has been included alongside this letter in the References folder.

39-16-501(2);502]. At times more than one of the Named Entities representatives was involved in making those reports to law enforcement, making their actions grounds for conspiracy charges [42 U.S. Code § 1985] [T.C.A. § 39-12-103] [18 U.S. Code § 371].

The Named Entities representatives have often claimed that they are required to make these reports to law enforcement as part of following the Named Entities organizational policies and practices; of fulfilling the terms of their employment [Cigna Healthcare, 2020, Company Profile]. On occasion representatives additionally claim that they are legally and ethically obligated to make these reports.

Instances of the Named Entities' misconduct extend well-beyond the topic of welfare checks and have occurred within Mr. Smith's interactions with nearly all of the Named Entities. This letter is intended to serve as an example which illustrates the illegal nature of one of those instances and the validity of alleging that extensive harm has been done to Mr. Smith. Do not mistake this letter as the sole basis nor even the primary basis of Mr. Smith's Legal Claim.

Due to the burdens Mr. Smith must endure he has elected to refrain at this time to provide fully detailed examples of the misconduct committed by UnitedHealthcare, TennCare, or the contracted partners. Mr. Smith's burdens impair his ability to function cognitively, physically, and emotionally and limit his time. Furthermore, a letter providing such detailed accounts would end up being quite similar to that which is demonstrated in this letter.

If the writing of such letters becomes necessary it will likely mean Mr. Smith will be in a position which requires he forgo the pursuit of an outcome in which he survives his circumstances and he will produce such letters as part of setting his affairs in order while expectant of death. Under such circumstances his intent would be to publicly disclose all allegations and evidence in his possession, including distributing through social media platforms an ongoing real-time documentation of his unmet medical needs slowly destroying him while he continues to pursue the acquisition of justice in apparent futility. Thereby all citizens may be presented a full account of Mr. Smith's struggles until the 'bitter end'. This campaign for justice will attempt to make person's in society very uncomfortable with allowing the misconduct and illegal activities of the Named Entities to injure and kill disabled adults and other persons made vulnerable by their health issues.

Throughout this campaign for justice citizens will be urged to demand and take action which would assure that no further harm befalls citizens and their communities. Performing this task will accelerate Mr. Smith's deterioration. Mr. Smith will readily communicate this and voice his expectation of being killed by the named entities misconduct or that he will become too overwhelmed by his unmet medical needs and will elect for suicide. That, during the course of public disclosure there will be no intent or expectation to survive and efforts to prolong his life will only be done only in service of his attempt to acquire Justice. Effort would also be made to make Citizens aware that upon Mr. Smith's very public wrongful death there is yet opportunity to become involved and file suit to prosecute the Named Entities for both Civil and Criminal offenses [T.C.A. § 71-6-120(b)]. They would be encouraged to achieve "justice" for Mr. Smith and any other persons who have been killed or injured by the Named Entities misconduct, so as

to preserve the health and well-being of the as-yet-living persons who are adversely impacted by the Named Entities misconduct.

This letter acts as both a declaration of the legitimacy of Mr. Smith's past, present, and future legal claims, and an invitation to the Named Entities to enter into formal discussions in order to seek an expeditious resolution which would allow Mr. Smith to attend to his physical and mental health and remediate the damages he has sustained. Omitting to provide a detailed explanation regarding a Named Entities misconduct does not intend to excuse any of the Named Entities from responding to this letter and engaging in formal discussion. Mr. Smith has afforded the Named Entities the opportunity to limit damages to themselves and plan beneficiaries, but grows tired of offering such affordances to them. This letter will also serve to make it clearer to the contracted partners and co-fiduciaries of Cigna, FedEx, UnitedHealthcare, and TennCare, how the misconduct of plan administrators exerts an influence upon the contracted partners and co-fiduciaries liability.

What Mr. Smith hopes to achieve through formal discussions would include, but is not limited to:
(1) obtaining the resources required to undergo rehabilitative care for his medical conditions and attempt to remediate the other damages sustained or expected to occur, such that;

(A) he may attempt to repair the physical, psychological, financial, and social damages he and his caregivers have sustained or will sustain and;

(B) the care he is afforded access to has the best chance of fully rehabilitating him such that he is no longer disabled and will thereby have been reasonably indemnified

(C) he will be afforded the means to achieve independence and exercise autonomy as part of attempting to remediate the damage done to him;

(i) those means including but not limited to: food, housing, transportation, utilities, the pursuit of education, hobbies, interests, and pursuing personal and financial opportunities.

(ii) the purpose of such affordances being to accelerate Mr. Smith's rehabilitation and remediation so as to reduce any further damages that Mr. Smith must endure and allow him to fully focus his attention on 'fixing this mess'.

(D) that the fulfillment of (1)(A)(B)(C) be performed in a manner wherein the actions of the Named Entities cannot impede or in any way jeopardize Mr. Smith's efforts to undergo rehabilitation and engage in remediation.

(2) that the Named Entities reform their organizations such that they are indeed in compliance with state and federal statutes and Mr. Smith is assured that this reformation will not only occur, but will be lasting

(3) the total cost of both (1) & (2) is such that the Named Entities are strongly deterred from engaging at any future date in the misconduct that they have subjected Mr. Smith and other plan beneficiaries to.

(A) Instruments of Deterrence to include stipulations in any settlement agreement wherein any future violations will incur additional and substantive penalties.

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

It was Mr. Smith's hope that in making the Plan Fiduciaries of the Cigna-FedEx and UnitedHealthcare-TennCare Health Plans fully aware of the seriousness of his situation that they would then set about to act in earnest to assist Mr. Smith. That in the process of providing assistance to Mr. Smith they would also act to reform their organizations so as to provide appropriate assistance to other plan beneficiaries with similar needs. For the purposes of fully disclosing the severity of his circumstances and as part of illustrating the extent to which the misconduct of the Named Entities has adversely impacted Mr. Smith's health and well-being - and by proxy those plan beneficiaries subject to circumstances of a similar nature - Mr. Smith disclosed in his medical appeal submitted to CignaFedEx and UnitedHealthcare-TennCare in 2019 and during the conference call with Cigna-FedEx his struggles with suicidal ideation[3].

Mr. Smith had disclosed in his medical appeal - which Dr. Martinez, Danielle Carneson, and some of the other call participants claimed or were indicated to have read [Cigna-FedEx Human Resources 2020 Conference Call Recording & Transcript (C-F 2020 Transcript), 00:02:34.25, 00:03:42.20, 02:30:59.10] - and in the conference call that his suicidal ideation is caused by the adverse impact that the Named Entities misconduct has had upon him: the repeated violation of his rights and suffering of abuses, being wrongfully denied needed medical care, sustaining injuries from those abuses and his unmet medical needs, how the medical conditions causing him to suffer medical disability are largely caused by those unmet medical needs, that the psychological injuries inflicted upon Mr. Smith by the Named Entities misconduct contributes to the severity of his medical disability, and coinciding with these events he has experienced a substantial loss of quality of life, as well as being subject to stress that to call it undue would be an understatement. Those and many other matters were covered in detail. Mr. Smith did seek to communicate to the Plan Fiduciaries that their ongoing misconduct causes him to be unsafe both medically speaking and in terms of his mental health.

He did communicate how no Emergency Room (ER) Hospital nor psychiatric facility in his area has the ability to provide adequate assistance for Mr. Smith's health issues, as evidenced by past encounters with those facilities. That the Named Entities misconduct has and continues to obstruct or prevent Mr. Smith from accessing the physicians who can provide rehabilitative treatment, and that Mr. Smith has sought to access that care for a number of years. That as a result of all of these things and many other related matters, Mr. Smith's mind does regularly focus upon the premise of suicide as a means to end his suffering and protest the egregious violation of his rights. Mr. Smith communicated how he finds it unacceptable that in order to remove himself from this abuse Mr. Smith is limited to physically removing himself from existence. For having been afforded no other means by which to meet his needs and cause his suffering to end, Mr. Smith is required to engage in the pragmatism of selecting from those things that are accessible to him. That, from a practical standpoint, from a goal-oriented

[3] Suicidal Ideation: thoughts about or a preoccupation with killing oneself, often as a symptom of a major depressive episode. Most instances of suicidal ideation do not progress to attempted suicide. **[Amer Psych Assoc, 2020]**

perspective, suicide is "a solution" [C-F 2020 Transcript 00:53:18.14]. Mr. Smith declared during the conference call:

"One way or another this is going to end for me. I'm tired of it. I'm tired of.. *a pause in speaking* being witness to crimes; I'm tired of being the victim of them; I'm just tired of it and *if* I have to physically remove myself from existence to achieve that then that's what I'll end up *having* to do, but you rest-assured people are going to be held responsible for what they did in contribution to that." [C-F 2020 Transcript 00:53:18.14].

During the conference call both Dr. Issac Martinez and Danielle Carneson claimed ignorance of previous welfare checks despite this information being extensively disclosed in Mr. Smith's medical appeal [C-F 2020 Transcript 00:39:46.04] [Sean Smith, 2019, Sean Smith's Medical Appeal (S.S. 2019 M.A.) pages 33-38]. They also asserted that due to their oath as medical professionals as well as because of other legal obligations, they each have a duty to report to law enforcement that Mr. Smith was a suicide risk and to request that a welfare check be performed by police officers, the sole purpose of which would be for officers to determine whether or not to suspend Mr. Smith's civil and constitutional rights and detain him without warrant in order to transport him to a psychiatric treatment facility to undergo immediate evaluation. [C-F 2020 Transcript 00:42:01.15, 01:42:54.10.]

Yet, not at any point did Mr. Smith convey any desire nor intention to cause immediate harm to himself or others. He did, in fact, convey much information demonstrating a clear intent and exceptionally persistent drive to stay alive and in as functional a state as he possibly can achieve with his available resources [S.S. 2019 M.A. pages 4-5, 12, 14, 17, 22, 27, 53-58] [C-F 2020 Transcript 00:08:06.21, 00:13:24.00-00:15:47.15, 00:16:23.25, 00:24:52.20, 00:29:56.19, 00:32:29.19, 00:34:04.05-00:35:45.12, 00:48:05.06-00:50:12.20, 00:50:12.20-00:55:03.24, 01:02:17.06-01:06:28.18].

Mr Smith made numerous requests of the Named Entities to cease in their misconduct so that they might then operate the health plan so that he can access "less drastic alternatives" [S.S. 2019 M.A. pages 3-4, 18, 29, 32, 39] [C-F 2020 Transcript 00:10:54.05-00:12:40.00, 00:23:02.10-00:25:47.20, 00:32:07.02-00:33:37.17, 00:34:04.05-00:35:45.12, 00:47:16.22, 01:03:10.28- 01:04:07.03, 01:04:30.21].

In addition to Mr. Smith's communications, his Mother conveyed that after over twenty years of suffering what has been defined medically and legally as psychiatric disability, not once, not ever, had Mr. Smith attempted suicide, neither is he, in her opinion, actively suicidal, nor has he ever caused or sought to cause harm to anyone else. [C-F 2020 Transcript 00:43:37.18, 01:44:25.18]. The plan fiduciaries were in receipt of medical records from 1998 which were included with the 2019 medical appeal evidencing Mr. Smith's long-standing battle with suicidal ideation[4] [S.S. 2019 M.A. Medical Records, "1 Dr. Smith Psychiatrist.pdf"].

[4] page 46 of this letter contains an excerpt from those records detailing some of those struggles

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

During the conference call Mr. Smith advised Cigna-FedEx's representatives that they should review the laws pertaining to involuntary commitment in the State of Tennessee [C-F 2020 Transcript 00:42:53.13]. When Mr. Smith's warning was disregarded in a dismissive manner by both Danielle Carneson and Dr. Martinez, he then proceeded to verbally recite the laws pertaining to involuntary commitment in order to demonstrate how per Mr. Smith's communications neither Danielle Carneson nor Dr. Issac Martinez, nor any other party holds an obligation to report the proceedings to police and request a welfare check [C-F 2020 Transcript 00:45:31.02]. Mr. Smith disclosed that there was no legal basis to call the police for a welfare check and that doing so would, in fact, be unlawful [C-F 2020 Transcript 00:47:16.22-00:48:19.00].

Neither Danielle or Dr. Martinez nor any other party could provide any information validating the assertion that they have a duty to report to law enforcement *their allegations* that Mr. Smith was at acute risk of suicide and by that assertion initiate a welfare check.

In Mr. Smith's 2019 medical appeal and in the conference call Mr. Smith outlined how calling the police would cause him both physical and psychological injury [S.S. 2019 M.A. pages 33-38] [C-F 2020 Transcript 00:41:46.21-00:50:12.20]. Mr. Smith's mother corroborated that the admitting facilities do work against the goal of safeguarding Mr. Smith's safety [C-F 2020 Transcript 00:43:55.19; 00:45:09.27]. To ignore the information provided by Mr. Smith and his caregiver and elect to call the police constitutes a direct violation of a physicians hippocratic oath as well as their fiduciary obligation as plan administrators. It is also grounds for asserting they have committed offenses civil and criminal wherein a citizen purposefully or negligently causes harm to another. They did act to satisfy their *perceived* legal liability at the expense of Mr. Smith's *actual* safety, fallaciously claiming that their actions were performed with concern for Mr. Smith's safety [C-F 2020 Transcript 02:23:02.12], while simultaneously engaging in misconduct that prevents Mr. Smith from meeting his physical and mental health needs such that he would then possess safety and well-being. One could go so far as to assert that the Plan Fiduciaries did attempt to place Mr. Smith in a situation likely to cause further injury and even death:

"In fact, roughly *a third to a half of all people killed by police are disabled.* Many more disabled civilians experience non-lethal violence and abuse at the hands of law enforcement officers.". "stigma about mental illness continues to inform reporting, [that reporting] suggesting that people with psychiatric disabilities are likely to be violent and that police have reason to fear them."

"Official documents and statements released by law enforcement frequently link disability to violence in ways that blame disability for the negative outcomes."

"A social worker who cares for the mentally ill and developmentally disabled...prefers that people avoid calling the police..." "the danger of dialing 911 is something he emphasizes in all orientation sessions for new employees at the organization where he works." [David M. Perry et al., 2016]

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

"Given the prevalence of mental illness in police shootings, reducing encounters between on-duty law enforcement and individuals with the most severe psychiatric diseases may represent the single most immediate, practical strategy for reducing fatal police shootings in the United States." [Doris Fuller et al., 2015]

"'Everything we've turned up about this case has been outrage after outrage,'...even the wellness-check request call, which catalyzed the deadly course of events, was 'illogical.'" [Natasha Lennard. 2020]

From Mr. Smith's 2019 Medical Appeal:
"All the while, patients like myself have to put up with the absurd lie that this was all done to keep us 'safe', even though at discharge we are less safe than we were prior to being admitted. Meanwhile, our claims, appeals, and other efforts to find access to care, get ignored and denied because they're not 'medically necessary'.
Which is a heinous lie. A vicious display of indifference that shows the health and well-being of fellow human beings lies very low on the list of priorities for medical insurers." [S.S. 2019 M.A. page 38]

"Sleep, food, pain...very basic needs unmet or neglected, and this is a facility to 'keep me safe'; to convince me to not engage in suicidal ideation. A facility contracted by TennCare, UnitedHealthcare, and Cigna." [S.S. 2019 M.A. page 36]

"Death doesn't scare me, but somehow I'm afraid of being asked "Are You Safe?" by doctors, police officers, and phone representatives of medical insurers. How do I deal with that?" [S.S. 2019 M.A. page 36]

"Sean: I have countlessly expressed how the mistreatment I have experienced as a result of these wrongful denials, as a result of all this misconduct, of one thing after another going wrong, over and over and over, has led me to contemplate suicide...*for years* [can hear Danielle breath as if going to speak]. For Years. Not, not...not just in the appeal; not just kind of a little bit, but for years. This has been disclosed to Cigna." [C-F 2020 Transcript 00:29:56.19]

"Danielle: ..are you feeling suicidal and are you feeling that you would like to harm yourself?"
"Danielle [speaking over Sean]: I do need to ask you another question. I do need to ask you one more question. Do you have a plan? Did you ever think of a plan as to how you would harm yourself?
Sean: You should discontinue this line of inquiry because it will not go well for yourself or other people; it will only make the matter worse. You should deal with the problem at hand.... Abuse.

Neglect. Exploitation. Misconduct. These things are what cause it [the suicidal ideation]." [C-F 2020 Transcript 00:32:07.02- 00:33:37.17]

"Pat[ient] is....bi polar, non medicated...is frustrated and is feeling suicidal...has expressed it multiple times in the past hour...unk[nown] weapons in the home per caller...caller says parents will deny that he needs intervention." [Bartlett Police Department, 5.26.2020]

"Sean: The health plan has engaged in the, uh, neglect, abuse, and exploitation of a disabled adult....
Officer Maser: Who's the disabled adult?
Sean: I am the disabled adult.
Officer Maser: Why do you feel that way?
1 second pause/silence
Sean: it's not a feeling. It's a, it's a, legal declaration. I'm a disabled adult.
Officer Maser: You're not handicapped, physically. So what is the [Sean: *audible frustrated sigh*] disability?
Sean: uh, well. Medically speaking it would start with childhood OSA that went undiagnosed and then led to what got defined as psychiatric, uh, a
Officer Maser (interrupting): Okay
Sean (continuing to speak): -mood disorder.
Officer Maser: Okay
Sean (continuing to speak): And from there it-
Sean (interrupted by Maser): -led to...*trails off due to interruption*
Officer Maser (interrupting Sean): So, some...ah. That's all I was wondering. Is it something psychological or are you like missing a limb. You know what I'm sayin.
Officer Maser (speaking same time as Sean): So that's what I'm trying to figure out.
Sean (trying to interject): I am missing a limb.
Sean: That limb is called my mandible. It's a jaw disorder. So me speaking to you at this very moment and having to engage with the psychological distress of having Officers in my home directly aggravate a musculoskeletal disorder. [Maser: "mhm"] Which is separate from a psychological disorder. So I have multiple disabilities per the Americans with Disabilities Act and pursuant also to Title 71 Chapter 6 of Tennessee State Code." [C-F 2020 Transcript 01:51:01.17-01:51:46.28]

"Officer Maser: What I'm here for is you apparently told somebody that you were having thoughts of harming yourself.
Sean (interjecting): no.
Officer Maser: Or feeling as though that you [Sean: "no"] may harm yourself. Correct?
Sean: Pursuant to Title thirty-three, six,
Officer Maser (interrupting Sean): Is that a yes or no?

Sean (interrupted by Maser): four-oh-one
Sean: Pursuant to title thirty-three, six, four-oh-one, I do not meet the criteria necessary to call the police.
Officer Maser: kay.
Sean: So they have filed a false-
Officer Maser (interrupting Sean): But do you feel...
Sean (interrupted by Maser): -police report.
Sean (reiterating with emphasis): They have filed a false police report." [C-F 2020 Transcript 01:51:46.28-01:53:16.05]

"Officer Maser: But when that didn't go the way you wanted to, that's when you threatened your own physical safety?
Sean: No. You're inserting fallacies. I have recorded this entire call.
Sean (being interrupted by Maser): I can present it as evidence.
Officer Maser (interrupting Sean): Right. I'm asking as a question.
Officer Maser: What made them call us? You must have done something or said something that triggered them to feel as though your physical safety was at risk." [C-F 2020 Transcript 01:53:16.05-01:54:02.13]

"Officer Maser: You, one of the things that apparently you stated was that your parents would not let you go to get help.
1 second pause
Officer Maser (Maser and Sean speaking same time): So why is it you feel that way?
Sean (Sean and Maser speaking same time): What are you talking about?
Sean: this is why I told you you should have a recording because for your own legal liability, for the city's safety, you should've had that, instead you're going to have to rely upon my good graces to provide that for your own defense.
Officer Maser: Okay. Is there a reason why you said that?
Sean: said what?
Officer Maser: That you wouldn't, that your parents wouldn't let you go.
Sean: I just told you twice that I didn't say that and you..." [C-F 2020 Transcript 02:01:07.03-02:01:42.21]

"But I just want you to know that I have a full right, legally, to take you against your will to Lakeside.
Sean: actually you don't." [C-F 2020 Transcript 02:15:05.23]

"Sean (interrupting Maser): Cite the law that allows you to do that.
Sean: Cite it. I dare you. Can you? No? I can. I want to.
Sean: I'm just asking for your partners name before doing that. You're-

Sean (interrupted by Maser): -the one withholding this process." [C-F 2020 Transcript 02:17:10.15]

"Officer Maser: kay, first of all can you just answer my question? Cause we have calls holding, man. No offense, but we have other people in need in the city.
Sean: Sorry, uh, I, I just said I wanted to report multiple felonies and misdemeanors and you have a better place to be?
Officer Maser: I've referred to you that they are all civil matters. The issues that you're referring to.
Sean: They're not civil matters. They're criminal matters." [C-F 2020 Transcript 02:18:00.06]

"Officer Maser: What's the next option is I'm going to place you in handcuffs and take you to Lakeside, because right now you have made the statement; I have enough to take you to Lakeside." [C-F 2020 Transcript 02:18:23.18]

"Sean: Alright, so, here is everything that you need. You need to present this to your legal department-
Sean (interrupted by Maser): -you need to present this...
Officer Maser (interrupting Sean): k. we're not gonna, we're not gonna...
Officer Maser (speaking same time as Sean): we're not gonna take possession of that
Sean (interrupting/speaking same time as Maser): you're not going to accept it?
Sean: You're denying receipt of it?
Officer Maser: I'm not going to take possession of that paperwork. No.
Sean: okay." [C-F 2020 Transcript 02:19:25.26]

"Officer Maser: In the future, I understand you're frustrated, I, *short pause in speech*, completely understand that. But you cannot reference those things [having suicidal ideation due to being abused by Cigna] because that puts them [Cigna] in a corner and it makes them obligated to call us." [C-F 2020 Transcript 02:19:55.18]

Officer Maser is informed that Cigna-FedEx is actively engaged in illegal activity that is causing and will cause further injury to a disabled adult. Officer Maser blames the victim of this abuse, Mr. Smith, for having made statements which caused this abuse to occur. He claims that disclosing to Cigna that their illegal activity causes Mr. Smith such harm that he experiences suicidal ideation then requires that Cigna file false police reports to commit further psychological injury and potentially cause further physical injury. Officer Maser asserts this in the *absence of any objective evidence* which verifies the integrity of the police report. The only party who has offered objective evidence of any kind is Mr. Smith, who asserts he can prove the law has been broken and that the matter is of a Criminal nature.

Officer Maser refuses to allow Mr. Smith to present objective evidences to him and is even unwilling to discuss the nature of the legal offenses which the Cigna-FedEx representatives have committed. At the same time Officer Maser defends Cigna's representatives for having broken the laws, implying that they followed the law, even while he denies Mr. Smith the opportunity to present him with objective evidence and documentation proving that the Cigna representatives broke multiple laws and are, at this moment, engaged in law-breaking by having filed a false police report as part of conspiracy to cause psychological and potential physical injury to Mr. Smith, who is a disabled adult.

Officer Maser made repeated threats to detain Mr. Smith, to violate his constitutional and civil rights, and present him for evaluation at a psychiatric facility that has illegally committed Mr. Smith twice and at each admission to the facility caused him physical and psychological harm. Mr. Smith, was, in essence, threatened by Officer Maser to be subjected to physical and psychological abuse if Mr. Smith did not provide Officer Maser what Officer Maser wanted and how he wanted it, even while Mr. Smith informed Officer Maser his demands were unjustified and acting to detain Mr. Smith would be illegal.

Mr. Smith's encounter with Cigna-FedEx, and particularly with the Police Officer, greatly aggravated his Chronic Stress Disorder which is but one of many health conditions contributing to his disability. Mr. Smith's encounter in May of 2020 precipitated a severe mental breakdown in which there was even more intense physical and mental incapacitation and suicidal ideation, the experience of which would likely be described by any prudent person as 'torturous'. Mr. Smith was damaged. It was not until three months later in mid-August of 2020 that any noticeable improvement in his ability to function cognitively and emotionally was noted. Again, Mr. Smith's perseverance and research abilities allowed him to devise and apply a treatment plan in the absence of access to needed medical services. The improvement Mr. Smith obtained still leaves him in a heavily impaired state. He is far worse off than he had been prior to the psychological injury caused in May of 2020 by the misconduct of Cigna representatives and law enforcement officers. The nature of that injury, the means by which Mr. Smith can be expected to be injured, how Mr. Smith is vulnerable to suffering injury due to his medical disabilities, and how the named entities actions are prejudiced against assisting Mr. Smith to meet his medical needs are well-evidenced in the medical literature:

"[Bipolar Disorder (BD)] is a complex medical condition whose etiology involves genetic and epigenetic factors acting alongside *environmental stresses* in causing expression of the disease."
"Stress, whether biologically or psychologically mediated, is responsible for the initiation and progression of the diathesis." [5]

[5] Diathesis: Pathology. a constitutional predisposition or tendency, as to a particular disease or other abnormal state of the body or mind. https://www.dictionary.com/browse/diathesis

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

"Life stresses acting on...individuals [with Bipolar Disorder] have an *enduring* effect on the neural substrate, causing rewiring of the nervous system with *increased sensitization* and *proneness to* recurrent affective episodes.There is mounting evidence that manic and major depressive exacerbations have a *neurotoxic effect*, damaging the neurons as well as the glial elements in the brain.8 The results of preclinical and human studies consistently show *accumulating organ damage* both in the center and in the periphery with illness progression. The neuroprogressive nature of BD is clinically manifested as increased frequency and severity of episodes, greater suicidal risk, and cognitive and functional impairment.9 In the final stages of the disorder there is no illness remission, persistence of inter-episode subthreshold affective symptoms, and *eventual loss of autonomy.*10 The course of BD is malignant in many cases; currently ***available medications fail to control the disease manifestations***, with *very high rates of polypharmacy, soaring frequency of treatment-emergent adverse effects*, and meager compliance from the patients.11 Considering that BD is a prevalent condition, the *application of less than optimal treatment strategies* and consequent illness progression place a huge *burden on the individual patient*, his or her family, and society as a whole. In view of these concerns, *it is vitally important* to cultivate better understanding of *the disease mechanisms* so *that adequate cures are made available* to the numerous people afflicted by this intractable illness." [Muneer, 2016]

"The reduction in life expectancy associated with moderate to heavy smoking ranged from 8 to 10 years. This range is similar to that reported for a single depressive episode or recurrent depressive disorder (7-11 years), but lower than that associated with...bipolar disorder (9-20 years)." [Chesney, E. et al. 2014]

"That individuals with psychiatric disorders suffer from poorer general health than the rest of the population is supported by several studies demonstrating a 10- to 25-year gap in life expectancy in individuals with psychiatric disorders.19,20" [S.S. 2019 M.A. Ref 128]

"Bipolar disorder is associated with a wide range of medical problems…" [S.S. 2019 M.A. Ref 153]

"many experts in psychiatric nosology and psychopathology now claim that our current classification systems have significantly impeded further progress in etiological research and treatment development (3, 23–25)."

"Finally, and worthy of note, some have suggested that DSM/ICD-based diagnoses may have clinical utility despite their poor validity (11, 17). However, how could a psychiatric nosology have clinical utility when it impedes the development of efficacious treatments and clinical tests, an improved understanding of etiology and a reliable prediction of illness course (26, 27, 66)?" [Michael Hengartner, 2017]

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

"The complexity of the processes described by participants suggests that traditional models of explaining non-adherence [to psychiatric medication] may over-simplify some individuals' experiences."
"Professionals should place more emphasis on non-medication approaches in order to increase engagement with people who do not use medication. This may involve focussing on individual's longer-term goals rather than on modifying moods in shorter-term. Conclusions are based on participants who had experienced significant bipolar moods, but who largely seemed satisfied living without medication."
"Services need to create a frame-work in which people are enabled to direct their own recovery process. Our findings indicate that choice regarding avenues of social contact, medication, and psychological interventions needs to exist, with resources more readily accessible. Those supporting the individual should aim to be attentive to their idiosyncratic needs and respond accordingly, encouraging, but being led by the recovering individual."
[Cappleman, R. et al., 2015]

Allsopp et al. communicated in publication:
"Although [Psychiatric] diagnostic labels create the illusion of an explanation they are scientifically meaningless and can create stigma and prejudice." [University of Liverpool, 2019]

"By focusing on diagnostic categories, individual experiences of distress and *specific causal pathways may be obscured*. A pragmatic approach to psychiatric assessment, which allows for recognition of individual experience, may therefore be a more effective way of understanding distress than maintaining a commitment to a disingenuous categorical system." [Kate Allsopp et al., 2019]

To which peers responded with correspondences:
"Our point is that, whatever one thinks of the virtues and flaws of a categorical approach to psychiatric diagnoses, the heterogeneous nature of the diagnostic process is not a relevant argument here.
We agree with the authors that "provision of care that is specific to a person's individual needs" is important. And it is true that medicine at times neglects the individual experience. However, good clinical practice is about working through and with the reality of a situation, of which diagnoses are often an important component (Saraga et al.,2019)." [Michael Saraga et al., 2020]

"The DSM-5 (APA, 2013) has been subjected to an abundance of critical reviews since (Vanheule, 2017; Vanheule et al., 2019) and even before (Kendler et al., 2008; Frances & Widiger, 2012; First & Wakefield, 2013; Frances, 2013; Insel, 2013) its official publication in 2013, making it clear that the theory and practice of psychiatric nosology is as contested as ever." [Jasper Feyaerts, 2019]

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

The Position of the National Institute of Mental Health on the DSM:

"The strength of each of the editions of DSM has been "reliability" – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever. Indeed, symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment.

Patients with mental disorders deserve better."
"NIMH will be re-orienting its research away from DSM categories." - Thomas Insel, 2013, Former Director of the National Institute of Mental Health [Thomas Insel, 2013]

"As psychiatric diagnoses do not represent valid disease entities, the NIMH decided to allocate its resources away from the DSM and toward genetic, neuroimaging, and cognitive sciences to design a diagnostic scheme based on neurobiological and behavioral phenotypes. Despite substantial efforts during the last two decades, genetic research and the neurosciences have largely failed to detect any reliable marker that could be applied for clinical tests to aid diagnosis and prognosis (23, 65). This failure is untenable for a specialty that contemplates a future within the clinical neurosciences (66), and lack of progress was in part attributed to the constraints imposed by the invalid DSM/ICD-based diagnostic categories (3)." [Michael Hengartner, 2017]

"...a bracing dose of honesty and humility is needed from both sides in the medication debate." "Advocates for medication, meanwhile, must identify gaps in their evidence base. Knowledge of the long-term effectiveness—and adverse effects—of medication is often lacking." [The Lancet Psychiatry, 2018]

"Given the questionable effectiveness of psychotropic medications over the long term and their unquestionable side effect burden, the clear indication is that these medications (if prescribed at all) should be taken sparingly and for the shortest time possible, and nonpharmacological approaches emphasized. Thankfully, the number of nonpharmacological options available for enhancing mental health and well-being *is extensive*." [Timothy Wand, 2018]

"stigma about mental illness continues to inform reporting…" [David M. Perry et al., 2016]

[Psychiatric] diagnostic labels…can create stigma and prejudice." [University of Liverpool, 2019]

"Pat[ient] is….bi polar, non medicated…" [Bartlett Police Department, 5.26.2020]

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

The Named Entities have in their possession the entirety of the conference call. The Named Entities possess proof that Mr. Smith's statements did not warrant initiating a welfare check as part of trying to have him involuntarily committed to a psychiatric facility. They have in their holding a record which shows Mr. Smith asserted that it is the Named Entities misconduct that prevents Mr. Smith from receiving the 'help' he really needs. The plan fiduciaries disclosed protected health information to law enforcement which misled on-site officers to believe that it is the fault of Mr. Smith's parents that he is without the help that he needs.

Danielle Carneson and Dr. Issac Martinez asserted that the law places upon them a duty to report that Mr. Smith was at acute risk of suicide and request a welfare check despite Mr. Smith only having conveyed experiencing suicidal ideation. Mr. Smith specified in his disclosures that his suicidal ideation occurs as a result of sustaining psychological and physical injuries because of the named entities flagrant misconduct. As part of exercising his own due diligence Mr. Smith has sought to determine if any such laws exist. Mr. Smith's investigation did not find any laws obligating a duty to report under the circumstances of that conference call. The closest he found are State statutes wherein a healthcare professional has a duty to report, "IF AND ONLY IF, a service recipient has communicated to a *qualified mental health professional* or behavior analyst an ***actual*** threat of bodily harm against a clearly identified victim, *AND*...the service recipient has the apparent ability to commit such an act and is likely to carry out the threat ***unless*** prevented from doing so" [TCA §§ 33-3-206;210] [TCA § 33-1-101(20)].

Without laws necessitating the reporting of suicidal ideation to law enforcement it would seem that Danielle's disclosure of Mr. Smith's Protected Health Information (PHI) [45 CFR § 160.103] to the Police and any other involved parties is a violation of the Health Information Portability and Accountability Act (HIPAA) pursuant to 45 CFR § 164.512(j). Note, that 45 CFR § 164.512(j) has a very similar wording to T.C.A. §§ 33-6-401;501 and P.S. § 50-7301. Each share in having similar criteria that must be met to then lawfully engage in actions which would violate a person's protected rights. Observe:

45 CFR § 164.512(j)(1)(i)(A);(B) - "(A) Is necessary to prevent or lessen *a serious and imminent* threat to the health or safety of a person or the public; ***and***
(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat;"

T.C.A. § 33-6-501(2) - "IF AND ONLY IF (2) there is a substantial likelihood that the harm will occur ***unless*** the person is placed under involuntary treatment".

P.S. § 50-7301 - (a)...a person...may be made subject to involuntary emergency examination and treatment...when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own

personal needs is so lessened that he poses a clear and **present** danger of harm to others or to himself.

(b)

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence...that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days ***unless*** adequate treatment were afforded under this act; or

(ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger may be demonstrated **by** the proof that the person *has* ***made*** threats to commit suicide and *has* ***committed*** acts which are in furtherance of the threat to commit suicide;

Given that Tennessee is the state in which Mr. Smith resides, then the laws of Pennsylvania are not applicable to Mr. Smith, and therefore, cannot be utilized in determining any need for a welfare check based upon the criteria stipulated within Mental Health Laws pertaining to involuntary commitment. The Pennsylvania statute has been provided to show that, indeed, both within Tennessee and even the state in which Danielle Carneson resides - which is also where Cigna is headquartered - there was no legal basis to initiate a welfare check.

Pursuant to 45 CFR § 164.512(j)(1) when making disclosures of PHI one must act "consistent with applicable law and standards of ethical conduct" and "in good faith". Which means, one must have cause to believe a threat to be "actual"; real; some factual basis to; not merely perceived [45 CFR § 164.512(j)(4)]. Note in T.C.A. § 33-3-206 the specific use of the word "actual" and the premise that the "service recipient" must possess the "ability to commit such an act and is *likely* to carry out the threat". Again, it is important to note that the premise under which Mr. Smith would be likely to commit suicide was communicated to be one in which the Named Entities continue to engage in misconduct which causes Mr. Smith to suffer harm. By electing to engage in further misconduct after such disclosures it can be asserted that the plan fiduciary's intention may have been to imperil Mr. Smith's safety.

Similar obligations to those described above are stipulated in a Certificate of Need, which is a document submitted to a court of law as part of asserting that there is a need to detain an individual and examine them for involuntary psychiatric commitment [State of Tennessee Dept. Mental Health And Substance Abuse Services, 2020].

In this Certificate of Need it is specified that a "professionals opinion" regarding the need to commit an individual is to be formed upon "facts and reasoning" [T.C.A. § 33-6-407(b)], not feelings. A threat cannot be something which causes one merely to be "worried" or "concerned" [C-F 2020 Transcript 1:41:57.29, 01:42:54.10]. They are threats one knows exist and which are "serious" and "imminent" *and* for which taking action would reduce that threat. If taking action to report matters to the Police cannot reduce that threat, or can be expected to worsen that threat,

then, much like the wording of TCA § 33-6-501, then T.C.A. § 33-3-206 requires that alternative actions or no action be undertaken.

Pursuant to 45 CFR § 164.512(j)(1) the disclosure of Protected Health Information would require Mr. Smith's authorization unless the criteria defined in T.C.A. Title 33 Chapter 3 Part 2 and/or T.C.A. Title 33 Chapter 6 Part 5 were met. Such criteria were not met. In addition, Mr. Smith's disclosures to the Named Entities, as well as those matters which were corroborated by one of his caregivers, also call into question the ethical basis of initiating a welfare check.

It was disclosed in Mr. Smith's medical appeal [S.S. 2019 M.A. pages 33-38] - a document considered Protected Health Information (PHI) - and in the conference call [C-F 2020 Transcript 00:45:09.27-00:50:12.20] - also considered PHI - that calling the police to Mr. Smith's home for welfare checks has caused him harm in the past and should be expected to cause him harm at every stage during any future occurrence. That if by chance officers detained Mr. Smith without warrant, thereby suspending his Constitutional and Civil liberties, and presented him to a psychiatric facility for evaluation and that evaluation led him to be involuntarily committed - with past commitments having been performed illegally and violating Mr. Smith's Constitutional and Civil rights it would be imprudent to expect these same facilities to engage in lawful behavior which would assure Mr. Smith's safety - that this would cause both physical and psychological injury to Mr. Smith's person.

Mr. Smith disclosed that these welfare checks represented both a perceived and actual danger to his health, safety, and well-being. That welfare checks provoke and worsen his psychological distress due to the threat that they pose to him. That the continued misconduct of the Named Entities has led Mr. Smith to develop a chronic stress disorder that magnifies the severity of his psychological distress in his encounters with the Named Entities - particularly when being subjected to rights violations and abuse - or with his interactions with police, but especially so does this occur during a welfare check; welfare checks performed by police undermine Mr. Smith's welfare.

It was disclosed that such psychological distress has caused Mr. Smith psychological injury and such injury would occur if a welfare check was performed. That this psychological injury will worsen his medical conditions, these same medical conditions being those that contribute to his disability, disabilities for which the nearby admitting psychiatric facilities have neglected during past admissions and should be expected to continue to neglect at any future admission to them. That such neglect has caused Mr. Smith to be abused and suffer injury in the past for which he has not been able to recover from. That due to the continued misconduct of the Named Entities, Mr. Smith has been unable to 'get help' for either his medical or mental health needs.

Mr. Smith made these and other disclosures within the conference call and within his medical appeal. This medical appeal was presented to the Named Entities in November-December of 2019, for which I remind the reader that Danielle Carneson and Dr. Issac Martinez both claim to have read the contents thereof [C-F 2020 Transcript 00:02:34.25, 00:03:42.20]:

"I arrive about 6 p.m. at Lakeside Behavioral Health Systems and spend eighteen hours at intake."[6]
"I was unable to sleep both because there is no bed and the constant artificial lighting at night causes me to experience insomnia, but in addition to those issues was fear. Fear that is present because I know if I fall asleep without the oral appliance I get injured and spend weeks with intense pain and dysfunction. Of course, I explain my situation to staff and nothing happens."
"I spend another night without the appliance, and this night I am not entirely successful in preventing sleep. Luckily, I was partially successful and between the lighting disrupting sleep and the effort to stay awake I avoided spending much time in the deeper stages of sleep wherein the disordered breathing becomes more severe and this in turn increases the occurrence of bruxism - I injure myself, but it is not as bad as it could have been. I complain the next day, in pain, to which staff largely ignore my grievance. I eventually find out later that day that LBHS has lost both the oral appliance and the mouth tape, but found the breathe right strips. I finally see the treating physician, who orders the oral appliance, and have my mother bring up a spare, but too little too late."
"During my involuntary commitment on February 5th 2019 I received no food for five days - I had very painful muscle cramps due to electrolyte imbalances, and with my caloric intake already a struggle to maintain, lost more body mass."
"My involuntary commitment in March was a repeat of what occurred in February.."
"they flood the rooms with light every fifteen minutes to do checks. I was acutely sleep deprived my entire stay there. "We show that sleep deprivation enhances pain responsivity within the primary sensing regions of the brain's cortex yet blunts activity in other regions that modulate pain processing, the striatum and insula. We further establish that even subtle night-to-night changes in sleep in a sample of the general population predict consequential day-to-day changes in pain (bidirectionally)." [150].
"Fear induced by pain in human subjects was rated higher for face than for extremities, despite comparable ratings of the pain intensity. fMRI studies further revealed that face pain resulted in higher levels of amygdala activation compared to the same intensity stimulation applied to the hand." "Our input-output circuit mapping of PB_L-nociceptive neurons revealed many limbic centers that are reciprocally connected with PB_L, providing a circuit basis for understanding closely associated and clinically highly-relevant comorbidities with pathologic trigeminal pain, namely anxiety, depression, disturbance of circadian rhythm and altered intake behavior." [156].

[6] addendum Aug 2020: see T.C.A § 33-6-404(2): "(2) the physician, psychologist, or designated professional shall ***immediately*** examine the person and decide whether the person is subject to admission to a hospital or treatment resource under § 33-6-403,"

> Sleep, food, pain...very basic needs unmet or neglected, and this is a facility to 'keep me safe'; to convince me to not engage in suicidal ideation. A facility contracted by TennCare, UnitedHealthcare, and Cigna."
> "I was having more intense thoughts of suicide throughout my commitments than I had experienced throughout the entire past month. At discharge I viewed suicide as being a more likely outcome than I did at intake. Contempt. Frustration. Trauma. I do need mental health services. Ironically, I need them to figure out how to deal with the trauma of being mistreated by physicians, insurers, officers, and other figures in the community who are 'supposed to help' but are instead causing harm to myself and others. Yet, step one of achieving 'get help' has been, and remains: fix sleep, fix pain, fix eating and digesting issues, return to exercise - address medical needs, then go talk about the psychological struggles." [S.S. 2019 M.A. pages 34-36]

From a publication referenced in the medical appeal 10 pages prior to the above excerpt:

"There are multiple lines of evidence suggesting that sleep contributes to relapse in bipolar disorder."
"the convergence of results provides a compelling case."
"A prodrome is an early symptom, or warning signal, that appears before an episode of depression or mania."
"Among patients with bipolar disorder, sleep disturbance was the most common prodrome of mania and the sixth most common prodrome of depression."
"Taken together, the evidence that extending sleep seems to stabilize mood symptoms indirectly supports the possibility that insufficient sleep may contribute to destabilization of mood."
[S.S. 2019 M.A. Ref 153]

The educational materials one will find supplied to medical professionals and law enforcement regarding how to interact with a person experiencing suicidal ideation advises one to deescalate a situation. A review of foundational theories of psychology regarding Universal Human Needs (UHN) will show that the deescalation of an encounter with a person experiencing intense acute negative subjective well-being involves meeting their basic needs. One of the more well-known theories of UHN's is Maslow's Hierarchy of Needs. Maslow's theory is worthy of mention because it demonstrates how long it has been recognized in the field of psychology the paramount importance of meeting a person's basic needs.

More modern understandings of Universal Human Needs act to modify rather than replace Maslow's Hierarchy of Needs. These theories point out that we humans are social organisms and rely upon our relationships with others to meet our needs and maintain our happiness. Indeed studies focused upon human longevity and well-being have recognized the importance of strong social bonds. Another modification is that some of the higher level

needs in Maslow's Hierarchy can be satisfied absent meeting those lower in the hierarchy: One can be hungry, and yet still find happiness. One can be impoverished, yet still find purpose. Yet, the staying power of Maslow's Hierarchy of Needs in the public awareness has occurred because people readily recognize that one's ability to be happy is impaired by the ill-effects of hunger; that being subjugated and impoverished limits one's opportunities to exercise their autonomy and find purpose in their daily activities. That misery and sickness tend to co-occur; that having the fiu does not cause oneself to be happy and will also upset those one holds strong social bonds to.

More still, it can be argued that some needs are so basic that they are non-negotiable and must be met as premised in Maslow's Hierarchy of Needs; hence its continued pertinence. An example being, when chronically sleep deprived the human brain becomes physiologically impaired in all its functions, thus any capacity the psychology has to attenuate that dysfunction in an individual does not negate the universal needs of mammalian biology for restful sleep, nor what harms will befall an organism should such needs remain neglected.

In considering the medical and psychological relevance of Universal Human Needs to Mr. Smith's case, one should not forget its legal ramifications. The Americans with Disabilities Act requires that disabled persons be provided "reasonable accommodations" for their disabilities. The admitting psychiatric facilities refused to provide such accommodations to the point that they starved, sleep deprived, and injured Mr. Smith. By their actions they placed Mr. Smith, who is a disabled adult, in "imminent danger" [T.C.A. § 71-6-102]. Mr. Smith was abused, exploited, and discriminated against based upon his disabilities. State laws mandate that all citizens report the abuse, neglect, and exploitation of disabled adults.

T.C.A. 71-6-103. Rules and regulations — Reports of abuse or neglect — Investigation — Providing protective services — Consent of adult — Duties of other agencies.
(b)
(1) *Any person*, including, but not limited to, a physician, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having *reasonable cause to* ***suspect*** that an adult has suffered abuse, neglect, or exploitation, **shall report** or cause reports to be made in accordance with this part. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death....

(c) An oral or written report shall be made immediately to the department upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: the name and address of the adult, or of any other person responsible for the adult's care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation, including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the

complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation....

Furthermore:

71-6-110. Violation of duty to report.
Any person who knowingly fails to make a report required by this chapter commits a Class A misdemeanor.

Alongside fulfilling their duty to report this abuse, neglect, and exploitation being perpetrated by their contracted partners and by their own organizations, plan fiduciaries have additional duties that they must fulfill.

These facilities are contracted in-network partners of the Named Entities. The illegal activity of the facilities and harms those activities caused to their plan beneficiary, Mr. Smith, have been brought to the Named Entities attention on multiple occasions. Plan fiduciaries must act to protect their beneficiaries from abuse, neglect, and exploitation not just by reporting it, but by acting immediately to put a stop to it. Plan fiduciaries must investigate and intervene, otherwise the integrity of a health plan is compromised and the fiduciary duty is broken.

Furthermore when Universal Human Needs are left neglected it is recognized that this can lead to disease onset or worsen existing pathologies. Thereby, many Universal Human Needs meet the definition of "medical necessity" adopted by health plans. Indeed, among the Universal Human Needs would be included the Activities of Daily Living (ADL) by which medical disability is defined and determined. As such, care requests which involve the treatment of disability almost always involve ADLs, which themselves involve UHNs, and thereby these care requests will predominantly meet the defined criteria for medically necessary care by merit of what they seek to treat [Cigna Healthcare, 2020, Medical Necessity Definitions]. Any denials of such requests would require an in-depth and well defended position. Such explanation has never, not once, been provided by the Named Entities in their denials of Mr. Smith's care requests. One wonders what rationalization can be supplied to justify the indiscriminate neglect of needs which are universally acknowledged as intrinsic to one's well-being and are actively contributing to medical disability. Especially from organizations tasked to function within a fiduciary role.

The Duties of a Fiduciary

Danielle Carneson and Dr. Issac Martinez claimed that their roles as physicians compelled them to report Mr. Smith as an acute suicide risk to law enforcement. Yet, neither Danielle Carneson nor Dr. Issac Martinez have entered into a physician-patient relationship with Mr. Smith. They are not his treating physician. Neither one of them is a "qualified mental health professional" nor do either of them possess the needed training or expertise required to attend to Mr. Smith's primary medical complaints. It would be inappropriate to impose themselves as if they possess the competencies to provide an informed opinion on these matters.

With respect to a physician or facility 'failing to provide adequate treatment' neither Danielle nor Dr. Martinez has any physician-based liability towards Mr. Smith, not for his Temporomandibular Disorder (TMD)[7], or for his Obstructive Sleep Apnea (OSA), nor for his Mental Health or any of his other medical issues; only a treating physician or facility could hold such liability. There is no legal duty compelling them to act as a physician to Mr. Smith due to having no such relationship established by Mr. Smith's express consent to receive treatment under their care. Their only established duty to Mr. Smith is the fiduciary duty they hold while operating the health plan.

> "Under general legal principles, a fiduciary owes a high duty of care to the beneficiary. That duty of care usually requires that the fiduciary inform themself or themselves of all material and available information prior to making a decision, and to make prudent decisions based on that information. Fiduciaries also owe their beneficiaries a duty of loyalty. That duty requires that a fiduciary avoid conflicts of interest and not use their position of confidence to further their own interests. Fiduciaries must also act in good faith, maintain confidentiality and communicate with complete candor by disclosing information." [Maggie Juliano, 2017]
>
> "Prudence: Carefulness, precaution, attentiveness, and good judgment, as applied to action or conduct." - BLACK'S LAW DICTIONARY 2ND ED.

The fiduciary obligation of Cigna-FedEx and UHC-TennCare representatives stipulates that plan fiduciaries must discharge their duties in the best interests of the beneficiaries [29 U.S.C. § 1104(a)] [42 U.S.C. 1396a(a)(19)]. Part of fulfilling this duty to act in the best interests of the plan beneficiaries requires that plan fiduciaries leverage opportunities to reduce the costs of administering the health plan [29 U.S.C. § 1104(a)(1)(A)(ii)] [42 U.S.C. 1396a(30)]. These

[7] TMD is also referred to as "TMJ". It is strongly advised the reader review the full definition of TMD on page 54.

mandates require plan fiduciaries to make certain that the health plan avoids forming contractual relationships with facilities that engage in misconduct, especially when this misconduct harms plan beneficiaries. And upon being made aware one of their contracted partners is engaged in misconduct, take all actions possible to prevent the contracted partner from being in a position which would allow them to cause further harm to plan beneficiaries and the health plan. Included in which would be fulfilling their legal duty to report the ongoing abuse, neglect, exploitation, and discrimination of a disabled adult [TCA 71-6-103(b)].

A fiduciary duty requires maintaining Protected Health Information pursuant to the law, and when PHI is disclosed that it is done in a manner which would not mislead law enforcement. This duty necessitates that a plan fiduciary act to deescalate an encounter and otherwise seek to understand and influence - within the limitations of discharging their duties - whatever circumstances are causing the beneficiary to experience a "serious emotional disturbance". A failure to not only deescalate an encounter but to instead engage in actions known to escalate and provoke the "serious emotional disturbance" can be asserted as, either through purposeful intent or negligence, acting to 'push someone over the edge'.

The fiduciary obligation also requires plan fiduciaries to recognize that their role in Mr. Smith's care is not one of a treating physician and that their education and training is exceedingly limited with respect to Mr. Smith's medical and mental health needs. They must admit to what they know and what they do not know. They must do this in order to be certain that the actions they take are prudent and lawful.

They must understand what was asserted over 300 years ago by René Descartes, the Father of Modern Philosophy:

"...[I] am finally compelled to admit that there is not one of my former beliefs about which a doubt may not properly be raised; and this is not a flippant or ill-considered conclusion, but is based on powerful and well thought-out reasons. So in the future I must withhold my assent from these former beliefs just as carefully as I would from obvious falsehoods, if I want to discover any certainty.".

Or as Socrates - who is credited as one of the great founders of Western philosophy - 2000 years before Descartes posited regarding his being in possession of wisdom:

"I do not think that I know what I do not know.".

Or, if one contests that a physician should only ever be obligated to behave as a physician, then one may reflect also upon what Hippocrates, the Father of Medicine, asserted 2500 years ago:

"As to diseases, make a habit of two things — to help, or at least, to do no harm."

"To do nothing is sometimes a good remedy."

"There are, in effect, two things, to know and to believe one knows; to know is science; to believe one knows is ignorance."

Or perhaps a more modern publication, from the British Medical Journal in the year 1999:

"...the most important thing to know is what you don't know. And you should feel good about not knowing. Pencheon plays a game with medical students. He asks them increasingly difficult questions, which they usually keep trying to answer, guessing as they go. Eventually a student will say, 'I don't know.' Pencheon awards that student a tube of Smarties. 'Those three words,' he says, 'are the most important words in education.'" [British Medical Journal, 1999].

Indeed, there does seem to be consensus on this point, even in ancient China Lao Tzu asserted:
"Not knowing that you do not know is an illness."

Mr. Smith has observed that the Named Entities have imprudently ignored wisdom both old and new; violated ethical and moral codes ancient and modern; disregarded the medical science; and are willfully noncompliant with the Law.

The Actual Knowledge

45 CFR § 164.512(j)(4) -
(4) Presumption of good faith belief. A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) or (ii) of this section, *if* the belief is based upon the covered entity's **actual knowledge** or in reliance on a credible representation by a person with apparent knowledge or authority.

Danielle and Dr. Martinez, and all other plan fiduciaries present at the conference call, learned of Mr. Smith's suicidal ideation in a medical appeal wherein he was requesting their assistance so that his medical needs could be met; care needs both psychological and physical. With great detail Mr. Smith had disclosed his long-standing desire and full intent to seek and receive rehabilitative medical care and to act in a manner which would mitigate the peril of his circumstances - that intent persisting for over six years. Mr. Smith was very clear in wishing to present himself to physicians who possess the knowledge and expertise required to meet his medical and mental health needs. Mr. Smith had focused nearly all of his daily activities around acquiring access to needed care for over three years. Indeed, Mr. Smith's commitment to "seek and receive needed care" is evidenced by the extensive amount of research he has performed and spending over ten months authoring the medical appeal he submitted to Cigna-FedEx and UHC-TennCare so that he could diligently communicate key findings to plan fiduciaries.

The Named Entities have engaged in misconduct which circumvents Mr. Smith's fastidious and concerted efforts. For many years the Named Entities have acted as a barrier which impeded the efforts of Mr. Smith and his treating physicians to identify the etiologic nature of Mr. Smith's medical conditions, a task that must precede efforts to identify efficacious therapies. Even after having identified which therapies would have or potentially have efficacy

for Mr. Smith, the Named Entities continued to engage in misconduct which obfuscates Mr. Smith's access to care, doing this even in the knowledge that this causes Mr. Smith physical and psychological injury.

Not only is there a clear violation of HIPAA, but calling a welfare check while such circumstances are present is especially unlawful pursuant to T.C.A. § 33-6-403(3);(4), in which it is stated that in order to qualify for admission to a psychiatric facility "all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person".

The Availability of "Less Drastic Alternatives"

If Cigna-FedEx or any other Named Entity determines it is lawful for them to engage in actions which advance towards involuntarily admitting Mr. Smith to a psychiatric facility, they are claiming there are no "less drastic alternatives". This means they and those other persons involved admit that the cause of Mr. Smith's "serious emotional disturbance" cannot be attended to with "less drastic alternatives". By initiating a welfare check some plan fiduciaries have thereby declared that they refuse to comply with state and federal laws such that health plan operations would then be able to afford Mr. Smith access to those "less drastic alternatives". Especially so as Mr. Smith has gone to so much effort to communicate his needs and request the assistance of the Named Entities in meeting those needs.

Cigna received Mr. Smith's medical appeal and did not review it within sixty days despite being repeatedly made aware to expect his appeal for a period of over ten months, and delivery and receipt of the appeal having utilized arrangements which necessitated that Cigna was in full expectation of receiving the appeal; Cigna had every indication to expect Mr. Smith's appeal. After being found to have failed to review the appeal within the time-frame specified by the law [29 CFR § 2560.503-1(l)(1)(i)], Mr. Smith told the Cigna representative he would afford Cigna additional time but that he expected a prompt and attentive resolution. Mr. Smith called a few weeks later to find that instead of reviewing his medical appeal Cigna had instead decided to assert Mr. Smith had not submitted a medical appeal and had instead submitted a medical claim.

There can be no mistaking that per the forms utilized, the past discussions, the title of the document being "Sean Smith's Medical Appeal", the special arrangements for receipt of documentation which were made, and the cumulative weight of evidences within Cigna's own records that an appeal was being authored and would be submitted by Mr. Smith, that the document submitted to them was a medical appeal.

One wonders how it is that an organization required by law to operate in a fiduciary capacity hires persons who think that after having failed to review an appeal in the required time-frame it is within the plan beneficiaries best interest to engage in misconduct and reclassify the medical appeal as a medical claim. This misconduct in and of itself requires decisive and

declarative action by the Plan Administrator, Federal Express Corporation. Yet perhaps the cause for such brazen disregard of the law is that plan fiduciaries have no intention or incentive to comply with the law.

Mr. Smith filed a grievance upon learning of Cigna's misconduct in handling his medical appeal (Cigna Call Ref # 5780). To date, Cigna has not performed "Full and Fair Review" of Mr. Smith's Medical Appeal. To date Mr. Smith's complaints on this matter have not been acknowledged. Neither has his grievance been attended to. There is no written response, no determination - Nothing. There is instead the accumulation of evidence of the Named Entities engaging in illegal activity.

One such accumulation of evidence involves Mr. Smith's claim for reimbursement for services provided by Dr. Rice. In Mr. Smith's 2019 medical appeal he described in detail how his requests for an out-of-network adequacy (NAP) to see specialists Dr. Rice and Dr. Blumenthal had been wrongfully denied [S.S. 2019 M.A. pages 63-76]. With respect to the events around Dr. Rice's NAP denial Mr. Smith stated in his 2019 medical appeal that, "After the first denial I sent in the aforementioned letter for reconsideration and the denial was maintained. It was a case worker who got the denial overturned because...They needed to list two providers able to provide similar services and only listed one." "...Cigna's negligence in reviewing the request for approval was so egregious their review team didn't even follow basic rules" and "I doubt they [Cigna] even reviewed any of the documentation I sent in.". Mr. Smith attended an appointment with Dr. Rice as a patient in December of 2018 for a diagnostic workup and acquired the necessary information to submit a claim to Cigna for reimbursement, and submitted that claim on May 20, 2019 [Sean Smith, 2019-2021, Dr. Rice Cigna Claim].

Case Manager Jessica Caroll as part of the Cigna MyChampion program was assisting Mr. Smith with submitting the Dr. Rice claim. Jessica had monthly checkups with Mr. Smith to update him on the claim. Despite this level of attention, at the last checkup with Jessica Caroll in July of 2020 the claim was still being processed. Mr. Smith received a letter in August of 2020 stating "Jessie Carroll has left the company", and that, "Your case has been transitioned to a new Personal Champion. Aracely Alvarenga will be assigned to take over your case." [Sean Smith, 2019-2021, Dr. Rice Cigna Claim]. The letter stated Aracely would contact Mr. Smith on Sept 17, 2020. Mr. Smith does not recall nor do his records show Aracely Alvarenga contacting Mr. Smith. Mr. Smith's records show he called Cigna on Feb 24th, 2021 to "dig into Dr. Rice claims and why I've not heard anything further", the call duration was 2 hours 17 minutes and 18 seconds.

Mr. Smith's call notes indicate he spoke with Jessica D. at Customer Service, and that he did "Explain my past interactions with My personal Champion. How monthly checkup[s], asking them to follow up on issues, then case transferred, then person who inherited case never responds to me, and so busy trying to survive Cigna-UHC abuse/illegal activity, overwhelmed, and can't follow up, but get reminded I need to, and it's been so long it 'just needs to be done even if it's going to hurt me/not go well'.". Jessica D. transfers Sean to Matthew D. and Sean explains to Matthew that Jessica Carroll had been assisting with the claims, and how the claims

"haven't been paid out, they haven't been processed. I haven't been able to get a straight story on them. I just get monthly updates about hey, ya, uh, we had another problem, or another problem, or another problem, or another problem".

Mr. Smith was functioning very poorly at the start of the call, and as Mr. Smith's PTSD was provoked by discussing all the problems he has been experiencing with the health plan, he became more impaired, and he got lost in the "litany" of his problems. Mr. Smith said to Matthew D., "you're asking me basically what you can do to help with the claims, and, I'm just... I know my problems [with the health plan misconduct] are beyond that. It's like, if you want to go look at Dr. Rice's claims and hammer those out and make'em get paid, go on right ahead...". Matthew D. says "I will certainly talk to my supervisor about these claims".

On July 27th, 2021 Matthew D. and Connie S. called and spoke with Mr. Smith about his care needs and the Dr. Rice claims. Mr. Smith's call notes indicate that he asked "Connie to look into the denials and improper review of medical appeal and the $1000 in claims for Dr. Rice that have sat for over two years in limbo despite me doing all I could to get things sent in and processed." To which, Connie S. said, "I'll look into that as well.". To Mr. Smith's knowledge, the claims for Dr. Rice remain unattended to. Mr. Smith knows of no further processing updates or notice of payment or determinations made with respect to the claims for Dr. Rice.

During the conference call with Cigna-FedEx, no representative of Cigna nor of FedEx acknowledged the fact that no review of Mr. Smith's appeal has occurred, nor of the wrongful denials of care requests covered within that appeal, nor of additional wrongful denials of care requests disclosed indirectly to Cigna through Mr. Smith's email to FedEx, nor of past grievances and complaints being unattended to or mishandled, nor of many other matters involving the Named Entities misconduct causing harm to Mr. Smith. With plan fiduciaries having refused to acknowledge such matters, no discussion could occur as to how healthcare operations might proceed in a manner which would be in compliance with the law and would not cause further harm to Mr. Smith.

UnitedHealthcare and TennCare have engaged in similar forms of misconduct regarding the review of Mr. Smith's medical appeal, requests for care, complaints, grievances, and other health plan operations, thereby denying him access to "less drastic alternatives" just as Cigna-FedEx have.

UnitedHealthcare and TennCare claim Mr. Smith's 2019 medical appeal was entirely about denied physical therapy claims - nothing could be further from the truth [UnitedHealthcare, 2019, UHC, Med Appeal Denial] [TennCare, 2019, Med Appeal Denial]. That these determinations occurred proves, beyond a doubt, UnitedHealthcare and TennCare's noncompliance pursuant to 42 CFR § 438.406. Another letter like this one would have to be written to go into the details required to speak fully on that matter. I would hope that readers of this letter would by now hold a desire that the writing of such a letter not be made necessary. Especially those who dare to review Sean Smith's 2019 medical appeal first-hand and see with their own eyes how absurd it is to assert that the appeal was about denied physical therapy bills.

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

The position adopted by UnitedHealthcare's denial demonstrates a willful disregard of how their past actions have caused physical and psychological injury to Mr. Smith. They too refuse to acknowledge the wrongful nature of the denials of past requests for Prior Authorization and the tremendous harm and suffering this has caused Mr. Smith. The gross misconduct of representatives, the supplying of misinformation, the refusal to offer accommodations which can assist him with his disabilities and burdens, let alone taking action to facilitate needed medical care. UnitedHealthcare and TennCare have demonstrated in their response to Mr. Smith's Medical Appeal that they have no intention to cease in misconduct so as to prevent further injury to Mr. Smith and other plan beneficiaries. They did in fact try to misrepresent material facts and use that information as an instrument to wrongfully deny Mr. Smith's Medical Appeal. Not but a few months later UnitedHealthcare and TennCare wrongfully denied another request for prior authorization for physical therapy, continuing to jeopardize Mr. Smith's health and safety.

Mr. Smith voiced complaints and grievances to TennCare regarding UnitedHealthcare's misconduct and TennCare's contribution to allowing this misconduct not only to occur but even acting to facilitate it. TennCare's Director of Medical Appeals, Don Sharp replied in a letter which merely regurgitated the same lies as were used to wrongfully deny Mr. Smith's medical appeal. Blatant Lies for which one will find no evidence corroborating Don Sharp's assertions. Don Sharp went on to state, "though you [Mr. Smith] have expressed dissatisfaction with TennCare policy and alleged that UHC and TennCare are not in compliance with federal and state laws, you have not provided any specific information for TennCare to investigate." [TennCare, 2020, TennCare Grievance of Appeal Rev].

Since 2018 Mr. Smith has repeatedly given specific examples of health plan misconduct and illegal activity to TennCare and UnitedHealthcare verbally over the phone and in writing and is at this time disinclined from searching through his hundreds of hours of phone recordings, years of call notes, and gigabytes of documents just to once again present that evidence to TennCare and UnitedHealthcare. If Mr. Smith elects to perform such a review of his records to present specific information as evidence it will be only as it is necessary during good faith discussions with the Named Entities, or to present that documentation publicly, as previously *specified* on page 6-7.

Don Sharp's May 2020 letter demonstrates that a competent good faith investigation was not performed and that Don Sharp - or whomever it is that truly wrote that letter despite it bearing her signature - relied upon the accounts of the wrongdoers to ascertain what had occurred as opposed to evaluating the evidence first-hand *to test the veracity of Mr. Smith's allegations*. Mr. Smith does allege here and now that Don Sharp is unfit to act as TennCare's Director of Medical Appeals due to her failure to investigate the appeal denial *and* that Don Sharp had been unaware of her department's noncompliance with state and federal laws, and after having had the noncompliance brought to her attention *chose* to try to maintain her ignorance by neglecting both the duties of her position as TennCare's Director of Appeals and as a plan fiduciary of the TennCare Medicaid health plan.

Furthermore, in stating that Mr. Smith did not provide sufficient "specific information" to support his allegations of UHC-TennCare legal noncompliance - again, Don Sharp's claim is false and demonstrates a failure to investigate - Don Sharp seems to imply that it is the duty of the health plans disabled adult plan beneficiaries to provide the information required for TennCare to regulate itself such that TennCare and it's MCOs remain in compliance with state and federal laws and do not neglect,abuse, and exploit their disabled adult plan beneficiaries. With such expectations being held by TennCare's Director of Medical Appeals, it is no wonder that misconduct is endemic within UHC:CP and TennCare. It is as if Don Sharp doesn't understand what being disabled is like; what her plan beneficiaries can and cannot do; what assistance TennCare's disabled adult beneficiaries need; what her duties are to the plan beneficiaries; why the Social Security Act is worded and organized as it is and the programs subject to it were brought into operation and receive federal and state funding. Which is something Mr. Smith explained verbally and in writing to TennCare at the TennCare Block Grant hearings at Jackson TN and Memphis TN in October of 2019 [Sean Smith, 2019, TNCARE Public Comments].

Mr. Smith did state at the TNCare Block Grant Meetings:

"The core mission of our disability programs have been clear since their inception. The Social Security Administration have reiterated this mission many times in their publications. In one such publication is a quote of President Eisenhower in which he says, "We will ... endeavor to administer the disability [program] efficiently and effectively, [and] ... to help rehabilitate the disabled so that they may return to useful employment .... I am hopeful that the new law ... will advance the economic security of the American people.""

"The medical issues disabling me are quite treatable, as are those afflicting many other medicaid recipients. It would cost less to provide the care we need than it does to continue to limit and deny access to that care. Some of us would be able to return to "useful employment". I've requested the care I need multiple times and my requests have been wrongfully denied - *so* wrongfully that it's beyond *any* doubt that they're breaking laws. This is no opinion: *they*_**are**_breaking_the_law. They present misinformation to members, they wrongfully deny care, they essentially torture people who can barely function by requiring them to navigate one obstacle after another, and when I have asked for assistance with the appeals process I get told that there is no one to assist - it's taken me years to figure out how I and others are being abused and exploited."

"I think what is most poorly understood by those in leadership roles in government and healthcare organizations are the problems that the medically disabled face and how to provide the comprehensive care required to meet their medical needs. We need doctors to be able to sit down with a patient, figure out what's going wrong, develop a treatment plan based upon *current* research and literature, and then provide care. That something so basic is absent from the

TennCare program indicates we really need to evaluate our priorities here. I mean, for crying out loud, the guidelines TennCare uses for sleep studies are over a decade out of date with respect to the scientific literature. I don't think now is the time to talk about Block Grants - there's a three-alarm fire going on. This *is* a state and federal fiscal disaster - finding a better way to fund TennCare won't change the nightmare patients like me are being abandoned to nor mitigate the colossal waste of public resources that is taking place."

Mr. Smith made his statements in a room full of citizens, state representatives, TennCare representatives, lawyers, doctors, reporters, etc, who were attending the Memphis Block Grant meeting.

Mr. Smith has also attempted to communicate with TennCare Oversight with regard to UnitedHealthcare and TennCare's collective misconduct. Mr. Smith wrote to TennCare Oversight requesting that they enter into an agreement wherein they would commit to abide by 42 U.S.C. 1396a(a)(19) in all their interactions with Mr. Smith [Sean Smith, 2020, Letter to Patricia Newton]. Mr. Smith did write, "I am hoping you will acknowledge your duties and then commit to fulfilling them prior to my investing time and energy in any disclosures.". TennCare Oversight did not enter into any such agreement.

TennCare Oversight replied claiming that they are only authorized to exert regulatory action over the Managed Care Organizations to ensure that they "operate in compliance with their TennCare contract and applicable laws", after which they assert that "The Division has no authority to resolve plan member disputes with their managed care provider or the Division of TennCare." [TennCare Oversight, 2020, TDCI Response Ltr 061220]. The law requires action [42 CFR § 438.66(b);(c)] [42 CFR § 438.100], so it is a strange thing for TennCare Oversight to say what it said in response to someone seeking to report an MCO's noncompliance with both its contract and the laws governing its operations and how TennCare's actions have contributed to that noncompliance. How can TennCare Oversight exert regulatory action over the MCO's if the MCO's are permitted to engage in misconduct due to TennCare's own misconduct? How can TennCare fulfill their obligations to vulnerable citizens under their stewardship if TennCare Oversight doesn't exert the required regulatory actions?

I would extend that a Division receiving federal funding to provide oversight which then refuses to provide oversight or is so crippled in it's operations that it cannot exercise oversight is thereby actively engaged in defrauding the United States of America [18 U.S. Code § 1031] [18 U.S. Code § 371].

One may even more broadly assert fraud is occurring within UnitedHealthcare and TennCare by noting that the duty to curb costs and assist beneficiaries [42 U.S.C. § 1396a(19);(30)] cannot be fulfilled when the program's operations prevent beneficiaries from receiving medical care for conditions that if not properly treated are known to lead to a high rate of medical utilization for a variety of services and cause injury to communities, the State, and the Nation. This fact was demonstrated in the references in Mr. Smith's medical appeal [S.S. 2019 M.A. Ref 40, 41, 42, 43, 44, 45, 52, 139, 140]. It's puzzling why the misconduct of these

organizations is allowed to antagonize vulnerable persons, injuring them and their communities, all while defrauding taxpayers. The individuals facilitating this misconduct have betrayed the plan beneficiaries, their communities, and their country. They honor neither Oath nor Law and they prey upon the most vulnerable among us while claiming, and perhaps even believing, they are providing a service to others.

Mr. Smith contacted UnitedHealthcare Community Plan on Aug 5th 2020 attempting to get information on how to submit claims for reimbursement for physical therapy services that have had to be paid out of pocket due to their misconduct and encountered further generalized dysfunction throughout the health plan and blatant misconduct. A complaint was filed on August 5th 2020. The response to that complaint dated August 31st shows a total disregard of the contents of the call and thereby the nature of the complaint. In the letter UnitedHealthcare asserts, "According to your request, you are unhappy with the member reimbursement process." "UnitedHealthcare Community Plan of Tennessee established the member reimbursement process per the direction from the Division of TennCare." [UnitedHealthcare, 2020, UHC 8.5.20 Complaint Determination]. In essence UHC claims that they're just doing what they're supposed to, which is quite similar to the response from TennCare Oversight. The UHC representative on the call also claimed something similar:

> **Akeema**: I wouldn't necessarily say 'the misconduct' it's just the way UnitedHealthcare have their rules and guidelines setup for reimbursement for this.
> **Sean**: No, no, no. You guys aren't following your rules and guidelines when I requested an out-of-network adequacy or I sent in a medical appeal or when my provider tried to file these claims on my behalf; you [UHC] weren't following any of your rules and guidelines. Federal, State, or even your internal ones. And I'm saying, through your misconduct I am now being required to sustain financial injury to send in for reimbursement and I can't even get some accommodation to send it in on a CD to obviate that financial injury to myself.
> **Akeema**: that is the way UnitedHealthcare has it setup sir.
> **Sean**: And you don't see a problem with this?
> **Akeema**: ...If you're not happy with it I could submit you a grievance...
> **Sean**: You keep mentioning rules and guidelines, but all of those are supposed to operate within compliance of these federal and state statutes. And I'm saying, that's not happening...

TennCare Appeals & Grievances refuses to investigate allegations of misconduct of their MCO and their organization and engages in misdirection and the use of lies in order to dismiss grievances. TennCare Oversight refuses to exert regulatory action over the MCO's. The MCO's engage in misconduct while claiming that they're just following TennCare's directions. The word "Collusion" seems fitting. What letters and reports one could write exploring that subject.

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

An Addendum to, The Availability of "Less Drastic Drastic Alternatives", written on 3.20.2021:

I have deteriorated physically, cognitively, and emotionally year by year, however, my ability to function has fallen apart during the Fall of 2020. I am very unwell. I was already impaired in my ability to function due to my disabilities. Yet right now I'm too compromised to do much of anything. I have been struggling to find a way to manage my disabilities so I might recover enough function that I could work on this letter and other tasks.

I wish I had the function to be able to cover the instances of misconduct perpetrated by UnitedHealthcare and TennCare from August of 2020 through 2021 that are grounds for asserting a conspiracy to commit assault and perhaps even attempted murder of myself. But I am not well enough to gather, organize, and analyze the documentation to cover that matter in this letter. I guess it's kind of silly to think I should. I'm too busy trying to find a way not to be killed by UnitedHealthcare and TennCare right now.

I find myself unable to adequately defend myself from the existing abuse, let alone keep up with documentation and responding to events as I should. The task of 'seeking care' is one I don't even know how to approach anymore. I have deteriorated too much.

I know I should at least note that these events have occurred though and I can do that much. Particularly as the severity of the offenses are grounds to assert assault and, well, attempted manslaughter or murder, I don't know. I never thought I'd encounter someone at the insurance company trying to use my protected health information to so directly try to injure and kill me. Neglect is one thing, but to weaponize information and engage in unsubtle misconduct for the purpose of harming plan beneficiaries is another matter altogether.

UnitedHealthcare and TennCare's actions are an instance that can be viewed as acting with intent to cause a disabled adult to be injured or killed by knowingly causing myself to be subjected to conditions that were disclosed to them to place me in imminent danger through an overwhelming submission of evidence. That evidence being written and verbal protected health information for which the only lawful response to it would have been to act to facilitate needed care. Needed care not only hasn't been facilitated, but the information has been used to disrupt existing care necessary to manage my disabilities, and my decline in function is in part related to that. The instances of misconduct that have been perpetrated by UnitedHealthcare and TennCare throughout this period of August 2020 to March 2021 will require people to be fired and face criminal charges.

A Full & Fair Review Provides Evidence of Illegal Activity And Injury Done to the Beneficiary

As previously demonstrated in this letter, the disclosure of Mr. Smith's Protected Health Information to Police was unlawful pursuant to 45 CFR § 164.512(j). This unlawful disclosure of PHI is also in violation of the Americans with Disabilities Act, T.C.A. § 39-16-502, and potentially other laws, both Civil and Criminal, particularly those relating to having intentionally or through negligence endangered a person or caused a person injury. This is due to the type of information disclosed and the manner in which it was disclosed to Police [Bartlett Police Department, 5.26.2020].

The plan fiduciaries had been made well aware that a welfare check has caused and could be expected to cause Mr. Smith to be placed in "imminent danger" [T.C.A. § 71-6-102] [S.S. 2019 M.A. pages 33-38] [C-F 2020 Transcript 00:45:09.27-00:50:12.20]. Despite this, not only did the plan fiduciaries initiate a welfare check, but they were in receipt of Protected Health Information which directly contradicted their assertions that Mr. Smith was an immediate danger to himself and in need of a welfare check. By withholding that information and instead presenting information which would mislead law enforcement by catering to prejudiced and discriminatory views which stigmatize and oversimplify Mr. Smith's mental health and disability, it can be declared that the plan fiduciaries actions increased the likelihood that significant harm might befall Mr. Smith. This being so because plan fiduciaries did act to cause Mr. Smith to be subject to conditions that had been communicated to them, per the information that their positions of trust afforded them about his disabilities and medical status, would place Mr. Smith in "imminent danger". One might even assert that the plan fiduciaries actions demonstrate a purposeful intent to place Mr. Smith health and safety in greater jeopardy.

Medical records were submitted to Cigna-FedEx as part of Mr. Smith's Medical Appeal. These materials were thereby made accessible to Dr. Martinez and Danielle Carneson and all of the other plan fiduciaries in receipt of Mr. Smith's Appeal. Over a month prior to the conference call Mr. Smith offered to provide additional copies directly to FedEx Human Resources should they fail to locate those records previously submitted with his medical appeal.

Mr. Smith requested, gathered, organized, and sorted through over 600 pages of medical records to produce the collation of records that was presented alongside his medical appeal. Mr. Smith even highlighted relevant sections of those records so that, if need be, a person could quickly skim through the record and see evidenced within it a long-standing history of his struggles with breathing, sleep, pain, and musculoskeletal dysfunction.

Included in those records were psychiatric records. Psychiatric records from 2017 disclosed that Mr. Smith while under the supervision of his psychiatrist "tapered off psychiatric medication" in 2014-2015, "and has been relatively stable with mood, off medications, for over 2 years. He continues dependent on his family for support and housing."

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

It was disclosed by Mr. Smith and his parents that he had been on continuous polypsychopharmacology since the age of 10. As a result neither Mr. Smith nor physicians could determine with any veracity which of his symptoms were part of an underlying disease and which were the side effects of medications and which of those side effects might in fact be indicative of iatrogenic harm due to underlying medical conditions being aggravated by the psychotropic medications.

It had become necessary to discontinue the administration of psychiatric medications in order to determine what was going on medically. The process of discontinuing those medications caused symptoms of withdrawal which were quite burdensome, difficult to manage, and quite likely caused brain damage. So much so, that Mr. Smith's current reticence towards undergoing the administration of psychotropics largely stems from how tortuous it was to taper off of them and the very limited assistance that psychiatry could provide in advising how to discontinue the medications safely.

Furthermore, both during and after the discontinuation of psychotropic medications it was observed that the medical conditions most affiliating Mr. Smith and contributing to his suffering and disability extended beyond those of a psychiatric nature. That fact, again, evidenced in the psychiatric records by the treating physician, who having been handling Mr. Smith's care since 1998, did assert "He [Mr. Smith] has become increasingly concerned with his physical health, especially jaw pain associated with sleep problems. I do not believe this is a psychiatric manifestation of his chronic mood disorder."

While off of medications, what symptoms Mr. Smith has which one might choose to define as being psychiatric in nature, symptoms that historically have been ascribed to cause him to be disabled his entire adult life, were one's which had proved resistant to pharmacologic treatment. The refractory nature of Mr. Smith's symptoms again evidenced within the records submitted to Cigna-FedEx. One such record being a copy of a medical appeal submitted to Cigna in 2014 by Mr. Smith's psychiatrist. This appeal was, like many other requests for care, wrongfully denied.

Within that appeal it is stated by the psychiatrist, who again, has handled Mr. Smith's care since the year 1998, "Mr. Smith has tried previous treatments with medication(s) but has not found any alleviation of symptoms and has not shown any significant improvement; the treatments including the following", thereafter listing over 15 different psychotropic medications. In the collated medical records submitted with Mr. Smith's medical appeal the segment of text quoted in this paragraph is highlighted within the document.

Rest-assured, far more than those medications which are listed in that 2014 medical appeal have been administered to Mr. Smith. Over twenty years of polypsychopharmacology has been applied to Mr. Smith since the age of 10 with limited to no efficacy. An example being that while committed to a psychiatric facility at the age of 15 the medication Geodon was administered and caused seizures. The facilities staff, including a nurse with over 20 years of experience in the mental health field, were gravely concerned and voiced that they had no idea what they could do to provide assistance to Mr. Smith. Their efforts were limited to administering

an intravenous shot of benadryl and physical massage of affected muscles as Mr. Smith's body contorted repeatedly over the course of about an hour. Geodon is not listed in the medical records included with the appeal. Neither are many other medications. Mr. Smith contemplates that the Geodon was one of many events which worsened his existing, and at the time undiagnosed, musculoskeletal dysfunction.

Mr. Smith's communications in the 2019 medical appeal he authored himself echo and expand upon those of his psychiatrist, "After a lifetime of psychopharmacological intervention aimed at symptom management I found myself in my mid-twenties with a collapse in my ability to function due to intense pain, cognitive deficits, depression, difficulty breathing, and exceptionally poor sleep." [S.S. 2019 M.A. page 12]. Mr. Smith further disclosed, "My health has continued to decline despite enacting many radical changes in lifestyle; my life currently revolves around managing pain, poor sleep, impaired digestion, trying to eat enough, compensating for cognitive deficits, and trying to live with the psychological distress I experience as a result of my situation." [S.S. 2019 M.A. page 13].

Mr. Smith has endeavored for many years to educate himself in order to find and apply interventions which can have efficacy in managing or resolving his refractory medical conditions. In his medical appeal he illustrated through the text's body and the references how refractory medical conditions often have an underlying cause that must be accounted for in order to supply efficacious treatment.

One such reference being a case study wherein a disabled women who suffered from epilepsy her entire life stopped having seizures after getting her airway and jaw disorder treated [S.S. 2019 M.A. Ref 34]. The treating physician admits to having known "little about any connection between epilepsy and TMD or SRBD [sleep-related breathing disorders]." This has pertinence to mood disorders, particularly Bipolar Disorders. Neuroleptics are a class of medications used by neurologists to treat epileptic seizures. Neuroleptics are also utilized by psychiatrists in an off-label manner to treat Bipolar Disorders.

Interestingly, refractory epilepsy has been known to be treatable by fasting since the time of Hippocrates. In the early 1900's medicine made more scientific observations regarding fasting and ketosis having efficacy in the treatment of refractory epilepsy. Ketosis fell out of favor when pharmacologic therapies were developed, and yet, ironically, when seizures proved refractory to those new pharmacologic interventions ketosis and fasting were noted to be efficacious. Similar evidence exists for other neurologic conditions and psychiatric disorders, such as narcolepsy, and even specifically for bipolar disorders. In one study, two women with bipolar disorder who had been taking the neuroleptic lamotrigine for a number of years found a ketogenic diet provided superior efficacy in treating their psychiatric symptoms, so much so, that they then required no further pharmacotherapy for their bipolar disorder [James R. Phelps et al., 2013].

Mr. Smith has been in receipt of this knowledge since the years 2013-2014. It was a process of discovery, one in which he would review articles, synthesize information, form hypotheses, then seek out additional information and perform further review. He eventually formed a hypothesis that a ketogenic diet may be of utility to persons with bipolar disorder, and

then did seek out information to further study the matter. At that time, few had bothered to ask these questions. In fact, the evidence suggested that efforts to test this theory were driven by patients and clinicians, not academics. The most plentiful evidence on this subject was to be found in the anecdotal accounts of online forums.

Many physicians are ready to dismiss these studies and reports as being little more than anecdotes. However, dismissal causes one to be in just as much error as those who make the mistake of thinking these evidences are substantive enough to be regarded as definite 'proof'.

It is unfortunate that so many physicians have a tendency to operate in the erroneous assumption that the biological underpinnings of psychiatric disorders require psychotropic medications to manage psychiatric symptoms in the short and long-term. This mindset asserts that no amount of wishful thinking can substitute for the efficacy of psychotropic medications. At the same time, when evidence which is contrary to this mindset is presented, there is a disposition to dismiss it, quite often asserting that the improvements reported by the patient can be explained away as a placebo response. An assertion which would imply that psychiatric conditions can be effectively managed by wishful thinking alone. This type of discordance doesn't belong in a scientifically-minded evaluation of anecdotes or more rigorous studies, yet it is a mindset which is prevalent throughout medicine. A mindset which inhibits the exercise of performing a full and fair review of information.

From Mr. Smith's endeavors to engage in personal research and discover solutions, he came to understand that for those that seek knowledge answers await, but only for those who are willing to perform a Full and Fair Review of information.

Refractory epilepsy is that which has proved unresponsive to pharmacologic management. Yet, such a case of epilepsy was resolved in a person after undergoing treatment for their breathing and sleep. Some of the same interventions observed to have efficacy in refractory epilepsy are also observed to have efficacy in mood disorders.

And indeed Mr. Smith referenced in his medical appeal an article demonstrating how an underlying issue with breathing which disrupts sleep can be responsible for symptoms which are classified and then treated as psychiatric illness, but remain refractory to treatment [S.S. 2019 M.A. Ref 52]. The primary author of the article is Dr. Christian Guilleminault, a legendary physician credited with being instrumental in the creation of the field of sleep medicine - expert testimony get's none more elevated, even if given from the grave. Alongside Dr. Guiellminaults work is an article from within the field of psychiatry, wherein Mr. Smith quoted the authors directly in his appeal with the following, "The adverse consequences of poor sleep on mood, motivation, and cognitive functioning are particularly relevant to bipolar disorder" [S.S. 2019 M.A. Ref 153].

Indeed a wealth of references were supplied with Mr. Smith's appeal that illustrate the intimate relationship breathing and sleep has to psychiatric illness and other chronic diseases. Thereby Mr. Smith did seek to demonstrate the primacy of attending to his medical issues and the secondary nature of his psychiatric symptoms.

Furthermore, after tapering off of psychotropic medications, Mr. Smith was able to observe that those medications offered little to no benefit to him, and had even been contributing to the pathology of his underlying medical conditions, as evidenced within his medical appeal by his disclosure of the ill-effects he experienced from Trazodone and Temazepam [S.S. 2019 M.A., page 54], those ill-effects implicating the presence of an underlying issue with breathing and sleep.

Examples of the harms Mr. Smith has sustained - those for which he is certain he can rightfully ascribe as having occurred from the administration of psychotropic medications - include tinnitus since age 10, seizures, fainting, head trauma, a worsening of Obstructive Sleep Apnea by undermining the Autonomic Nervous Systems ability to maintain airway patency as well as by inducing weight gain, difficulties with balance and a worsening of musculoskeletal dysfunction, extreme musculoskeletal pain, depression, adhodenia, acute suicidality, mania, hypomania, irritability, intense anxiety, chronic dissociation, acute and persistent depersonalization/derealization, lethargy, fatigue, digestive issues, and more.

Psychotropic medications have been observed to aggravate Mr. Smith's mood disorder and underlying medical conditions. It has been observed that in the absence of those medications Mr. Smith experiences a partial remission. Indeed, Mr. Smith has for nearly a decade observed that upon apprising himself of research materials one can find a wealth of information which one may apply in order to strongly influence psychiatric disease and other chronic diseases through a systems biology approach, and he has found many of those methods to be quite efficacious. A fact that stands firmly against the inexperienced and scientifically unsound opinions of Dr. Issac Martinez [C-F 2020 Transcript 00:21:16.27].

Mr. Smith has worked for many years to identify the medical care that he requires. While doing so he has encountered obstacle after obstacle. A majority of these obstacles exist as a result of the Named Entities willful and blatant misconduct. Between disease pathology and the misconduct of the Named Entities obfuscating access to care, Mr. Smith's has been prevented from applying the knowledge and tools he has possession of to maintain his health and well-being.

Mr. Smith's physical health has grown substantially worse since 2017, and the toll it exacts on his mental health - both cognitively and emotionally - has grown more severe. Mr. Smith has communicated to Cigna-FedEx and UnitedHealthcare-TennCare that he has learned that the psychiatric issues he has struggled with throughout his lifetime are most likely caused by or severely aggravated by his issues with breathing, sleep, his jaw disorder and musculoskeletal dysfunction, and his gastrointestinal issues. That the path to meeting his medical needs is, as communicated in the 2019 medical appeal, to "fix sleep, fix pain, fix eating and digesting issues, return to exercise - address medical needs, then go talk about the psychological struggles." [S.S. 2019 M.A. page 36].

Mr. Smith credits his persistence to seek out information, evaluate it, and implement his findings as the reason he has been able to achieve the level of function he has despite the ongoing deterioration and decline his unmet medical needs have caused him to sustain. Mr.

Smith notes that had he been less capable he would assuredly already be dead or too incapacitated to achieve the most minimal levels of function, and suspects, upon close inspection one might find many other beneficiaries which have been subjected to misconduct were also greatly harmed, and some even unable to survive.

Danielee Carneson and Dr. Issac Martinez were provided the observations and opinions of parents who have acted as caregivers to Mr. Smith for thirty-four years, a collation of medical records which included materials from Mr. Smith's psychiatrist who has provided care to him for over 20 years, Mr. Smith's own self-reports of his observations as well as Mr. Smith's reported findings after performing over six years of concerted research specific to his circumstances, and a 76 page medical appeal containing 157 references. Instead of utilizing these resources to the fullest, Danielle Carneson, Dr. Issac Martinez, and other plan fiduciaries did largely ignore them. They even took action to weaponize the information provided to them against Mr. Smith *and* those who care for him, which provides parties other than Mr. Smith grounds to file separate civil suits [42 U.S.C. § 12203].

An example of that weaponization includes how Dr. Martinez extended an opinion that Mr. Smith's Temporomandibular Disorder[8] (TMD) is caused by Sleep Bruxism which is caused by Tardive Dyskinesia which is caused by the treating psychiatrist having been neglectful in selecting and monitoring Mr. Smith's medications and then implying that Mr. Smith may have an underlying psychological condition and his needs can best be met by administering a safer class of psychiatric medication, and absent seeking mental health services that other treatment modalities will be ineffectual [C-F 2020 Transcript 00:21:16.27].

Such opinions being held by those operating the health plan also imply that requests for what are being judged as ineffectual treatment modalities would not be authorized and thereby care would be withheld from Mr. Smith under the claim that the treatment modalities would not be medically necessary, despite the fallaciousness of the opinions upon which that claim is based and the manner in which that fallacious opinion is used to actively discriminate against the patient population Mr. Smith is a part of. A patient population for which many within it readily meet the American with Disabilities Act's definition of disability.

Nowhere in the medical records or oral medical history is it suggested that Tardive Dyskinesia is present. The treating psychiatrists professional reputation is impeccable amongst local physicians. Many such 'safe' medications are evidenced as having been prescribed and lacking efficacy per the psychiatric records submitted with the medical appeal. It was disclosed that per the TMD literature Bruxism does not cause TMD, it contributes to it based upon the pathologies causing the TMD. "Psychological conditions" have been observed to resolve after treatment of TMD and OSA; many references were supplied in Mr. Smith's medical appeal evidencing this. Suggesting otherwise demonstrates that despite being in receipt of Mr. Smith's appeal Dr. Martinez continues to possess substantial ignorance regarding not simply TMDs and

[8] TMD is also referred to as "TMJ". It is strongly advised the reader review the full definition of TMD on page 54.

the treatment of Mood Disorders, but musculoskeletal disorders and pain conditions as a whole. On these matters Mr. Smith did relay the opinions of experts in his medical appeal.

Such expert opinions as that offered at the National Academies of Science Engineering and Medicine's 2019 TMD Workshop by Dr. Daniel Clauw, a professor of Anesthesiology, Medicine, and Psychiatry at the University of Michigan, "Having a sleep disorder in the population is a more powerful predictor of developing pain than having depression or anxiety" [S.S. 2019 M.A. page 7].

Or those words offered by Dr. Mark Cruz (DDS) in describing the Continuing Education courses he provides to physicians, "Sleep disordered breathing, Temporomandibular Disorders (TMD), dental crowding, bruxism/clenching, craniofacial distortions, ADHD (Attention Deficit Hyperactivity Disorder), ARCD (Airway Related Craniofacial Dysfunction) and many other medical sequelae are considered signs and symptoms of the deficient airway in the vast majority of cases." [S.S. 2019 M.A. page 15].

Dr. Cruz works with researchers at the University of Stanford, The University of Chicago, UCLA, and others, including having had interactions with Dr. Christian Guilleminault whose works were referenced in the medical appeal. Mr. Smith disclosed in his 2019 appeal [S.S. 2019 M.A. page 31] and in a care request included with his appeal [S.S. 2019 M.A. page 67] that Dr. Cruz is also part of a task force created by the American Dental Association. A cursory investigation into the matter will bring one to an article wherein the task force's mission is defined as being, "...to suggest for the dental profession appropriate methods of screening, assessment, and diagnosis of SRBD's [Sleep-Related Disordered Breathing] (with medical collaboration) and to provide means for dissemination of this information to the profession." [Barry Raphael et al. 2019].

A simple google search of "Dr. Mark A. Cruz" yields further information that is readily accessible. One resource is a podcast interview taking place not long after the conference held by the American Dental Association which was mentioned in the medical appeal and care request. In the interview Dr. Cruz states, "I work with well-known sleep physicians, pulmonologists and ENTs that this [breathing & sleep paradigm] is their world. And they agree with what we're teaching; what we're saying. The average physician knows very little about it. They get one hour of sleep science in medical school." And what they're teaching is that, "The 22-year-old college Grad that is suffering from mood swings and anxiety and irritable bowel syndrome and TMD and Bruxism. Something like that, the first thing we do is we stabilize sleep and then we address structure, function, and [breathing] behavior." "CPAP is not going to address that very effectively. The way the physicians are dealing with it, it's giving them an anxiolytic. They don't recognize the problem for what it is. I could delve into all the research having to do with the effect of chronic intermittent hypoxia on the brain and how it actually destroys the white matter causing depression. A high correlation with depression. Same thing with anxiety." "...we could go on and talk about all those correlations. All they're doing is they're treating symptoms and I just say, let's step back and take a more global approach to what's actually happening rather than chasing signs and symptoms." [Future Tech Podcast, 2019]

Dr. Cruz has further observed that, "people are predictably cured from the [breathing and sleep] problem...It changes their life. They turn into a different human being and they'll tell you that...I could show the outcomes, *we measure everything*" "[Physicians are] using surgery, medications, and devices because that's all we know and how we were trained. And yet there are all these validated approaches that are very very effective." [Future Tech Podcast, 2019]

Dr. Cruz and Dr. Peter Litchfield (PhD) both make the concise and astute observation that, "Behavior is physiology in action."

Dr. Mark Cruz (DDS), Dr. Barry Raphael (DDS), Dr. Richard Roblee (DDS), Dr. Peter Litchfield (PhD), and many of their fellows and peers are at the forefront of meaningful change in our healthcare system. As are other leaders in this field, such as Dr. Jeff Rouse (DDS) and Dr. Steve Carstensen (DDS) and Dr. Jerald Simmons (MD, neurologist, sleep medicine specialist) whose publications and presentations were referenced in Mr. Smith's medical appeal [S.S. 2019 M.A. Refs 68, 69, 71, 75]. Despite these references being of immediate relevance to Mr. Smith's circumstances they appear to have not been reviewed by Dr. Martinez or Danielle Carneson nor any other Plan Fiduciaries at Cigna-FedEx or UnitedHealthcare-TennCare.

From Dr. Jeff Rouse's articles on Bruxism, TMD, and Sleep-Disordered Breathing referenced in Mr. Smith's medical appeal:

"The rate of OSA may be as high as 30% in the TMD population. In addition to OSA, close to 50% of [Upper Airway Resistance Syndrome] UARS patients complain of bruxism."
"obstructive sleep apnea (OSA) syndrome has been called the highest risk factor for tooth grinding during sleep."
"The majority of [Sleep Bruxism] episodes occurs in a supine position and may be associated with either a reduction in the airway passage or increase in its resistance."
"mild apnea patients have more bruxism than moderate apnea patients." [S.S. 2019 M.A. Ref 75]

"Historically, popular theories have postulated that the generator for bruxism was stress, neurochemical, or occlusion. *PSG-based research has **disproven** these theories.* Stress leads to awake bruxism, not sleep bruxism.59,60 Most chemical irregularities in bruxers are linked to sleep fragmentation.61"
"sleep bruxism serves a functional role in protecting and improving the airway during episodes of inspiratory flow limitation and obstruction. The activity of increasing genioglossal and infrahyoid muscle tone along with the lateral movement of the mandible dilates the upper airway, raises inspiratory flow, and reduces upper airway resistance.68"
"80% or more of the bruxing episodes have related respiratory events.6"
"Without esophageal pressure monitoring to demonstrate the increase in respiratory effort, bruxism activity may not be recognized as being associated with a respiratory event."
"A healthy autonomic nervous system...can fix the airway before it can be detected within the framework of a normal PSG."

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

"researchers concluded that pediatric sleep-related tooth wear could be used as a marker for SDB [sleep disordered breathing]"
[S.S. 2019 M.A. Ref 76]

"anterior open bite have been correlated with an increased risk of TMD.1"
"Many dentofacial physical risk indicators for malocclusion and TMD are also identified as indicators of increased risk for sleep-disordered breathing"
[S.S. 2019 M.A. Ref 77]

Even 10 years ago in 2010, it was scientifically evidenced and understood that there is a strong relationship between Sleep Bruxism and the Airway. Dr. Rouse and others have long been aware that sleep and breathing and bruxism is not about diagnosable OSA, but the autonomic nervous system intervening to maintain or reestablish airway patency.

From Dr. Simmons' 2018 presentation, "What about Sleep Bruxism? We now know that sleep bruxism protects the airway. It brings the jaw forward. The tongue goes forward, there's tongue thrusting; all these maneuvers are protective of the airway. They're occurring during sleep because the airway is trying to improve." [S.S. 2019 M.A. Ref 71].

Dr. Simmons and similarly knowledgeable physicians understand that the severity rating of sleep-related breathing disorders is misleading, as the more 'mild' the OSA the more likely it is that the autonomic nervous system will be able to respond with protective actions which will reduce the Apnea Hypopnea Index (primary measure used when scoring sleep studies), even to the point that a patient who has breathing issues which cause significant disruption to their sleep quality and substantive medical burdens can be declared as not having OSA. These physicians understand that the progression from mild to severe sleep-related breathing disorders - those being UARS, and mild, moderate, and severe OSA - occur due to "a progressive destruction of the sens[ors] of the upper airway" [S.S. 2019 M.A. Ref 53] as well as "brain injury" which causes a "disruption of functional responses to autonomic and ventilatory challenges" [S.S. 2019 M.A. Ref 88].

From this awareness a knowledgeable physician comprehends that Sleep Bruxism is an early warning sign of a problem with breathing and sleep and that *only after ruling out* the presence of breathing issues disrupting sleep would it be acceptable to entertain and investigate other hypotheses. This being so as the methods typically used to manage bruxism involve interventions that can make an underlying breathing issue worse, and thereby accelerate the pathophysiology, causing a person to undergo more aggressive brain injury and damage to the sensors of the airway and even experience life-threatening medical emergencies.

Mr. Smith disclosed in the patient history of his medical appeal, [S. S. 2019 M.A. Page 53]:

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

"ADHD DX age 6, Mild Asthma DX age 6, bed wetting throughout childhood
A slow gradual change in mood, interests, and athletic ability beginning around age 9. Memories of distress regarding not being able to breathe properly with my mouth closed (not enough tongue space)."
"Depression DX Age 9"
"back/neck pain since age 9, changes in posture/gait, changes in masticatory function, instances of reflux"
"Bipolar II DX age 10
Tinnitus age 10 to date
First memories of signs of Nocturnal Bruxism and the start of an anterior open bite age 10.
History of Mouthbreathing and Rhinitis, onset coinciding with a progression of psychiatric symptoms."
"Pediatric Sleep Apnea DX age 17, Tonsil/Adenoid/Septoplasty 2004"

In the psychiatric records [S.S. 2019 M.A. Medical Records, "1 Dr. Smith Psychiatrist.pdf"] submitted with his 2019 medical appeal was an evaluation from 1997 stating:

"Sean was referred for a case study evaluation due to a recent emergence of severe behavior problems including *disrespect, disruption, destruction and aggression.*"
"His voice was somewhat robotic, his muscles were tight about his face and neck and he held himself rigidly."
"Sean reported difficulty waking up too early, having little appetite, and overwhelming tiredness."
"He also reported wishing he were dead."
"He also described many repeated *nightmares* containing feelings of frustration, helplessness and fear."
"His symptoms seemed to be more clustered in an affective domain."

Multiple Medical Records were submitted alongside the medical appeal which document that Pediatric Obstructive Sleep Apnea had been present since Mr. Smith's childhood and did not get diagnosed until the age of 17. As well as medical records from an ENT seen in 2018 whose practice specializes in sleep medicine - to whom Mr. Smith was referred to by an Oral Surgeon, an ENT, a Dentist, and a Pulmonologist - who wrote, "Mr. Smith has REM OSA, obstructed nasal breathing, upper airway resistance syndrome, and open bite."

Submitted with the medical appeal were examples evidencing the harms Mr. Smith has sustained due to his unmet medical needs. Including, records of multiple nights of overnight pulse oximetry reports and Mr. Smith's analysis of those reports. That analysis was quoted on page 23 of his medical appeal, "This data suggests that over the past 19 months there has been a 3-fold increase in the incidence of SpO2 desaturations occurring during sleep. It also highlights that for me a supine sleep position significantly increases the severity of sleep-related disordered breathing. These studies also allowed observations which indicate respiratory events

are contributing directly to the pain and dysfunction of the Temporomandibular Disorder and that the two conditions are in a complex relationship which contributes to sleep maintenance insomnia and impaired daytime function." [S.S. 2019 M.A. page 23].

Dr. Carstensen's presentation synthesizes the research of Dr. Avram Gold - both of which were referenced in Mr. Smith's medical appeal. Those materials can enable one to understand the relationship between breathing, sleep, bruxism, and psychology. I advise a full review of Dr. Carstensens presentations. A briefer synopsis of Dr. Gold's research is included herein by quoting the referenced article itself:

"[Sleep Disordered Breathing] SDB serves as a chronic *physical* stress (or *allostatic challenge*) activating the hypothalamic-pituitary-adrenal (HPA) axis"
"The neural sensitization paradigm postulates that SDB stimulates the limbic system through the effect of subatmospheric pressure in the nasal airway on the olfactory nerve." "In the neural sensitization paradigm... The HPA axis and sympathetic nervous system create a state of hyperarousal...enabling them to recognize and respond to a threat."
"Neural sensitization of the limbic system demonstrates a certain degree of non-selectivity with cross-sensitization between stimuli occurring."
"Neural sensitization of the brain's limbic system is a phenomenon that has been studied extensively as a model for substance abuse/addiction, bipolar disorder and anxiety disorders."
[S.S. 2019 M.A. Ref 66]

"[Mood Disorders] are *stress*-related conditions with overt expression in individuals with an underlying genetic vulnerability."
"The *allostatic* load model has been proposed to explain the progressive nature of BD [Bipolar Disorder]."
[Muneer 2016]

One statement in particular from Dr. Carstensen's 2018 Presentation is quite fitting to this situation, imparting a wisdom that the Named Entities seem to lack, "So why do some patients have more trouble than others? Because they haven't been listened to well enough." [S.S. 2019 M.A. Ref 68].

In the medical appeal Mr. Smith explained:

"The way that disordered breathing can act as a perpetuating allostatic challenge which sensitizes the limbic system and HPA-axis is critical to understanding TMD patient populations and the clinical symptoms they present with."
"As part of how respiratory events lead to arousal from sleep, the autonomic nervous system instigates behaviors to compensate for the airway compromise, such as bruxism or posturing the jaw, head, and neck. To support those compensations for breathing the rest of the postural

chain will adapt, affecting the thoracic, lumbar, and pelvic regions as well as the legs and feet. For some individuals the consequences of these behaviors and other factors lead to further arousability which fragments sleep and contributes to the development of musculoskeletal issues through multiple physiological and neurobiological pathways. This fragmentation of sleep is known to play a pivotal role in driving central sensitization of the nervous system which is a primary mechanism contributing to the development of a chronic pain Condition."
"Individuals vary in their vulnerabilities; this variance in individual vulnerability is in large part why it has been so difficult to understand the link between TMD, breathing, sleep, and other comorbidities such as the somatic syndromes and psychiatric diagnoses." [S.S. 2019 M.A. pages 15-16.]

Mr. Smith makes numerous mentions to the relevance of "understanding the systems biology", particularly the neurobiology, of TMDs and psychiatric conditions and how they interrelate in his medical appeal [S.S. 2019 M.A. pages 1, 13, 16, 17, 28] as well as in the conference call [C-F 2020 Transcript 00:17:28.08, 00:18:59.25, 01:08:23.13, 01:09:36.13, 01:11:31.16, 01:21:51.25], even going so far as to assert to the plan fiduciaries, "somebody doesn't understand the neurobiology of bipolar disorder. You want me to hand you that article? I can." [C-F 2020 Transcript 01:05:44.12]. If one searches in PubMed, or even in Google's main search, for "neurobiology bipolar" two of the first three articles are one's Mr. Smith had reviewed in the year 2018[9] [Sean Smith, 2020, Google and Pubmed Search Screenshots]. One of those articles is already referenced in this letter [Muneer, 2016], the second article is a masterful review of the scientific literature:

"*From a neurobiological perspective there is no such thing as bipolar disorder.* Rather, it is almost certainly the case that many somewhat similar, but subtly different, pathological conditions produce a disease state that we currently diagnose as bipolarity."

"a provisional "unified field theory" of the disease...sees bipolar disorder as a suite of related neurodevelopmental conditions *with* interconnected functional abnormalities that often *appear early in life* and worsen over time."
"**Alterations in HPA axis function in bipolar disorder have been well substantiated (168).** Exaggerated release of corticotropin-releasing factor (CRF) contributes to greater adrenocorticotropic hormone (ACTH) secretion and a subsequent **elevation of circulating glucocorticoids** (i.e., cortisol) (168)." [10]

---

[9] One can confirm the article was reviewed in 2018 by noting the .pdf of the article provided via USB in the References folder has a date modified of 7/11/2018 2:07 PM. Additionally, Mr. Smith reviewed the article in full, highlighting portions of it and taking notes, to share with his doctors, and has included a copy of this highlighted-noted document, file name "Integrated Neurobiology of BPD with Footnotes.pdf" date modified 10/20/2018 10:28 AM.
[10] See S.S 2019 M.A. Ref 155, quoted on S.S. 2019 M.A. page 27

"Evidence suggests that stress and excessive, inadequately regulated glucocorticoid signaling may *interfere with hippocampal neurogenesis* in the context of bipolar illness (218). The hippocampus plays an important role in the inhibitory regulation of the HPA axis; therefore, impairment in its plasticity may have a relevant role in the pathophysiology of bipolar disorder. Individuals endowed with at-risk alleles of the BDNF gene may have compromised ability to normalize HPA axis activity, thereby adding to mood-disorder pathology (219)
"bipolar disorder may be associated with excessive sympathetic nervous system (SNS) activity."
"*Autonomic dysregulation*, more generally reflected by decreased parasympathetic activity and *elevated sympathetic activity*, may be a trait marker for bipolar disorder"
"bipolar sufferers have inherent instability and blunting of biological rhythms"
"eveningness has a significant correlation with important clinical manifestations of bipolar illness"
"bipolar patients have higher awakening and evening cortisol than control groups."
"In response to light exposure, both euthymic and actively affected bipolar patients manifest two-fold greater reduction of nocturnal plasma melatonin concentrations compared with the healthy controls"
"Multiple lines of evidence indicate a relationship between bipolar disorders and circadian dysregulation. Circadian disturbances are not likely to be an epiphenomenon of bipolar illness given that they are present during mania, depression, in euthymic state, and in healthy relatives of bipolar patients (181, 182)." [11]
"In this review, we have emphasized the *complexity* of bipolar illness, not just because this is what *current science* suggests, but also because this perspective implies **a need for parallel dynamic changes in the ways we diagnose and treat the condition.**"
"As our scientific understanding advances, we suspect that we will gain greater understanding of how the ever-changing nature of the disease process requires different combinations of therapeutic interventions, with these treatment modalities tracking changes in the substrate and pathophysiological mechanisms of the disease in an iterative manner." [Maletic, 2014]

The pathophysiology described to afflict persons with Bipolar Disorder are nearly the same as those afflicting persons with breathing issues that disrupt sleep. Research publications have done a poor job assessing the prevalence of UARS and OSA in psychiatric populations. The methods which have been predominantly used to score nocturnal polysomnograms in research studies utilize scoring criteria known to cause misdiagnosis [Guilleminault et al., 2009] [Berry et al., 2012] [Vu Ho et al. 2012]. The systematic and meta-analysis reviews of studies assessing the prevalence of psychiatric population likewise suffer from the failings of the studies having

[11] Epiphenomenon: *n.* a mere by-product of a process that has no effect on the process itself. The term is used most frequently to refer to mental events considered as products of brain processes. Thus, though mental events are real in some sense, they are not real in the same way that biological states and events are real, and not necessary to the explanation of mental events themselves. Epiphenomena are conceived of as having no causal power. [Amer Psych Assoc, 2020]

utilized insensitive sleep scoring criteria. Mr. Smith is unaware of any large-scale population-wide studies assessing the prevalence of OSA within a psychiatric population which utilizes the recommended scoring criteria as specified in the 2012 update to the American Academy of Sleep Medicine's 2007 Scoring Manual or the alternative scoring methods specified in the 2007 scoring manual [Berry et al. 2012], let alone utilizing criteria which is more sensitive.

Nevertheless, the field of psychiatry and other branches of medicine suffer from the false perception that Obstructive Sleep Apnea is less of a problem than it really is for psychiatric patients. Psychiatry, by and large, has a limited understanding of sleep-related disordered breathing and almost no conceptualization whatsoever of Upper Airway Resistance Syndrome despite publications from leaders in sleep medicine seeking to communicate their relevance. The underlying neurobiology of breathing and sleep and how it directly relates to the presentation of symptoms so often diagnosed as being psychiatric in nature is well-evidenced but underappreciated. This matter is directly within a psychiatrists scope of practice as patients afflicted by these breathing issues are regularly directed to psychiatric care, not merely by untrained physicians but even from a multitude of physicians board-certified in sleep medicine who have failed to keep their practice up-to-date.

These collective knowledge-gaps in the mental health and sleep medicine communities are responsible for causing the methodological flaws in studies examining the relationships between sleep-related disordered breathing and psychiatric diseases. Those studies are relied upon in clinical psychiatry to inform practitioners as to how to practice medicine. Compounding this situation is how insurance billing models work against those physicians who are interested in and willing to attend to the needs of patients with greater scientific rigor. These circumstances cause there to be many patients with fully treatable, and sometimes readily curable, diseases that go unattended to and thereby remain refractory to the care being erroneously applied, causing patients years, decades, even an entire lifetime of suffering which ends with their premature death, whereafter they are noted as little more than a epidemiological statistic that get's largely ignored by clinicians and medical insurers.

And yet, all these matters notwithstanding, these flawed research studies observe remarkably higher rates of OSA in psychiatric populations. Indeed some authors note, "Once thought to be relatively rare, there is increasing evidence that obstructive sleep apnea (OSA) is both common and associated with significant medical and psychiatric comorbidities." [Christopher A. Baker et al., 2016], with some studies observing rates of OSA prevalence as high as 84% in psychiatric populations [Knechtle et al., 2019]. The study by Knechtle which observed an 84% prevalence of OSA in a cohort of psychiatric patients had a noted selection bias, but also was, remarkably, "the first according to [the American Academy of Sleep Medicine's] new diagnostic criteria". The authors also noted the importance of scoring Respiratory-Effort Related Arousals. To which I note it is exceedingly rare to see awareness in psychiatric literature regarding the importance of sleep scoring methodologies.

Despite marked failings the field of psychiatry has long acknowledged the importance of sleep upon mental health. Indeed, authors note that, "Sleep disturbances are very highly

prevalent among many psychiatric populations." and that, "sleep quality appears to be an important potential confounding factor in studying CNS alterations responsible for many psychiatric disorders." [S.S. 2019 M.A. Ref 128]. It is, "essential for clinicians to better understand this debilitating yet treatable condition." [Christopher A. Baker et al., 2016].

These and other factors played a role in why Mr. Smith provided the information he did in his 2019 medical appeal. The narrative of Mr. Smith's appeal is one in which the reader can review the contents and through the provided details and references corroborate any statements that the reader's existing knowledge base causes them to experience any uncertainty or doubt. In addition, if one should so require, there are many experts mentioned or referenced in the medical appeal for which one may seek additional information from and even request consultation with. Mr. Smith went to great lengths to respect the general format and nature of medical literature and scientific publications so as to assure there would be no claim of lack for information - the reader will learn and be granted understanding in accordance with the prudence one exercises during review; Mr. Smith provided the materials and information a plan fiduciary would require to fully understand the medical necessity of his care needs in a format that they would be - should be per their medical training - fully familiarized with.

In example, Mr. Smith disclosed that he received an adenotonsillectomy and that despite this treatment continued to struggle and be symptomatic of OSA as it did not treat the etiologic factors which cause one's breathing issues. Referenced in the medical appeal is a publication authored by Dr. Guilleminault, in which it is stated, "These studies demonstrate that treating children with adenotonsillectomy without checking for and treating abnormal orofacial growth lead to either incomplete resolution or to recurrence of abnormal breathing during sleep as a teenager or young adult." "A prospective study showed that there is recurrence of abnormal breathing during sleep within 3 years." [S.S. 2019 M.A. Ref 49].

Mr. Smith provided within the medical records submitted with his appeal some excerpts of published literature that he had presented to his treating physicians in the past. The document of excerpts is titled "0 Supplemental Info by Sean Smith" [Sean Smith, 2018, Supplemental Info], and highlighted within it was the following:
"Elimination of oral breathing, i.e., restoration of nasal breathing during wake and sleep, may be the only valid end point when treating OSA."

Mr. Smith asserted that his development and progression of psychiatric symptoms is related to his pediatric OSA going undiagnosed during his formative years of life which were critical to neurodevelopment, and that his continued struggles during adulthood were largely caused by misdiagnosis, inadequate treatment, and the Named Entities misconduct limiting or preventing access to needed care [S.S. 2019 M.A. pages 12, 29, 53-55] [C-F 2020 Transcript 00:59:35.02]. The medical records demonstrate this. Even to the point of providing insight into the anatomical nature of Mr. Smith's breathing issues - which are the etiology of his OSA - through clinical findings, diagnostic reports, sleep studies, and 3-dimensional x-ray slices of the head, which are proof that not only has he suffered from this issue since childhood, but that the presence of this insult has been involved in the neurobiology of his psychiatric symptoms since

their initial onset. Those medical records and the literature referenced in Mr. Smith's medical appeal are material facts which act to corroborate the validity of his statements while also demonstrating that his need for care is one that not only meets but exceeds the definition of "medical necessity":

"Genetic and environmental factors have *a direct impact* on *the* *development* of the [Upper Airway] UA and its supports."
"the absence of normal stimulation of the orofacial growth centers leads to further abnormal growth."
"Absence of normal nasal breathing leads to mouth breathing and development of local inflammation that may become more general progressively, having an impact on the normal reflexes involved in maintenance of a patent UA."
"Abnormal tonsillar growth seems related to mouth breathing, and enlarged tonsils then accentuate the problem and have a further impact on orofacial growth and mouth breathing."
"With puberty and increased secretion of the sexual hormones, there is enlargement of muscles and soft tissues—more in boys than in girls. This also leads to further narrowing of the [upper airway] UA, with the decrease in size varying depending of the degree of abnormal orofacial growth and the speed of pubertal changes. As these structural changes occur, a positive feed-back loop is reinforced with progressive development of snoring and resultant negative impact on UA reflexes." [12]
"the only valid treatment goal is restoration of nasal breathing, not only during wakefulness but also during sleep." [S.S. 2019 M.A. Ref 49]

From a physician's analysis of a 3D X-ray of Mr. Smith's head:
"Inferior nasal concha distance from nasal septum: Right: 0.7mm (markedly reduced); Left: 0.7mm (markedly reduced)." [S.S. 2019 M.A. page 55] [S.S. 2019 M.A. Medical Records, "22 Dr. Rice's Case study #VIV-01163 Sean Smith.pdf"] [S.S. 2019 M.A. Medical Records, "CBCT dec2018_Coronoal Turbinites, Septum, Arch Dist.jpg"]

"An understanding of these principles offers an opportunity to recognize and intervene in [sleep-disordered breathing] SDB far earlier in its development, to avoid the many serious and life-altering comorbidities that have been so ***well associated with OSA.***" [S.S. 2019 M.A. Ref 49]

"sleep disturbances (and anxiety disorders) were identified as antecedents to the onset of bipolar disorder in a subset of high-risk youth" [13]
"children diagnosed with bipolar disorder have significantly higher rates of sleep difficulties"

---

[12] This research article allows Mr. Smith's health history on pages 46 to illustrate how his childhood onset psychiatric symptoms are related to his abnormal orofacial development.
[13] Antecedent: a preceding event, condition, or cause. [https://www.dictionary.com/browse/antecedent]

"the evidence suggests that pervasive sleep disturbance is characteristic of bipolar disorder. Sleep disturbance is a feature of bipolar disorder in adults as well as children and teenagers." [S.S. 2019 M.A. Ref 153]

"In a general pediatric clinic, habitual snoring was documented in...56% of the children diagnosed with psychiatric disorders."
"In a 2-year follow-up on habitually snoring children, 30% of subjects had worsened from baseline. OSA developed more often in boys, especially if adenotonsillar hypertrophy or an increase in waist circumference was present" [14]
"it is believed that snoring independent of OSA may cause neurocognitive dysfunction and impaired daytime performance.24,25 Habitually snoring children are at higher risk for social problems, poor academic performance, decreased attention, and anxiety/depression issues.26"
"By 4 years old, children who had a history of [Sleep-disordered Breathing] SDB were 20% to 60% more likely to exhibit behavioral difficulties; by 7 years, they were 40% to 100% more likely"
"The neurocognitive and behavioral damage from snoring in children appears to be related to the fact that their brains are still developing."
"SDB during periods of brain development is *very predictive* of later damage"
"T&A alone may not completely resolve the OSA. The longer the airway dysfunction [occurs], the greater the [adverse] structural impact on the airway."
"It can be concluded that many children must be treated with multiple therapies before resolution [of OSA], especially if the SDB has previously altered the airway to a significant degree." [S.S. 2019 M.A. Ref 76]

"The clinical symptoms associated with [pediatric] OSA are well-documented and are multi-faceted, including *agitated* and *disrupted sleep*, parasomnias (sleepwalking, *sleep terrors*, enuresis, etc.), and noisy breathing at night, as well as daytime sleepiness, fatigue, morning headache, and learning, behavioral, and attention problems." [15] [S.S. 2019 M.A. Ref 154]

"pediatric OSA subjects show extensive regionally-demarcated grey matter volume reductions in areas that control cognition and mood functions". "We should further emphasize that the alarming findings indicating grey matter losses in multiple brain regions as reported earlier and in this present study in children are of substantial relevance considering the inability to detect significant improvements in neurocognitive functioning outcomes by the first randomized controlled trial on pediatric OSA and adenotonsillectomy." [16] [S.S. 2019 M.A. Ref 125].

---

[14] Note that tonsils and adenoids were both enlarged in Mr. Smith during childhood, leading to their removal. Also note that psychiatric medications induced weight gain multiple times throughout childhood and adolescence and such weight gain is noted to worsen OSA.
[15] See page 46 patient history and psych records evidencing bedwetting, ADHD, night terrors, tiredness, behavioral problems, symptoms of TMD, "affective domain".
[16] See page 46 patient history, adenotonsillectomy

"it is clear that pediatric [Sleep Disordered Breathing] has significant adverse effects on the brain in areas related to autonomic control, respiration, behaviors, and neurocognition." "*these changes to brain morphology and function are occurring during childhood* when the brain is still undergoing significant development." [S.S. 2019 M.A. Ref 126].

"An exciting collection of recent human neuroscience findings has established a causal role for sleep in the optimal regulation of *affective* brain function." [17] [S.S. 2019 M.A. Ref 130].

"PTSD-like symptomatology was experimentally induced by selective deprivation of REM sleep in healthy individuals; this manipulation resulted in increased autonomic sensitivity to previously extinguished conditioned stimuli (that is, heightened sensitivity) and impaired autonomic discrimination of conditioned from safety signals (decreased emotional specificity)177–179. Conversely, the *amount* and EEG *quality of REM sleep predicts participants' ability to accurately discriminate between threat and safety signals* (indicating improved emotional specificity)180." [S.S. 2019 M.A. Ref 131]

"Sleep loss *reliably triggers* **changes in negative (aversive) emotional processing**, including *irritability, emotional volatility*, anxiety and *aggression* 56, 74–77, as well as suicidal ideation, suicide attempts and suicide completion 78–80. These findings suggest that [Sleep Deprivation/Disruption] SD alters specific process domains, including basic affective reactivity, as well as emotional discrimination and emotional expression, which are more complex." [12] [S.S. 2019 M.A. Ref 131]

Temporomandibular Disorder (TMD):

A musculoskeletal (MSK) condition primarily affecting the function of the jaws, jaw joints, cranium, and neck the cause of which involves multiple biological systems. These musculoskeletal structures can influence postural function throughout the body while also contributing to the underlying dysfunction within biological systems. The pathophysiology of TMD varies case-by-case but often involves developmental growth abnormalities, macrotrauma, and comorbid medical conditions which cause localized and systemic cellular burdens alongside systems-wide dysfunction. TMD is not defined by the presence of pain, but may cause chronic pain, and that pain may be debilitating. The noxious input of hypertonic muscles, chronic and acute pain, sleep disturbance, and malalignment of underlying anatomical structures exerts a potent neurobiological influence that contributes to cognitive dysfunction, avoidance behaviors, psychological distress, mood dysregulation, and the underlying pathophysiology of TMD and comorbid conditions. TMD can cause a substantial loss of quality of life and lead to medical disability which goes unacknowledged by physicians, burdening patients with both untreated

[17] See page 46 1997 psychiatric evaluation

disease and unaccommodated disability. Suicide rates in this patient population are unstudied. TMD is also referred to as "TMJ". [Sean Smith, Sept 2020. Untitled Work.]

"fMRI studies further revealed that face pain resulted in higher levels of amygdala activation compared to the same intensity stimulation applied to the hand." "Our input-output circuit mapping of PB_L-nociceptive neurons revealed many limbic centers that are reciprocally connected with PB_L, providing a circuit basis for understanding closely associated and clinically highly-relevant comorbidities with pathologic trigeminal pain, namely anxiety, depression, *disturbance of circadian rhythm* and altered intake behavior." [S.S. 2019 M.A. Ref 156]

"Many dentofacial physical risk indicators for malocclusion and TMD are also identified as indicators of increased risk for sleep-disordered breathing"
"[REM Sleep] is the first time during the evening that a hyperresponsive patient with UARS cannot adequately protect his or her airway."
"Sleep deprivation, especially deprivation of REM sleep, induces spontaneous pain and hyperalgesia" [S.S. 2019 M.A. Ref 77]

"Nonrestorative sleep, as self-reported by the patient, is one of the most powerful predictors of musculoskeletal pain" [S.S. 2019 M.A. Ref 5]

"sleep deprivation enhances pain responsivity within the primary sensing regions of the brain's cortex yet blunts activity in other regions that modulate pain processing, the striatum and insula." [S.S. 2019 M.A. Ref 150]

"[Sleep deprivation] SD causes a state of central and peripheral emotional hypersensitivity that prevents emotional reactivity from being appropriately graded 84. As a result, SD impairs the afferent–efferent communication between the brain and body, which is crucial for the 'embodied' mapping of, and disambiguation between, different emotions. The consequence is *a behavioural phenotype* of indiscriminate emotional generalization, or blunting, consistent with poor signal-to-noise balance during emotional processing 84" [18] [S.S. 2019 M.A. Ref 131]

"Such blunting may disrupt not only the internal mapping of an individual's own affective state but also the ability to simulate the feelings of others." [19] [S.S. 2019 M.A. Ref 131]

"we have remarkably little understanding of the whole-brain consequences of long-term, chronic sleep loss, as most studies have focused on acute, total SD (BOX 1). Such knowledge would be crucial considering that chronic partial sleep restriction, from weeks to years, is representative of

[18] see S.S. 2019 M.A. page 54 "dissociation, depersonalization, derealization"
[19] see: "strong social bonds" discussed in this letter on page 23-24

(and thus relevant to) the sleep deficiency observed in the developed world." [S.S. 2019 M.A. Ref 131]

"different brain networks in the same individual may be differentially susceptible to sleep loss." [S.S. 2019 M.A. Ref 131]

"[Obstructive Sleep Apnea] OSA can induce significant brain tissue injury"
"central brain injury occurs in OSA, especially to autonomic, affective, and cognitive regulatory areas."
"A major concern with sleep-disordered breathing conditions...is the high incidence of accompanying *autonomic dysfunction*..." [20]
"impaired autonomic control may stem from injury to central sympathetic and parasympathetic regulatory areas" [15]
"Among structures that influence hypothalamic regions, especially for sympathetic regulation, are the cingulate cortex and cingulum bundle, which are *severely injured* in OSA"
"The anterior cingulate is *especially* affected in OSA, but posterior regions are also injured"
"the hippocampus showed major injury, as did key recipients of its projections, the mammillary bodies, and the fibers composing those projections"
"a substantial, and heavily lateralized loss of [hippocampal] volume in OSA" [21]
"we found injury to hypothalamic-projecting fibers from the insular cortex and to the cerebellar climbing fibers, hippocampal projections to the mammillary bodies, and ponto-cerebellar projections." [22]
"Other autonomic regulatory fiber bundles are also injured, including the cingulum bundle (major projections to the insula, amygdala and hypothalamus)"
"several other laboratories describe structural damage in limbic structures, especially in the hippocampus and anterior cingulate cortex, frontal and parietal cortices, and in the cerebellum" [S.S. 2019 M.A. Ref 88]

"The hypothalamic-pituitary-adrenal (HPA) axis is the central coordinator of the mammalian neuroendocrine stress response systems"
"several brain pathways modulate HPA axis activity."
"The medial prefrontal cortex (PFC) comprises the anterior cingulate cortex (ACC)
"The medial PFC exerts inhibitory control over stress responses and emotional reactivity in part by its connections with the amygdala."

---

[20] See page 49 of this letter, keywords "sympathetic" "autonomic".
[21] See page 49 of this letter, keyword "hippocampus"
[22] "damage to pathways that connect the mammillary bodies to the hippocampus or thalamus is associated with deficits in consolidating new memories."
[https://www.neuroscientificallychallenged.com/blog/know-your-brain-mammillary-bodies]

"The amygdala is a limbic structure involved in emotional processing and is critical for the acquisition of fear responses."
"the amygdala and aminergic brain stem neurons stimulate [the HPA-Axis]"
"the hippocampus and prefrontal cortex (PFC) [modulate HPA axis activity]."
"reduced volume of the hippocampus, the major brain region inhibiting the HPA axis, is a cardinal feature of PTSD." [S.S. 2019 M.A. Ref 86]

"Brain regions that are altered in patients with PTSD include the *hippocampus* and *amygdala* as well as cortical regions including the *anterior cingulate*, *insula*, and orbitofrontal region. These areas interconnect to form a neural circuit that mediates, among other functions, adaptation to stress and fear conditioning. ***Changes in these circuits*** have been proposed to have a **direct** link to the development of PTSD." [23] [S.S. 2019 M.A. Ref 86]

"The [medical prefrontal cortex] MPFC exerts top-down control on the limbic area (including the amygdala)"
"sleep contributes to maintaining the ***connectivity*** between the MPFC and the amygdala, which is critical for responding appropriately to next-day emotional challenges."
"this finding is *particularly relevant* to patients with bipolar disorder whose affect regulation system is likely to be even ***more*** *vulnerable to the adverse consequences of sleep deprivation.*" [S.S. 2019 M.A. Ref 153]

"MRI studies have reported significant structural and functional changes to the brains of children with SDB..."
"These include reduced white and gray matter and structural changes to a multitude of brain areas including, but not limited to, the *hippocampus, cortex, amygdala, insula,* thalamus, cerebellum, and basal ganglia." [24] [S.S. 2019 M.A. Ref 126]

"OSA is accompanied by a very high incidence of depressive symptoms, with over half of subjects affected"
"We examined OSA subjects with and without depressive symptoms, and found *enhanced brain injury* in OSA subjects with increased depression symptoms in the insular, cingulate, and ventral frontal cortices, hippocampus, and amygdala, among other areas above that found in OSA-alone subjects." [S.S. 2019 M.A. Ref 88]

"The hippocampus is implicated in the control of stress responses, declarative memory, and *contextual aspects* of fear conditioning."

---

[23] "The [orbitofrontal cortex] is considered anatomically synonymous with the ventromedial prefrontal cortex. [https://en.wikipedia.org/wiki/Orbitofrontal_cortex]
[24] The insula, cerebellum, striatum and basal ganglia are activated by movement of the tongue and jaws, as found in chewing, bruxism, swallowing, or tongue thrusting.

"decreased hippocampal volumes might be a *pre-existing vulnerability* factor for developing PTSD." [S.S. 2019 M.A. Ref 86]

"The potential implications for patients with psychiatric disorders are provocative; one pathway by which sleep disturbance may contribute to maintenance of symptoms and impairment may be poorer memory for the positive domains or events in their lives."
"adverse effects in this domain are likely to be particularly critical for youth" [25] [S.S. 2019 M.A. Ref 153]

"[Sleep Disordered Breathing] SDB serves as *a* chronic physical stress (or allostatic challenge) *activating* the hypothalamic-pituitary-adrenal (HPA) axis" [S.S. 2019 M.A. Ref 66]

"a bidirectional relationship may exist through which PTSD may worsen SDB and through which sleep breathing problems may worsen posttraumatic stress." [S.S. 2019 M.A. Ref 87]

"Circuits involved in affect regulation and circuits involved in sleep regulation interact in bidirectional ways." [S.S. 2019 M.A. Ref 153]

"Sleep disturbances are frequently observed among psychiatric disorders" [S.S. 2019 M.A. Ref 123]
"Sleep disturbances are very highly prevalent among many psychiatric populations." [S.S. 2019 M.A. Ref 128]
"Sleep disturbance is pervasive across the phases of bipolar disorder and across affected youth and adults." [S.S. 2019 M.A. Ref 153]

"Sleep abnormalities are robustly observed in every major disorder of the brain, both neurological and psychiatric. Sleep disruption merits recognition as a key relevant factor in these disorders at all levels, from diagnosis and underiying aetiology, to therapy and prevention." [S.S. 2019 M.A. Ref 131]

"Bipolar Disorder is a systems disorder, it is not a psychological disorder, it is not even a psychiatric disorder, it's a disorder of systems. And that is evident in the psychiatric literature." -Sean Smith [C-F 2020 Transcript 00:19:42.15]

"There is convincing evidence of crosstalk between different biological systems that act in a deleterious manner causing expression of the disease in genetically predisposed individuals."

---

[25] Note: The Pathophysiologies of Pediatric OSA and Childhood onset Depression and Bipolar have shaped who "I" am 'now'. Mr. Smith is heavily disadvantaged due to disrupted neurocognitive and psychological development.

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

"Dysfunctions in crucial bodily homeostatic systems acting in an orchestrated manner feed into one another leading to a progressively worsening course of bipolar disorder."
[Muneer, 2016]

"many somewhat similar, but subtly different, pathological conditions produce a disease state that we currently diagnose as bipolarity." [Maletic, 2014]

"there is evidence of a two-way relationship between sleep disorders and changes in the gut microbiome that induces potential metabolic, cardiovascular, and neurocognitive changes in the patient."
"An altered circadian rhythm is associated with changes in the gut microbiome, particularly in the presence of another stressor." [S.S. 2019 M.A. Ref 111]

"The brain–gut axis is becoming increasingly important as a therapeutic target for gastrointestinal and psychiatric disorders"
"This brain–gut axis, includes the brain, the spinal cord, the autonomic nervous system (sympathetic, parasympathetic, and ENS), and the hypothalamic–pituitary–adrenal (HPA) axis (1)."
"The definition of the sympathetic and parasympathetic nervous systems is primarily anatomical. The vagus nerve is the main contributor of the parasympathetic nervous system."
"[the vagus] nerve plays important roles in the relationship between the gut, the brain, and inflammation."
"The vagal afferent pathways are involved in the activation/regulation of the HPA axis (29), which coordinates the adaptive responses of the organism to stressors of any kind (30)."
"vagal tone is correlated with capacity to regulate stress responses and can be influenced by breathing"
"It is estimated that the human ENS [Enteric Nervous System/the Gut] contains about 100–500 million neurons. This is the largest accumulation of nerve cells in the human body (23–25)."
"the vagus nerve plays an important role in the pathogenesis of psychiatric disorders, obesity as well as other stress-induced and inflammatory diseases."
[S.S. 2019 M.A. Ref 92]

"Intriguing findings on genetic and environmental causation suggest a need to reframe the etiology of mental disorders."
"The effect of environment is likely conditional on genetic factors, resulting in gene-environment interactions. The impact of environmental factors also depends on previous exposures, resulting in environment-environment interactions."
"Integrative analyses of poly-causation including gene-environment and environment-environment interactions can realize the potential for discovering causal types and mechanisms that are likely to generate new preventive and therapeutic tools." [Rudolf Uher, 2017]

"The [Upper Airway] UA size is related to the development of its bony supports, which are controlled initially by genetic input and later on joined by environmental factors and *the interaction of environmental factors on genes.*" [S.S. 2019 M.A. Ref 49]

"Conceptualized as a polygenic condition, the expression of [Bipolar Disorder] BD is *secondary* to a stressful event."
"The glucocorticoid receptor (GR) is the *most important factor* in the formulation of the cortisol response"
"The immediate control of [glucocorticoid receptor] GR function by circadian genes is allegedly of great importance in modulating the reaction to persistent stress."
"The principal circadian synchronizer is placed in the suprachiasmatic nucleus of the hypothalamus where it gets **light** input by a direct connection, the retinohypothalamic tract.."
"the suprachiasmatic nucleus appears to synchronize the timing of rhythms in the periphery through changes in body temperature, which serve as a common signal to **harmonize** multiple organ systems **to** the ***light/dark cycle***."
"Brain-derived neurotrophic factor (BDNF) and its receptor tyrosine kinase B (TrkB) are known to be crucial in the effects of antidepressants and mood stabilizers, and both of these have a strong circadian rhythm in expression in the hippocampus.103 BDNF is no longer effective as a neurotrophic agent in the nonexistence of a normal diurnal rhythm of glucocorticoids, demonstrating that the daily oscillations of cortisol control the salutary activity of psychotropic drugs on neuronal growth via BDNF/TrkB signaling in the hippocampus."
"Dysfunction of the molecular clockwork genes has repeatedly been shown and circadian disturbances are present not only during acute episodes but *also in remission.*"
"stressful life events cause ***alterations*** in the sleep/wake pattern, which then affect molecular and cellular rhythms in susceptible people, ***inducing*** affective episodes." [26]
"a number of clinical studies showing an *unambiguous connection* between the extent of rhythm disruptions and the severity of mood episodes**"**
"*all* present therapies for mood disorders modify or even out circadian rhythms."
[Muneer, 2016]

"oxygen is involved in resetting circadian clocks."
"After realizing that tissue oxygenation undergoes physiological diurnal oscillations, the authors observed that these normal cycles were sufficient to synchronize cellular clocks in a way that depended on hypoxia-inducible factor-1a (HIF1a), which is one of the core nuclear factors

[26] For clarity, as covered in Avram Gold's research which was supplied in the medical appeal, sleep-related disordered breathing causes respiratory events provoking the HPA-Axis and glucocorticoid release. This in turn will alter sleep-wake. This is evidenced by a number of things, one being associations between SRDB and sleep onset and maintenance insomnias, particularly in patients with UARS.

controlling the hypoxic response and plays a central role in the response to hypoxic events in sleep apnea."
"the hypoxia-clock reciprocal regulation occurs at the genomic level and thus **operating in all tissues.**" [S.S. 2019 M.A. Ref 112]

"more effective and targeted therapies are likely to be discovered that are not palliative but curative in nature." [Muneer 2016]

"trying to treat the psychological...can never readily occur when you try to isolate it from the other diseases that are the reason that [the psychological distress] occurs". -Sean Smith [C-F 2020 Transcript: 00:10:54.05]

"you can influence [the etiology of psychiatric illness] heavily if you fix the dysfunction in [biological] systems that has been present since childhood." -Sean Smith [C-F 2020 Transcript 00:23:02.10]

'TMDs have been noted to have a 300% higher amount of healthcare utilization in every field except one [S.S. 2019 M.A. Ref 140], obstetrics, in which non-TMD subjects had greater utilization. "One might conclude that the nature and extent of the healthcare problems of individuals with TMJ disorders influences the normal activities leading to pregnancy and childbirth." "Utilization and cost differences were consistent over a wide range of service categories and could not be explained by TMD alone." [S.S. 2019 M.A. Ref 139]' [Sean Smith, 2020, Medical Insurance Coverage for TMDs]

"Untreated OSA leads to multiple medical problems (such as systemic hypertension, cardiovascular disease, injuries, and **mood disorders**)..."
"A number of studies in various countries have shown that untreated patients with sleep apnea consume a disproportionate amount of healthcare resources and that healthcare expenditures decrease after treatment [26]." [S.S. 2019 M.A. Ref 40]

"Not only does treating OSA improve sleep and breathing, it also improves the management of other costly comorbid diseases, reduces overall health care utilization, improves work productivity, and reduces motor vehicle and workplace accidents." [S.S. 2019 M.A. Ref 41]

From Cigna-FedEx's Denials of Sleep Study Requests:

July 2019;
"The service [nocturnal polysomnogram] you request is not covered."
"We found the service requested is not medically necessary in your case."

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

"The documentation [received] lacks a co-morbid condition such as; seizures during sleep, heart rhythm problems, congestive heart failure, severe lung problems or a neurological disorder." [Cigna Healthcare, 2019, July and November PSG denials.]

November 2019;
"After reviewing the information we have, we've determined that this service [nocturnal polysomnogram] is not covered"
"The [submitted] documentation lacks mention of a co-morbid condition such as; seizures during sleep, heart rhythm problems, congestive heart failure, severe lung problems or a neurological disorder, that would make a home sleep study inappropriate or difficult to interpret." [Cigna Healthcare, 2019, July and November PSG denials.]

From Mr. Smith's 2019 Medical Appeal:
"How much does someone have to suffer before they can 'get help'? According to Cigna's denial for the in-lab PSG they're waiting until I develop, "seizures during sleep, heart rhythm problems, congestive heart failure, severe lung problems or a neurological disorder." I suppose Cigna intends to save FedEx money by denying requests for in-lab polysomnograms until people are showing up to the ER with heart attacks."

From Mr. Smith's Email to FedEx Human Resources:
"[Home Sleep Apnea Testing] HSAT can be worthless for some patients. A complete waste of resources to perform. For me, when I sleep on my back, I wake up in pain, then I experience insomnia because of the pain *and* the way the more severe apnea influences the nervous system. And the HSAT's that most of Cigna's physicians use don't track arousal. Which means, it can't tell the difference between awake or asleep. Which means, if you spend half of your time awake in pain, the HSAT has virtually no diagnostic relevance for Obstructive Sleep Apnea.

Yet still, despite such disclosure to in-network physicians - and to Cigna as well as I recall; though I'm not 100% on that; I would have to review documentation and call logs - Cigna insisted I undergo an HSAT, to the point that they pretty much held access to an in-lab study hostage. Not happening. No way. Never. HSAT first or NoGo. It's our policy. A policy to hurt people and not bend to medical necessity."

"...it's pretty much abuse to require a person with needs like mine to have had to jump through all these hoops. To be frank, I think the only reason I am alive at this moment is because of the complicated referral to my physical therapist, and that I'm just unusually perseverant. The way I see it, the scope of this problem is not a 'me' thing; I stand on top of a pile of bones from those who didn't survive the journey through this nightmare. And, honestly, I don't know yet if I can expect to have a fate any different from theirs."

The Illness of Not Knowing That You Do Not Know

> "Half of what you'll learn in medical school will be shown to be either dead wrong or out of date within five years of your graduation; the trouble is that nobody can tell you which half - so the most important thing to learn is how to learn on your own." - Dr. Dave Sackett, the father of evidence based medicine.

During the conference call Dr. Martinez asserted, "the biochemical nature of Bipolarity and Manic Depression still requires an intervention with medications, probably of a different class than what you were on with a lower risk of side effects, but to simply come off entirely is not the general approach for management of this condition." [C-F 2020 Transcript 00:21:16.27].

Dr. Martinez, for some reason, considers himself to have the "appropriate training and experience in the field of medicine involved" [29 CFR § 2560.503-1(h)(3)(iii)] to impose medical judgements upon Mr. Smith's case, even while his declaration is in clear opposition to the substantial amount of information supplied to him in Mr. Smith's medical appeal, of which only a part has been reiterated in this letter. Let alone the additional information and references presented in this letter which an expert in this field should be expected to already know. It should also be noted that even after substantial amounts of information and evidence were made available to plan fiduciaries their response is not one of a circumspect and well-defended position which acknowledges the submitted materials. Indeed, as the previous section of this letter demonstrated, when Full and Fair Review of the information submitted by Mr. Smith is performed, it is then that Dr. Martinez' views can be clearly seen as an archaic anachronism which not only disqualifies him, but makes him a danger to plan beneficiaries and a liability to health plans.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) stopped using the term "Manic Depression" in the 1980's. Dr. Martinez wants to assert his opinion's validity while using terminology that has been depreciated for nearly four decades *and* while having neglected to review the materials referenced in the medical appeal. One such reference directing the reader's attention to an interview between Dr. Peter Attia (MD) and Dr. Matthew Walker (PhD in psychiatry and sleep medicine), in which Dr. Walker stated:
"We do a lot of work on sleep and mental health. It's very clear that I can take people who don't have any problems with mental health, depression, poor mood, anxiety, suicidality, and when you sleep deprive them you can instigate many of those conditions."
"You can stack up the different physiological body systems and operations of the mind, but I would put mental health pretty high up there in terms of one of the things that fall apart quickest." [S.S. 2019 M.A. Ref 93].

Dr. Walker is more directly quoted in the appeal as stating, "I think if there is one central pathway through which we can understand almost all aspects of the deleterious impact of

insufficient sleep it is through the autonomic nervous system." [S.S. 2019 M.A. Ref 89E]. Which, to persons truly familiar with the field of psychiatry, one immediately understands that there are many mechanisms by which the autonomic nervous system has immediate relevance to psychiatric disorders. Such is embodied in Dr. Stephen Porges' (PhD Psychiatry) Polyvagal Theory. Or Dr. Richard Brown's work with breathing practices. Indeed, as previously referenced in this letter:

"Autonomic dysregulation...may be a trait marker for bipolar disorder."
"Alterations in HPA axis function in bipolar disorder have been well substantiated (168)."
[Maletic, 2014]

"the vagus nerve plays an important role in the pathogenesis of psychiatric disorders"
"vagal tone is correlated with capacity to regulate stress responses and can be influenced by breathing" [S.S. 2019 M.A. Ref 92]

The above quotes in turn tie back into the materials by Dr. Steve Carstensen and Dr. Avram Gold upon breathing and sleep which were previously referenced in this letter [S.S. 2019 M.A. Ref 66, 68, 69] [27].

To a person whose study of the field of psychiatry is informed, the materials Mr. Smith has presented can be synthesized into a coherent understanding which not only stands firmly against the notion of medication as the only means of management, but also calls into question presumptions that psychopharmacotherapy is the most appropriate intervention for mood disorders. Moreover, previously quoted in this letter were two facts which stand against Dr. Martinez' attempts to validate his opinions by asserting that psychotropic medications are required to treat mood disorders because he views them as the "general approach for management of this condition":

(1) "*available medications fail to control the disease manifestations*" . [Muneer, 2016]
(2) "The reduction in life expectancy associated with...bipolar disorder [is] (9-20 years)".
[Chesney, E. et al., 2014]

The "general approach" has abyssal outcomes. It's a game of chemical-roulette being played, wherein those that enter into this gamble pay dearly with their health, well-being, and longevity. Pill after pill gets applied to treat the symptoms of a problem the cause of which receives limited clinical investigation. People lose the essence of who they are to disease or sometimes the very treatments aimlessly applied to treat the disease. Clinical psychiatry regularly fails patients, such failure being present even in much of what they credit to be a success. Failure being so common it is assumed inevitable and acceptable. Iatrogenic harms being largely ignored or

[27] See page 44 (Carstensen Ref 68, 69) & page 47 (Gold Ref 66)

misunderstood, or purposefully hidden by industry interest's until whistleblowers dare to shatter illusions of efficacy and safety. Problem after problem stacks up, increasing the price-being-paid by the patient, until, as is so often witnessed, it's too much, and the pathology rules in an absolute dictatorship. A tyrannical rule in which those who have been subjugated are medicated until they are made to believe that their freedoms remain intact.

Mr. Smith has become aware that for him and many others there is a better answer. Freedom from that tyranny is possible. Independence is possible. One need not be alienated from "Life, Liberty, and the pursuit of happiness" by fully treatable, even curable, health conditions. But these things have remained withheld from Mr. Smith. The misconduct of the Named Entities is a barrier between those in need of care and solutions; it is a Berlin Wall that is long past due for demolition.

Dr. Martinez' opinions were not scientific, nor evidence based, but are instead discriminatory and prejudiced when placed before the scientific evidence and the clinical realities that Mr. Smith has had to face and overcome.

Indeed, if one had bothered to review the references provided by Mr. Smith one would have noted that the entirety of Matthew Walker's interview with Peter Attia is broken into three parts. One might reason it prudent to review the first part of the interview prior to reviewing parts 2 and 3. Indeed, the majority of persons would no doubt deem it an exercise in prudence to watch the first movie in a series before the second movie, or the first season of a show before the second season, or read book one prior to reading book two. More so for any person whose task it is to fuliy review the content and provide an informed report upon it. Indeed, if one authored a review of a movie or a book without having seen or read the material they would be the subject of dismissal, ridicule, and scorn. If such basic circumspection had been exercised in reviewing Mr. Smith's appeal one would have heard in the interview:

"Attia: "What's the biggest detriment that persons face clinically with the reduction of REM [Sleep]?" Walker: "I think right now based on the weight of the evidence it probably starts with mental health. Mood. Anxiety. Depression. And then suicidality....**Sleep is emotional first aid. Bottom line. Period.**"
"And what we've been finding is that it's REM Sleep that seems to provide essentially a form of overnight therapy. And it's REM sleep that resets, or recalibrates, the emotional networks in the brain. And there's a network of them that involves an area called the prefrontal cortex, and particularly the middle part of the prefrontal cortex. Which acts like a top down regulator of your emotions. So there's deep emotional brain centers, centers like the amygdala, which is a centerpiece region for the generation of strong impulsive aversive negative reactions." [Peter Attia, 2019]

The attention of Cigna-FedEx was drawn to the interview between Dr. Attia and Dr. Walker, as well as many other materials of similar depth and scope. It is the duty of Cigna-FedEx to provide full and fair review [29 CFR § 2560.503-1(h)] and during said review consult with healthcare

professionals who possess the training and expertise required to provide an educated opinion upon the claimants case [29 CFR § 2560.503-1(h)(3)(iii)].

Underlying 29 CFR § 2560.503-1(h) is a premise wherein:

(1) If Dr. Martinez possesses the "appropriate training and experience" then:
(A) he would be familiar with or fully able to comprehend the information which has been communicated in Mr. Smith's verbal and written submissions and;
(B) he would possess an even greater depth of knowledge and comprehension of the information which was presented in Mr. Smith's verbal and written submissions, for Mr. Smith is not a Doctor of Medicine and an expert within this field of medicine must, by default, possess greater knowledge and comprehension than those the plan fiduciary designates as a layman who does not have possession of the "appropriate training and experience".
(i) that "greater knowledge and comprehension" would include already being aware of the additional information contained in the materials referenced in this letter which were not included in the appeal;
(I) i.e. if one possessed the "training and experience" required to lawfully pass medical judgements on a case involving multiple medical issues and a mood disorder, such as bipolar disorder, one would already have full command and comprehension of the information presented in the materials providing an overview of the Neurobiology of Bipolar Disorders and the failings of Psychiatric Diagnostic Schema, especially so as most of those materials had been published since the years 2010-2017.
(C) pursuant to (1)(A);(B), Dr. Martinez acted in the manner he did in full knowledge of the harm his actions would cause Mr. Smith and other plan beneficiaries.

Alternatively;

(2) If Dr. Martinez did not possess the "appropriate training and experience" then:
(A) it would only be prudent to have conceded and disclosed his ignorance to the plan beneficiary and other plan fiduciaries.
(B) failing to declare his ignorance and despite his ignorance then act in a capacity where he passes medical judgment would be unlawful pursuant to 29 CFR § 2560.503-1(h), 29 CFR § 1104, and other statutes.

Additionally:
(3) If plan administrators allow Dr. Martinez or another to violate their obligations and harm plan beneficiaries they then become accomplices to the misconduct.
(A) allowing misconduct to occur can be defined as having knowledge that it will occur or is likely to occur and then permitting it to occur unopposed.

(B) Mr. Smith's medical appeal, email, complaints, grievances, call notes, and other documentation in the possession of Cigna and the other Named Entities demonstrate that they possess knowledge of misconduct that has occurred and is likely to continue to occur.
(C) Due to having foreknowledge that this misconduct had occurred and was likely to continue occurring, allowing it to occur can be asserted as gross incompetence or a conspiracy to commit the offense.

Mr. Smith communicated that he has REM OSA in his medical appeal on page 19, page 54, and within the medical records submitted alongside the appeal. Mr. Smith also provided an extensive and detailed update and addendum to the appeal via email to Dierdra Royston at FedEx Human Resources, which given that the response to that email was to setup the conference call, one would expect those materials to have been shared with Cigna prior to the conference call so as to allow a process of Full and Fair Review to occur.

In that email it was disclosed that a sleep study was performed in 2020 for which Mr. Smith had exerted much effort so that the study utilized adequate scoring criteria, even though no esophageal pressure sensor could be made available by the sleep practice to provide the complete accuracy his case warranted. This sleep study showed Mr. Smith's REM OSA to have greater severity than was acknowledged in the 2017 sleep study. The 2017 sleep study utilized insensitive scoring criteria that is known to provide and did provide a False Negative diagnosis, as was explained in the medical appeal [S.S. 2019 M.A. Ref 46] [S.S. 2019 M.A. pages 21-24].

That False Negative diagnosis went unchallenged by the treating physician because, as he disclosed to Mr. Smith, he believed attempting to fight with Cigna for approval of an appropriately scored sleep study would be an act of futility. The practice manager also echoed the physicians account and elaborated further that what Cigna does is basically "harassment" to physicians where denials for sleep services have little to nothing to do with medical necessity. Indeed every sleep medicine practice Mr. Smith has interacted with provides this same account of Cigna's actions, be they doctor, nurse, medical assistant, practice manager, PSG technician, billing department, and even on occasion the front desk. And indeed, as Mr. Smith's Email to FedEx Human Resources outlined, Mr. Smith's efforts to get a nocturnal polysomnogram approved with a different sleep medicine physician demonstrated that Cigna engages in misconduct which presents significant barriers to those seeking accurate sleep diagnostics. Many other matters regarding the misconduct of Cigna-FedEx and the adverse effects this has had on Mr. Smith were also provided in this email [Sean Smith, 2020, Email To Deirdra at FedEx HR].

Mr. Smith had already presented in his medical appeal materials that show his breathing issues have grown more severe within the past three years [S.S. 2019 M.A. pages 23-24]. Between clinical symptoms, patient history, and existing diagnostic data, it was already known Mr. Smith needed care, but he was being required to undergo further testing to get 'the diagnosis' for which the writing was already on the wall for those willing and able to read it. Requiring further diagnostics to qualify for coverage of treatment was and is a waste of plan

resources. That misconduct only further compounded by denying Mr. Smith access to the services required to diagnose his sleep-related breathing disorder and then requiring the plan beneficiary to harm himself by 'jumping through hoops' to satisfy alleged coverage policy. This coverage policy requiring that he undergo a Home Sleep Apnea Test that previous diagnostics and his clinical presentation of symptoms provided every indication would be non-diagnostic; the application of that coverage policy to Mr. Smith was not in compliance with multiple laws.

Barriers were repeatedly inserted between Mr. Smith and appropriate diagnostics and treatment. One such barrer even being the in-network sleep medicine physicians themselves, who have in their careers become accustomed to the misconduct of the Named Entities and subsequently have relegated their practice of medicine to operate within the limitations imposed by the misconduct of the Named Entities, for which the few physicians who exert an effort to deviate from this pattern encounter much difficulty in their practices of medicine and must nevertheless compromise the quality of care that they are able to deliver to their patients.

The Named Entities misconduct creates a situation in which a majority of their in-network physicians are conditioned by the health plans illegal activities to provide suboptimal care, and in so doing the clinical experience physicians gain is similarly lacking. Alongside which their efforts to seek and acquire continuing education become constrained by the direction in which their medical practice has gone. This in turn prevents plan beneficiaries from receiving services which inform them as to what their medical needs really are and then communicating the medical needs with accuracy to the health plan.

As a result of the Named Entities misconduct their in-network physicians tend to lack the "training and experience" required to understand the medical needs of Mr. Smith and other patients with similar health needs. Even amongst those with sufficient training to understand those medical needs, most do not wish to become actively involved in advocating for the patient to the health plan as their clinical experience causes them to expect to encounter wrongful denials of requests for care which will waste their time, this then further undermining the quality of care they can deliver to their patients.

Mr. Smith provided references illustrating that the pathology of Sleep-Related Disordered Breathing involves known mechanisms [S.S. 2019 M.A. page 28] [S.S. 2019 M.A. Ref 53, 88] [28]. That it is known and to be expected that Mr. Smith's condition is likely to grow worse and thereby place him in even greater danger. In fact, in the medical records which were submitted with the appeal, Dr. Kellye Rice, a physician Mr. Smith consulted with whose practice operates in an airway-centric paradigm, asserted, "I strongly urge you to cover the cost of this therapy. Failure to do so would place the patient's health in jeopardy." [S.S. 2019 M.A. Medical Records, "Dr. Rice Vivos Dx Tx.pdf"].

It has been disclosed in great detail to Cigna-FedEx and those plan fiduciaries in receipt of Mr. Smith's medical appeal that Mr.Smith has REM OSA, that REM sleep is "emotional first aid", that when REM sleep in insufficient or greatly disturbed that emotion regulation is similarly

[28] See page 45 "a progressive destruction"

disrupted, thereby, it would be expected that due to his medical history including multiple psychiatric diagnoses and a history of sleep-related disordered breathing since childhood that Mr. Smith would experience "serious emotional disturbance" in response to those things which will illicit "strong impulsive aversive negative reactions", such as the continued abuses he has been made to suffer as a disabled adult plan beneficiary under the stewardship of the Named Entities. This very matter was disclosed in Mr. Smith's medical appeal, "having...my pleas for assistance met with inaction, complacency, and at times discrimination has been *traumatizing*". It is "a psychosocial wound with profound effects on my well-being." And, "when I hear medical professionals describe PTSD it sounds much like what I'm experiencing." [S.S. 2019 M.A. pages 27-28].

It was disclosed that Mr. Smith has strong negative reactions to welfare checks, as these welfare checks are both a perceived and *actual* threat to Mr. Smith's safety and well-being. That previous welfare checks have led to involuntary commitment and those commitments not only were performed illegally but while committed to these facilities Mr. Smith was denied access to the tools which help him manage his medical conditions and disabilities. That during an involuntary commitment Mr. Smith is injured both psychologically and physically. That in response to being denied needed care and continually subjected to the misconduct of the Named Entities Mr. Smith has developed a chronic stress disorder [S.S. 2019 M.A. pages 27-28]. Mr. Smith did also disclose the immediacy that this stress disorder has to the neurobiological impact of his REM OSA [S.S. 2019 M.A. Ref 86, 87] and his mood disorder [S.S. 2019 M.A. Ref 66, 123, 128, 130, 131, 153], for which admitting facilities can be expected to worsen the stress disorder, REM OSA, TMD, medical anorexia, gastrointestinal issues, and even continually subject him to physiologic insults known, per the scientific literature, to undermine the health and well-being of persons with mood disorders[29].

What's more is that these facilities have sought and received reimbursement for having caused these harms to Mr. Smith in the past, and would seek to receive reimbursement at any future instance. Being made aware of the fraudulent activity of the treating facility, it is wildly inappropriate for a plan fiduciary to initiate a sequence of events that would aid those facilities in perpetrating further fraud against the health plan and while simultaneously causing injury to a plan beneficiary [29 U.S. Code § 1104] [42 U.S.C. §1396a (a) (19)].

It has, therefore, been disclosed that Mr. Smith's medical issues and the abuses he's suffered would make him vulnerable to attacks upon his health and safety, and instead of acting to protect Mr. Smith from further assaults, Dr. Issac Martinez and Danielle Carneson conspired to commit such an assault upon Mr. Smith, and those Cigna-FedEx representatives party to that conference call became accomplice to this by voicing no protest of the actions undertaken by Dr. Issac Martinez and Danielle Carneson [42 U.S. Code § 1986]. It was the legal Duty of the plan fiduciaries on the call to voice protest at the mistreatment of the plan beneficiary and, if

[29] See pages 22, 47-49, and 60-61.

necessary, attempt to intervene so as to assure the plan beneficiaries safety [29 U.S.C. § 1104] [T.C.A. § 39-16-604].

Dr. Martinez and Danielle Carneson elected to engage in these actions known to cause harm to Mr. Smith while claiming such action is required of them in order to honor their oath as physicians. Taking such action would be one of the greatest betrayals a physician could have towards a patient. Yet, as previously demonstrated, neither plan fiduciary holds a physician-patient relationship to Mr. Smith[30]. Instead their betrayal is that of Plan Fiduciaries to a beneficiary who is a disabled adult, which is a class of persons protected by federal and state laws. An offense egregious enough in its own right, but one committed under the false pretense that they were honoring a noble oath. Worse yet, this was done while claiming that, "Everything that has been done is to assure your safety." [C-F 2020 Transcript 02:23:02.12].

Collective Cognitive Dissonance and Deliberate Misdeeds

Mr. Smith was subjected to misconduct, misdirection, and placating words that amount to little more than lies wrought with malice. Such words that claim, "...we do have many resources available and we're willing to, you know, to...help you with what you would like help with." [C-F 2020 Transcript 00:25:47.20] "And we, you know, if we have the ability to help you with throwing those resources into place we will certainly do that. And we want to do that." [C-F 2020 Transcript 00:28:14.16] These claims are made while refusing to offer an explanation as to how they would provide those resources in a manner which would not continue to perpetuate the misconduct that has so greatly harmed Mr. Smith.

It is a situation wherein the resources one is supposed to have access to are being withheld - a cookie jar, full of cookies, with the people in stewardship of the cookies saying they want to give you cookies, but the cookies are locked in a safe. How does it open? What's the combination? Submit a request. Get denied or receive no response and upon confrontation with the cookie-stewards receive more declarations about how they have so many cookies and they want to give them to you. All while one slowly starves and becomes emaciated while trying to get the cookies.

"00:27:54.00
Danielle: We wanted to get on the call, you know, to talk with Sean and um, to share the fact that we appreciate what he has sent over to us and, um, you know, to um, really hear what it is that he would like us to help with. So if you could name three things Sean that you would like us to help with.
00:30:49.08

[30] See page 26.

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

Sean: The reason I got to this point in even initiating communications with you is because I had somebody tell me about my legal rights and how they weren't respected and I reviewed all of those [Rights/Laws] and I realized I'm a witness to too many crimes to count. I've been the victim of them; too many to count.
00:31:13.25
So it's like, what can we do to make things better...I..inferred in my previous communications with Deirdra that the legal side of this is tied into everything. And I don't hear [female voice interrupts, unclear if Deirdra or Danielle: "mhmm"] much acknowledgment on the medical side. I have heard nothing about the legal side. I haven't even heard a coherent story that acknowledges what my communications with your organizations has been over the duration of years. And me, frankly, I just want it all [the misconduct] to end. You know, I don't need three items. I just need it that simple a premise. I want it to stop. I want to stop being abused and exploited by Cigna and the rest of their partners."

To which Danielle Carneson and Dr. Issac Martinez subject Mr. Smith to further abuse. And after having engaged in further misconduct which jeopardized Mr. Smith's safety then have the audacity to assert:

"02:30:59.10
Danielle: I do want to say that, um, we appreciate your time Mr. and Mrs. Smith. Sean, we appreciate all of the information that you've shared with us. Um, I'm sorry, um, you know, for all of the anguish that you, and the pain, that you have had to go through. Um, with everything that you've shared and the information that you, um, submitted, ummmm, in your information that we all read through.
02:31:37.24
Please know that we, um, you know, are here for you if we can help you in any way with the resources that we do have available. And we're willing to work with you, um, on a plan. On a, you know, on a treatment plan if you so desire us to do that."

Perhaps they truly do appreciate the information Mr. Smith disclosed, as it aided them in furthering their abuses against him. Perhaps they really do wish to help him develop a treatment plan, so that they might work to undermine all efforts to rehabilitate him. Perhaps they truly wish to help Mr. Smith, in that same way that some ER physicians believe they help society at large by withholding life-saving care from disabled adults that they determine would be unproductive members of society. Mr. Smith is reminded of America's history of eugenics in which over 60,000 disabled adults were forcibly sterilized after being deemed "unfit" [Buck v. Bell], and that such laws continued to be in place and utilized until the year 2012 in at least one state [Virginia Sterilization Act of 1924].

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.
From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

The statements of the plan fiduciaries are typical of the type of behavior Mr. Smith has come to expect from Cigna and UnitedHealthcare representatives. It's their usual two-facedness. A corporate culture of collective cognitive dissonance and deliberate misdeeds.

"Cigna is committed to helping the people we serve improve their health, well-being, and peace of mind. That is our mission."
"Cigna believes...care must be patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values."
"Every treatment decision must allow for the consideration of the unique situation of the individual."
"Providing every individual with access to quality, evidence-based, patient-centered care is the core tenet of our approach at Cigna." [Cigna Healthcare, 2020, Cigna Standards and Guidelines/Medical Necessity Criteria]

This is a situation where one must also entertain that the person's in-stewardship might not even realize what they're doing because they do not understand nor seek to understand what their obligations really are. For which, it was the duty of those hiring them to make certain that they did. And if by chance they understood what they were doing, they will never admit to it. And those that hired them can likewise be expected refuse to admit to what they've done. Which prevents reconciliation between harmed beneficiaries and plan administrators from occurring.

At no point in time in the call was there any comment upon the failure to review the medical appeal, the wrongful denials, the years of pain and suffering, or the physical and psychological injuries sustained due to their organization failing in their duties. "we at Cigna empathize with all that you've endured throughout your health journey that you described in your appeal..." [C-F 2020 Transcript 00:02:34.25]. Really? Considering that the primary problem preventing Mr. Smith from accessing needed medical care has been a lack of integrity in the review process, it is therefore premised that resolving matters would require addressing that *prior* to the conference call or at least as part of the conference call. Why was there no comment by *any* plan fiduciary regarding Mr. Smith's requests for care having been wrongfully denied without even the pretense of full and fair review?

How does one work with such people? Can one trust them to stop misbehaving when they never seem to acknowledge the fact that their behavior is a problem? How does one work on a treatment plan with a group of persons whose behaviors indicate that they will disregard the practices, policies, and laws which serve to protect plan beneficiaries? How does one get such people to abide by the contracts and laws that they claim to honor while they simultaneously violate them? Where when presented with evidence of their illegal activity and the harms they have caused they yet assert a belief contrary to the facts while engaging in a masquerade that with their actions they are caring for other human beings in an ethical and moral manner?

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

What of the injured and maimed? Do you not hear them cry out and plead for assistance? What of the dead? Do the corpses not give odor? Do the flies and the magots which eat the flesh not provoke revulsion? Does the wailing of the bereaved not shake you? The dead, and the dying, and the crippled caused to be by your hand, how do you entertain to be blameless when even the law, as written, condemns you? What madness grips you?!

A Choice - To Heal or To Harm

Mr. Smith made requests to Danielle Carneson, Dr. Issac Martinez, and all other Cigna-FedEx representatives present that they cease their misconduct and facilitate the care he requires [C-F 2020 Transcript 00:29:18.09-00:30:49.08, 00:50:45.16- 00:53:18.14, 00:55:03.24-00:58:38.10, 01:04:30.21, 01:32:33.17-01:35.09.29]. This request was also made previous to the conference call in Mr. Smith's 2019 Medical Appeal [S.S. 2019 M.A. page 4, 39]. It was even made previous to Mr. Smith's medical appeal over the phone *at least* since the year 2018 to many of the Named Entities representatives. Despite the Named Entities being in receipt of Mr. Smith's repeated requests for assistance, the response on the conference call which took place on May 26th 2020 was one in which the plan fiduciaries elected to engage in actions which had been disclosed to themselves and their organization to be unlawful and cause harm to Mr. Smith.

Neither Danielle Carneson nor Issac Martinez or any other Cigna-FedEx representative present at the Conference Call on May 26th 2020 acted in a manner which can be demonstrated to have prioritized the health and safety of Mr. Smith.

Mr. Smith's safety continues to be jeopardized by the Named Entities misconduct. Mr. Smith continues to be subjected to circumstances which dispose him to experience suicidal ideation and a deterioration of his physical and mental health.

Mr. Smith has had to write this letter and other documents while under the collective burden of his unmet health needs. He finds himself required to function despite those burdens that greatly impair him in order to attempt to defend himself against the misconduct of the Named Entities and others. He must complete difficult tasks while burdened by even more difficult problems, and do so while knowing the circumstances he is subjected to will worsen his medical conditions and disability and thereby cause him even further impairment. And also while knowing that this path he is forced upon endangers what possibility there is for him to benefit from rehabilitative treatments. Mr. Smith is placed in jeopardy now and in the future irrespective of the timeliness and quality of the care he receives. And while his suffering and loss of quality of life cause him to contemplate suicide, experiencing a total "loss of autonomy" would necessitate it as then he would no longer have the ability to act in his own defense.

Mr. Smith is haunted by the uncertainty of if he will be able to receive the care he needs before the injuries he sustains are too significant and lasting to respond to therapies; by the knowledge that there are some medical complications he is unwilling to even try to live with. By the prospect that his life might not truly be able to start until 41 years old. Who starts life at 41?

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

If Mr. Smith was enabled to start getting needed care right now, in ~~July~~ ~~August~~ ~~September~~ ~~October~~ ~~November of 2020~~ November of 2023, it would be 4-6 years later until treatment was complete and he could expect to have been reasonably indemnified for physical and psychological damages. Mr. Smith would be 41-43 years old. It is disturbing, indeed it is very disturbing, to contemplate that one's ability to live life without disabling injury or disease cannot be expected to start until 41 years old.

What peers would Mr. Smith have to relate to? Who shares in similar life experiences? Are there examples of 'starting life at 41'? Those persons who say they had to start-over later in life really did not. They had a previous start upon which they were building. Independence is not a new thing to them. The ability to work is not new. Acquiring education and having a career is not something they have never done. Having strong social bonds with friends and close-relationships are not distant brain-damaged memories of childhood, but experiences that have been present and ongoing throughout their lifetime.

Trying to salvage this mess is a monumental task that there is no doctorate degree in. There is no evidence-based approach - no map to guide by. One must learn to be an expert cartographer and chart their own course. Every tool and advantage one can find and apply will matter. For underlying such late-life rehabilitation, such a long lifetime of damages, is a haunting question, "Am I salvageable or have I been irreparably damaged?".

So much about biology becomes impaired and inflexible in middle-age. The capacity for rehabilitation is much more limited. In fact, the outcomes for orthognathic surgeries begin to experience marked complications past age 35. Accommodating this reality requires extra effort from the patient and exceptional physicians. Even with the best care, Mr. Smith questions if there will ever be any easiness to his life, or, at least, easy in comparison to what he has had to endure thus far. Undoubtedly, it would be nice to entertain having 'a few good years'; but that involves a race that may have already been lost.

The future doesn't wait for people, it usually just consumes anything that's not ready for it. This is because reality doesn't require acknowledgement. It just is. That lesson gets received with rather brutal instruction by persons with severe chronic medical disease. Reality will exert a war of unabated attrition upon those that refuse to acknowledge *and* accommodate it.

"Sean: This is what I mean by documented damages is, you know, I sort through documents and I find things from 2014 and, uh, when I read it in hindsight I'm like, my goodness. The things I went through. And at the same time I'm emotionally distressed by realizing my ability to, um, write was better. I've had serious degradation in my intellectual capacity.
It's like, I can't do that anymore. Why can't I do that? And the answer is in hindsight very obvious.
[I] had to give up reading. [I] had to give up exercise. [I] had to give up eating properly. [I] had to give up having any type of socialization. [I] had to give up hopes and dreams. [I] had to give up all the things that lead to happy healthy human beings."
[C-F 2020 Transcript 01:37:11.25-01:38:25.26]

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

Mr. Smith has been unable to receive the care he needs due to the illegal activities of the Named Entities. It is their misconduct which has required he forfeit so much and for so long. Mr. Smith continues to suffer damages while the Named Entities persist in illegal activity.

Mr. Smith's Personal Journal:

"10.6.2020

20:35

I do not feel well. Why did that happen. Idk. Gut very unsettled. I'm too 'bad feeling' to try to find words for how I feel. No words come to me. Jaw not good either. Chest feels weird. Nose not clear as it should be. Maybe I need to stop digestive enzymes. But, in some ways, different, even better, than I was. Idk. Stick with it. Or give up. Nothing really seems to help manage things anymore. Everything has grown less and less effective. Really fallen off a cliff here. I need to get phone fixed. Documents done. I need to no more use FB or Reddit. I need to force myself to do nothing but the work I need to all day. Exclude all all. Just grab PCP names, schedule, show up, present document, tell read, and yes or no help and when no request letter decline help me. No more discussion or talking or anything. And if they don't read document just stand up and leave.

20:50

My gut and probably other issues are really messing me up. I really feel unwell. I know if I spent more time managing TMD I'd be doing better too. But I have to...have to Do Something. I don't..I've been unable to do much. My cognitive ability poorer much of the time. Not up to writing letter. But, I need to try I need to keep trying.

I realized...tonight, brain...can't remember but can, it was...The reason I..right, I think of suicide, like really think about it as a 'do it now'. Not impulsive but in a it's not worth delaying any longer, you will only suffer more, so now, be at peace with doing it now, and yes it seem peaceful, though I have no experience of peace at any time, so calling it peaceful is really just saying 'this action seems very good to do because what is happening now will stop and that is good enough for me to settle for since feeling peace is not possible'. So, I'm ready, mentally, to kill myself. Ready, willing, able to set out. But there's this part of me that screams, and wails, HELL FUCKING NO, You have to make those bastards pay for what they did to you. You have to finish that letter. You have to send it off. You have to communicate things to others. You have make them pay in as many ways as possible. You can kill yourself then, but not until then, so go do it. The sooner it's done, the sooner it's over.

So I need to do it. I need to get it done. In order to commit suicide with some semblance of being at ease and at peace, without something that screams at me to live, I must make that effort to get Justice. After that, I know I'll be ready. I, well, I expect to be ready. I believe that knowing who I am I will then have all I need to kill myself without any internal protests.

So, to die on one's own terms, sometimes one must satisfy internal demands."

An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment:

To: Cigna, FedEx, UnitedHealthcare, TennCare, et al.

From: Sean Smith DOB: [REDACTED] 1986 November 18, 2023

Is Mr. Smith to have any chance at a life of independence which affords him the capacity to pursue happiness?

Awaiting Your Decision,
Sean P. Smith

References:

American Psychological Association. (Sept 1, 2020). "Suicidal Ideation". American Psychological Association's Dictionary of Psychology. [web page]. Retrieved: https://dictionary.apa.org/suicidal-ideation
Suicidal Ideation: thoughts about or a preoccupation with killing oneself, often as a symptom of a major depressive episode. Most instances of suicidal ideation do not progress to attempted suicide.

American Psychological Association. (Oct 1, 2020). "Epiphenomenon". American Psychological Association's Dictionary of Psychology. [web page]. Retrieved: https://dictionary.apa.org/epiphenomenon
Epiphenomenon: n. (pl. epiphenomena) a mere by-product of a process that has no effect on the process itself. The term is used most frequently to refer to mental events considered as products of brain processes. Thus, though mental events are real in some sense, they are not real in the same way that biological states and events are real, and not necessary to the explanation of mental events themselves. Epiphenomena are conceived of as having no causal power.

Barry Raphael, Steve Carstensen, Mark Cruz, Jerald Simmons, Jill Ombrello, Glennine Varga. (March 12, 2019). Organized Dentistry Take a Turn Toward the Airway. [web article]. Retrieved: https://www.oralhealthgroup.com/features/organized-dentistry-takes-a-turn-toward-the-airway/
Copy in References as: "Organized Dentistry Takes a Turn Toward the Airway (Raphael, 2019).html".

Bartlett Police Department. (5.26.2020). "CAD Operations Report, Call Number 200526-115" Copy in References folder as: "6402 Baird CAD info, rec resp for 6.12.20 req (safety check on 5.26.20).pdf".

Berry, R. B., Budhiraja, R., Gottlieb, D. J., Gozal, D., Iber, C., Kapur, V. K., Marcus, C. L., Mehra, R., Parthasarathy, S., Quan, S. F., Redline, S., Strohl, K. P., Davidson Ward, S. L., Tangredi, M. M., & American Academy of Sleep Medicine (2012). Rules for scoring respiratory events in sleep: update of the 2007 AASM Manual for the Scoring of Sleep and Associated Events. Deliberations of the Sleep Apnea Definitions Task Force of the American Academy of Sleep Medicine. Journal of clinical sleep medicine : JCSM : official publication of the American Academy of Sleep Medicine, 8(5), 597–619. https://doi.org/10.5664/jcsm.2172

British Medical Journal. (1999). "I don't know": the three most important words in education. *BMJ (Clinical research ed.)*, *318* (7193), 0.

Cappleman, R., Smith, I., & Lobban, F. (2015). Managing bipolar moods without medication: a qualitative investigation. *Journal of affective disorders*, *174*, 241–249. https://doi.org/10.1016/j.jad.2014.11.055

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. World psychiatry : official journal of the World Psychiatric Association (WPA), 13(2), 153–160. https://doi.org/10.1002/wps.20128

Christopher A. Baker, Robin A. Hurley, Katherine Taber. (2016). Update on Obstructive Sleep Apnea: Implications for Neuropsychiatry. Jour Neuropsych Clin Neurosci. A6-159.

Cigna-FedEx Human Resources Conference Call Recording & Transcript (C-F 2020 Transcript). (May 5, 2020). [audio & text file].
Call Recording File in References folder: "2020-05-26 14-01-09 FedEx HR & Cigna Meeting, Call Audio - All Audio Combined.mp3".
Call Transcript File in References folder: "Calls, Cigna-FedEx HR Conference Meeting, 5.26.20 Transcript.odt".

Cigna Healthcare. (2019). July and November PSG denials. Files in References as: "Cigna PSG Denial Jul 2019.pdf" and "Cigna PSG Denial Nov 2019.pdf"

Cigna Healthcare. (2020). "Company Profile". [web page]. Retrieved: https://www.cigna.com/about-us/company-profile/. File in References folder as file "Cigna Company Profile _ More than a Health Insurance Company.html".
"Our global workforce of more than 70,000 employees is dedicated to living our mission and being champions for our customers and communities."
"Our goal is to provide the right services and solutions, in the right setting, at the right time, to address the diverse health needs of our customers and patients in a highly personalized way – each and every day."

Cigna Healthcare. (2020). "Medical Necessity Definitions". [web page]. Retrieved: https://www.cigna.com/health-care-providers/coverage-and-claims/policies/medical-necessity-definitions Copy in References folder as: "Cigna 2020 Medical Necessity Definitions.html"

Cigna Healthcare. (2020). Cigna Standards and Guidelines/Medical Necessity Criteria - For

Treatment of Mental Health Disorders. [PDF]. Retrieved: https://www.cigna.com/static/www-cigna-com/docs/health-care-providers/medicalnecessitycriteria.pdf Copy in References folder as: "Cigna 2020 Medical Necessity Criteria.pdf". On pages 3-4:
"Cigna is committed to helping the people we serve improve their health, well-being, and peace of mind. That is our mission."
"Cigna believes...care must be patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values."
"Every treatment decision must allow for the consideration of the unique situation of the individual."
"Providing every individual with access to quality, evidence-based, patient-centered care is the core tenet of our approach at Cigna."

David M. Perry, Lawrence Carter-Long. (2016). The Ruderman White Paper on Media Coverage of Law Enforcement Use of Force and Disability. Ruderman Family Foundation. Retrieved: https://rudermanfoundation.org/white_papers/media-coverage-of-law-enforcement-use-of-force-and-disability/

Doris A. Fuller, H. Richard Lamb, Michael Biasotti, John Snook. (2015). Overlooked in the Undercounted: The role of Mental Illness in Fatal Law Enforcement Encounters. Office of Research & Public Affairs. Retrieved: https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf

Future Tech Podcast. (Apr 24, 2019). A New Approach to Dentistry – Mark A. Cruz, D.D.S, Dental Innovator – Oral Health Perspectives. [podcast]. Retrieved: https://futuretech.findinggeniuspodcast.com/podcasts/new-approach-dentistry-mark-cruz-d-d-s-dental-innovator-oral-health-perspectives/
Copy in References as: "A new approach to dentistry - Mark A. Cruz_Future Tech Podcast 4.24.2019.mp3"

Guilleminault, C., Hagen, C. C., & Huynh, N. T. (2009). Comparison of hypopnea definitions in lean patients with known obstructive sleep apnea hypopnea syndrome (OSAHS). Sleep & breathing = Schlaf & Atmung, 13(4), 341–347. https://doi.org/10.1007/s11325-009-0253-7

James R. Phelps, Susan V. Siemers & Rif S. El-Mallakh. (2013). The ketogenic diet for type II bipolar disorder. Neurocase, 19:5, 423-426, DOI: 10.1080/13554794.2012.690421

Jasper Feyaerts. (2019). The many faces of heterogeneity in psychiatric diagnostics: a response to Allsopp et al. Psychiatry Research. doi:https://doi.org/10.1016/j.psychres.2019.112693

Kate Allsopp, John Read, Rhiannon Corcoran, Peter Kinderman. (2019) Heterogeneity in psychiatric diagnostic classification. *Psychiatry Research*. 279; 15-22. DOI: 10.1016/j.psychres.2019.07.005

Knechtle, B., Economou, N. T., Nikolaidis, P. T., Velentza, L., Kallianos, A., Steiropoulos, P., Koutsompolis, D., Rosemann, T., & Trakada, G. (2019). Clinical Characteristics of Obstructive Sleep Apnea in Psychiatric Disease. Journal of clinical medicine, 8(4), 534. https://doi.org/10.3390/jcm8040534

Maggie Juliano. (Apr 26, 2017) . Fiduciary Services Rules 3921), 3(38), and 3(16): What Does It All Mean and What Do Your Clients Need to Know?. [web article]. Retrieved: https://www.bcgbenefits.com/blog/fiduciary-services-rules-321-338-and-316 Copy in References folder as: "Fiduciary Services Rules_What Does It All Mean.html"

Maletic, V., & Raison, C. (2014). Integrated neurobiology of bipolar disorder. *Frontiers in Psychiatry*, *5*, 98. https://doi.org/10.3389/fpsyt.2014.00098

Mason, B. L., Brown, E. S., & Croarkin, P. E. (2016). Historical Underpinnings of Bipolar Disorder Diagnostic Criteria. Behavioral sciences (Basel, Switzerland), 6(3), 14. https://doi.org/10.3390/bs6030014

Michael Hengartner, Sandrine Lehman. (2017). Why Psychiatric Research Must Abandon Traditional Diagnostic Classification and Adopt a Fully Dimensional Scope: Two Solutions to a Persistent Problem. Frontiers in Psychiatry. https://doi.org/10.3389/fpsyt.2017.00101

Michael Saraga, Friedrich Stiefel, Laurent Michaud. (2020). Heterogeneity in diagnostic criteria does not undermine categorical diagnostic classification. Psychiatry Research, 112882. doi:10.1016/j.psychres.2020.112882

Muneer A. (2016). The Neurobiology of Bipolar Disorder: An Integrated Approach. *Chonnam medical journal*, *52*(1), 18–37. https://doi.org/10.4068/cmj.2016.52.1.18

Natasha Lennard. (Aug 22, 2020). Her Former Colleagues Called in a "Wellness Check." Then

Police Shot Her to Death. The Intercept. [Web Article]. Retrieved: https://theintercept.com/2020/08/22/police-shooting-wellness-check-sandy-guardiola/?fbclid=IwAR3WE3dSTj-HhhuWEUjuyZKV33kVB6tgtzl_qlUtQB_jwSuHapKRJ_oZpfU
Copy in References folder as: "Killed in a Wellness Check_Why Cops Shouldn't Police Mental Health.html"

Peter Attia. (2019). #47 - Matthew Walker, Ph.D., on sleep - Part I of III: Dangers of poor sleep, Alzheimer's risk, mental health, memory consolidation, and more. [Podcast]. Retrieved from: https://peterattiamd.com/matthewwalker1/
Copy in References folder as: "Mathew Walker EP47, The Drive (Attia, 2019).mp3"

Rudolf Uher, Alyson Zwicker. (2017). Etiology in psychiatry: embracing the reality of poly-gene-environmental causation of mental illness. World Psychiatry. 16(2).

Sean Smith. (2018). "0 Supplemental Info by Sean Smith.pdf'. Copy in References as: "0 Supplemental Info by Sean Smith.pdf".

Sean Smith. (2019-2021). Dr. Rice Cigna Claim Documents. Copies of documents in References folder subfolder "Dr. Rice Cigna Claim Documents", (21 items, 21.5MB) containing 8 .pdf, 12 .eml, 1 .jpg.

Sean Smith. (2019). "Sean Smith's Medical Appeal". [document]. Submitted to Cigna-FedEx and UnitedHealthcare-TennCare Nov-Dec 2019. Copy in References folder as: "Sean Smith's Medical Appeal Winter 2019.pdf".

Sean Smith. (2019). "Sean Smith's Medical Appeal; Medical Records". [files]. Copies in References Folder as:

- "1 Dr. Smith Psychiatrist.pdf"
- "22 Dr. Rice's Case study #VIV-01163 Sean Smith.pdf"
- "23 Dr. Rice Vivos Dx Tx.pdf"
- "CBCT dec2018_Coronoal Turbinites, Septum, Arch Dist.jpg" *contained in folder* "24 Dr. Rice Pictures Bite, Profile, CBCT images".

Sean Smith. (2019). "Sean Smith's Medical Appeal; References". [documents & files].

- 5. Lavigne, G. J., & Sessle, B. . (2016). The Neurobiology of Orofacial Pain and Sleep and Their Interactions. Journal of Dental Research, 95(10), 1109–1116. https://doi.org/10.1177/0022034516648264
- 34. Daniel E. Tache. (May 23, 2019). Dental Sleep Medicine: A Case Study of a TMD Patient with a 24-year History of Refractory Epilepsy Entirely Controlled with a Mandibular Advancement Device. [Web article]. Retrieved from:

https://dentalsleeppractice.com/ce-focus/dental-sleep-medicine-a-case-study-of-a-tmd-patient-with-a-24-year-history-of-refractory-epilepsy-entirely-controlled-with-a-mandibular-advancement-device/

- 40. Nayef AlGhanim, et al. (2008). The Economic Impact of Obstructive Sleep Apnea. Lung. 186; 7-12.
- 41. Watson NF. (2016). Health care savings: the economic value of diagnostic and therapeutic care for obstructive sleep apnea. J Clin Sleep Med. 12(8):1075–1077.
- 42. Frost & Sullivan. (2016). Hidden health crisis costing America billions. Underdiagnosing and undertreating obstructive sleep apnea draining healthcare system. Darien, IL: American Academy of Sleep Medicine. Retrieved from: http://www.aasmnet.org/sleep-apnea-economic-impact.aspx.
- 43. Ginger Pinholster. (2014). Sleep Deprivation Described as a Serious Public Health Problem. [web article]. Retrieved from: https://www.aaas.org/news/sleep-deprivation-described-serious-public-health-problem
- 44. American Academy of Sleep Medicine. (2013). AASM partners with CDC to address chronic sleep loss epidemic. [Web Article]. Retrieved from: https://aasm.org/aasm-partners-with-cdc-to-address-chronic-sleep-loss-epidemic/
- 45. Vijay Kumar Chattu, Sateesh M. Sakhamuri, Raman Kumar, David Warrent Spence, Ahmed S. BaHammam, and Seithikurippu R. Pandi-Preumal. (2018). Insufficient Sleep Syndrome: Is it time to classify it as a major noncommunicable disease?. Sleep Science. 11(2); 56-64
- 46. SeatleStudyClubHQ. June, 7, 2018. Practice Inspiration - Dr Jeff Rouse - Hypopnea Is the Real Issue [Web video]. Retrieved from: https://www.youtube.com/watch?v=w_A6zvwCnl8
- 49. Christian Guilleminault, Shannon S. Sullivan, Yu-Shu Huang. (2019). Sleep-Disordered Breathing, Orofacial Growth, and Prevention of Obstructive Sleep Apnea. Sleep Medicine Clinics. 14(1); 13 - 20.
- 52. Christian Guilleminault, Ceyda Kirisoglu, Dalva Poyares, Luciana Palombini, Damien Leger, Mehran Farid-Moayer, Maurice M. Ohayon. (2006). Upper airway resistance syndrome: A long-term outcome study. Journal of Psychiatric Research, 40(3); 273-279, ISSN 0022-3956, https://doi.org/10.1016/j.jpsychires.2005.03.007.
- 53. Steven, Park. (Producer). (2011, July 22). Expert Interview: Dr. Christian Guilleminault on UARS [Breathe Better, Sleep Better audio podcast]. Retrieved from http://doctorstevenpark.com/expert-interview-dr-christian-guilleminault-on-uars [Transcript excerpt: "The big thing is to realize the severity of the future. We know that these people very often are young individuals which have a problem. We

know that if we do nothing, there will be a progressive destruction of the sense [mechanoreceptors, etc] of the upper airway. And let's face it, we [humans] have a [physiological] limit. We have people who still have a good response, the ability to fight and to breath, and that's why we don't see the terrible oxygen saturation drop, the same drop in oxygen we have with obstructive sleep apnea. But, a certain number of these people will have - how long it will take we don't know, we don't know enough about this syndrome [UARS] yet - an evolution [from UARS to OSA] and the neurogenic problem in the upper airway are going to develop. And then, if this neurogenic problem occurs they will switch from A [UARS] to B [OSA] where they have apnea. And once you have destroyed the sense, once you have destroyed the very small nerves we don't know yet how to make them come back. So we go from a status where we can cure the person, to a status where the person will have permanent impairment. So that's the big issue, we have to recognize these people early, and treat them early to keep them on the side with normal innervation." "We don't know who is going to progress [from uars to osa] and who is not going to progress." -Dr. Christian Guilleminault, 2011, Professor of Stanford Sleep Medicine Center; a legendary figure in sleep medicine]

- 66. Avram R. Gold. (2010). Functional somatic syndromes, anxiety disorders and the upper airway: A matter of paradigms. Sleep Medicine Reviews. 15(6); 389-401
- 68. SeatleStudyClubHQ. April, 11, 2018. Practice Inspiration - Dr Steve Carstensen - Why Do Some Patients Have More Trouble Than Others?. time: 10:55-11:10. Retrieved from: https://www.youtube.com/watch?v=mAAfzwvms78
- 69. Foundation for Airway Health. (Nov 25, 2017). "Dr. Steve Carstensen, DDS: UARS - The Grey Zone Means More Than You Think | GNYDM 2017 Airway Summit". [Web video]. Retrieved from: https://vimeo.com/259946643/63c2a0e4cd
- 71. Foundation for Airway Health. (2019). Dr. Jerald H. Simmons, MD: Medical Dental Connection - Collaborative Care: Key to the Future | GNYDM 2018 Airway Summit. [Web video]. time: 9:10-9:30. Retrieved from: https://vimeo.com/337873944/6404926cce
- 75. Jeffrey S. Rouse. (May, 2010). The Bruxism Triad: Sleep bruxism, sleep disturbance, and sleep-related GERD. Inside Dentistry. [Web article]. Retrieved from: https://www.aaoinfo.org/system/files/media/documents/Rouse%20--%20Interdisciplinary%20Airway%20Management%3B%20A%20Call%20to%20Action.pdf
- 76. Jeffrey S. Rouse. (2013). Sleep Prosthodontics: A New Vision for Dentistry. Inside Dentistry. [Webarticle]. Retrieved from: https://www.aaoinfo.org/system/files/media/documents/Rouse%20--%20Interdisciplinary%20Airway%20Management%3B%20A%20Call%20to%20Action.pdf

- 77. Jeffrey S. Rouse. (2013). Sleep Prosthodontics: Understanding Myofascial pain. Inside Dentistry. [Web article]. Retrieved from: https://www.aaoinfo.org/system/files/media/documents/Rouse%20--%20Interdisciplinary%20Airway%20Management%3B%20A%20Call%20to%20Action.pdf
- 86. Sherin, J. E., & Nemeroff, C. B. (2011). Post-traumatic stress disorder: the neurobiological impact of psychological trauma. Dialogues in clinical neuroscience, 13(3), 263–278.
- 87. Barry J. Krakow, et al. (2015). Posttraumatic stress disorder and sleep-disordered breathing: a review of comorbidity research. Sleep Medicine Reviews. 23; 1-9. "...among more recent reviews, there is a growing indication that individuals with PTSD suffer a disproportionately higher rate of SDB compared to the general population."
- 88. Ronald M. Harper, et al. (2012). Functional Neuroanatomy and Sleep-Disordered Breathing: Implications for Autonomic Regulation. The Anatomical Record. 295; 1385-1395.
- 89.
  E. See Also: "In fact, we're writing a paper right now. I think if there is one central pathway through which we can understand almost all aspects of the deleterious impact of insufficient sleep it is through the autonomic nervous system and specifically an excess leaning on the fight or flight branch of the nervous system. Which is to say, that your sympathovagal balance is way off." - Matthew Walker, The Drive EP48: 16:00:00. https://peterattiamd.com/matthewwalker2/
  Copy in References folder as: "89E Mathew Walker EP48, The Drive (2019, Attia).mp3"
- 92. Breit, S., Kupferberg, A., Rogler, G., & Hasler, G. (2018). Vagus Nerve as Modulator of the Brain-Gut Axis in Psychiatric and Inflammatory Disorders. Frontiers in psychiatry, 9, 44. doi:10.3389/fpsyt.2018.00044
- 93. Peter Attia. (2019). #49 - Matthew Walker, Ph.D., on sleep - Part III of III: The penetrating effects of poor sleep from metabolism to performance to genetics, and the impact of caffeine, alcohol, THC, and CBD on sleep. [Podcast]. Retrieved from: https://peterattiamd.com/matthewwalker3/
  Copy in References folder as: "93 Mathew Walker EP49, The Drive (2019, Attia)"
- 111. Nuria Farre, David Gozal. (2018). Sleep and the Microbiome: A Two-Way Relationship. Archivos De Bronconeumologia. Vol 55. Num 1. Pages 1-64. DOI: 10.1016/j.arbr.2018.04.014
- 112. Nuria Farre, Marta Torres, David Gozal, Ramon Farré. (2018). Sleep and Circadian Alterations and the Gut Microbiome: Associations or Causality?. Current Sleep Medicine Reports. 4. 10.1007/s40675-018-0100-0.
- 123. Goldschmied, Jennifer & Cheng, Philip & Hoffmann, Robert & M. Boland, Elaine & J. Deldin, Patricia & Armitage, Roseanne. (2018). Effects of slow-wave

activity on mood disturbance in major depressive disorder. Psychological Medicine. 1-7. 10.1017/S0033291718001332.
"In major depressive disorder (MDD) specifically, sleep disturbance has been shown to be an independent risk factor for the development and maintenance of the disorder"

- 125. Mona F. Philby, Paul Macey, Richard A. Ma, Rajesh Kumar, David Gozal, Leila Kheirandish-Gozal. (2017). Reduced Regional Grey Matter Volumes in Pediatric Obstructive Sleep Apnea. Scientific Reports. 7. 44566. 10.1038/srep44566.
- 126. Walter, Lisa M., C. Horne, Rosemary S. (2018). Obstructive sleep-disordered breathing in children: Impact on the developing brain. Pediatric Respirology and Critical Care Medicine. 2. 58. 10.4103/prcm.prcm_16_18.
- 128. Patricia Boksa, Ridha Joober. (2018). Who should be "controls" in studies on the neurobiology of psychiatric disorders?. Journal of psychiatry & neuroscience : JPN. 43. 292-297. 10.1503/jpn.180128.
"There is emerging evidence that sleep quality alone has measurable effects on brain structure and function in healthy humans."
- 130. Goldstein, A. N., & Walker, M. P. (2014). The role of sleep in emotional brain function. Annual review of clinical psychology, 10, 679–708. doi:10.1146/annurev-clinpsy-032813-153716
- 131. J Krause, Adam & Ben-Simon, Eti & Mander, Bryce & Greer, Stephanie & Saletin, Jared & Goldstein, Andrea & Walker, Matthew. (2017). The sleep-deprived human brain. Nature reviews. Neuroscience. 18. 10.1038/nrn.2017.55.
- 139. Alex White, Louise A. Williams, Joseph R. Leben. (2001). Health care utilization cost among health maintenance organization members with temporomandibular disorders. Journal of Orofacial Pain. 15:158-169.
- 140. Shimshak DG, DeFuria, MC: Health care utilization by patients with temporomandibular joint disorders. The Journal of Craniomandibular Practice, July 1998, Vol. 16, No. 3:185-193.
- 150. Adam J. Krause, Aric A. Prather, Tor D. Wager, Martin A. Lindquist, Matthew P. Walker. (2019). The pain of sleep loss: A brain characterization in humans. Journal of Neuroscience. 39 (12) 2291-2300. DOI: 10.1523/JNEUROSCI.2408-18.2018 See also: http://www.sleepreviewmag.com/2019/01/sleep-loss-pain/
- 153. Allison G. Harvey, Lisa S. Talbot, Anda Gershon. (2009). Sleep Disturbance in Bipolar Disorder Across the Lifespan. Clin Psychol Sci Prac. 16; 256-277.
- 154. Caroline Rambaud, Christian Guilleminault. (2012). Death, nasomaxillary complex, and sleep in young children. Eur J of Pediatr. 171(9); 1349-1358.

- 155. Peter Attia, Robert Sapolsky. (April 29, 2019). #51 – Robert Sapolsky, Ph.D.: The pervasive effect of stress – is it killing you?. Excerpt at: 1:00:00-1:02:00. [Podcast interview]. Retrieved: https://peterattiamd.com/robertsapolsky/
  "[If] you're stressed 24/7...you're in the range of where glucocorticoids do exactly the opposite. They decrease oxygen and glucose delivery to the hippocampus, they make neurons less excitable, they disconnect synapses, they cause the processes and neurons to scrivel, they block the birth of new neurons there, they make other insults more damaging to neurons in the hippocampus. ....**what we're increasingly realizing is if you're exposed to excessive glucocorticoid levels like on a scale of years to decades you're going to make this part of the brain get older faster**." - Robert Sapolsky, PhD, Stanford professor of biology, neurology and neurological sciences [155; 1:00:00]
  Copy in References folder as: "155 Robert Sapolsky Ep 51, The Drive (2019, Attia).mp3"
- 156. Erica Rodriguez, Katsuyasu Sakurai, et al. (2018). A craniofacial-specific monosynaptic circuit enables heightened affective pain. Nature Neuroscience. 20(12); 1734-1743.

Sean Smith. (Oct, 2019). "TNCARE Public Comments at Block Grant Hearings. Copy in References as: "TNCARE Public Comments 10.3.19 10.15.19.pdf"

Sean Smith. (2020). Email to Deirdra at FedEx HR. File in References folder as: "Email to Deirdra at FedEx HR Apr-May 2020.pdf".

Sean Smith. (2020). Google and Pubmed Bipolar Neurobiology Search Screenshots. Screenshot files in References as: "Proof of Google Search Neurobiology Bipolar 9.14.20.png" and "Proof of Pubmed Search Neurobiology Bipolar 8.26.20.png".

Sean Smith. (2020). Letter to Patricia Newton, TennCare Oversight. Copy in References as: "Letter to Patricia Newton, TennCare Oversight, Response Email 6.12.20.pdf".

Sean Smith. (2020). "Medical Insurance Coverage for Temporomandibular Disorders (TMDs) and Comorbid Diseases: It's Interactions and Influence on Physicians and Patient Populations - An Incomplete and Flawed Report of What I've Learned:". Private communication, no copy included in References.

State of Tennessee Department of Mental Health And Substances Abuse Services. (2020).

Forms for Involuntary Commitment MH-5542. Retrieved: https://www.tn.gov/behavioral-health/mhsa-law/legal-forms/legal-forms/forms-for-involuntary-commitment.html
Copy of Form in References as: "MH-5542_Form.pdf".

TennCare. (2020). Med Appeal Denial TennCare. Copy in References as: "Med Appeal Denial TennCare_Case Closed 1.2.2020.pdf".

TennCare. (2020). TennCare Grievance of Appeal Rev. Copy in References as: "TennCare Grievance of Appeal Rev & PHI Req Misconduct, Denies Wrongdoing 5.27.20.pdf"

TennCare Oversight. (2020). TDCI Response Ltr 061220. Copy in References as: "TDCI Response Ltr 061220.pdf"

The Lancet Psychiatry. (2018). The medication debate: Time to change the record. The Lancet Psychiatry. 5(10); 769. https://doi.org/10.1016/S2215-0366(18)30359-6

Thomas Insel. (April 29, 2013). Post by Former NIMH Director Thomas Insel: Transforming Diagnosis. [web article]. Retrieved: https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/transforming-diagnosis.shtml Copy in References folder as: "NIMH » Transforming Diagnosis Thomas Insel.html".

Timothy Wand. (2018). Is it time to end our complicity with pharmacocentricity?. Int Jour of Mental Health Nurs. 28; 3-6. https://doi.org/10.1111/inm.12554

UnitedHealthcare. (2019). Med Appeal Denial UHC. Copy in References as: "Med Appeal Denial UHC, Tora Benton Negligence 12.31.2019"

UnitedHealthcare. (2020). UHC 8.5.20 Complaint Determination. Copy in References as: "UHC 8.5.20 Complaint Determination, go talk to TennCare.pdf"

University of Liverpool. (July 8, 2019). Study finds psychiatric diagnosis to be 'scientifically meaningless'. [web article]. Retrieved: https://medicalxpress.com/news/2019-07-psychiatric-diagnosis-scientifically-meaningless.html
Copy in References folder as: "Study finds psychiatric diagnosis to be 'scientifically meaningless' (Uni of Liverpool, 2019).html"

Vu Ho, Cipirian M. Crainiceanu, Naresh M. Punjabi, Susan Redline, Daniel J. Gottlieb. (2015).

Calibration model for apnea-hypopnea indices: Impact of Alternative Criteria for Hypopneas. Sleep. 38(12): 1887-1892.

EXHIBIT C

TennCare Deputy Director Stephen Smith's 2023 Oath of Office

STATE OF TENNESSEE

Oath of Office

I, ***Stephen M. Smith,*** do solemnly swear that as Deputy Commissioner of Health Care Finance and Administration and Director of TennCare for the State of Tennessee, I will support the Constitution of the State of Tennessee and the Constitution of the United States, and that I will perform with fidelity and faithfully execute the duties of the office to which I have been appointed, and which I am about to assume. So help me God.

This the 21st day of January, 2023.

Stephen M. Smith

STATE OF TENNESSEE)

COUNTY OF DAVIDSON)

I, ***Bill Lee***, Governor of the State of Tennessee have this day administered the Oath of Office to Stephen M. Smith, as prescribed by law. This the 21st day of January, 2023.

Bill Lee

EXHIBIT D

Sean Smith's filled TennCare Appeal Authorization Form dated 11.16.2023

Having problems getting health care or medicine in TennCare?

Use this page **only** to file a

TennCare Medical Appeal.

Need help filing a medical appeal?
☐ Call **1-800-878-3192** for free.

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192.** If you call, we can also take your **appeal by phone.**

FILED 2024 APR 11 PM 12:08 DAVIDSON CO. CHANCERY & MASTER CLERK & MASTER

1. Who is the person that wants to appeal?

Full name Sean Smith Date of birth [redacted] 1986

Social Security Numbe [redacted] Or number on their TennCare card _____

Current mailing address 6402 Baird Lane

City Bartlett State TN Zip Code 38135

The name of the person we should call if we have questions about this appeal:

A daytime phone number for that person (901) 522 - 5775

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name. _____

Are you a: _____Parent, relative, or friend _____Advocate or attorney _____Doctor or health care provider*

(*You need your patient's written permission to file this appeal. See the third page.)

3. What is the appeal for? (Place an **X** beside the right answer below.)

_____Want to **change health plans.** (Fill out **Part A** on page 2.)

__X__**Need care or medicine.** (Fill out **Part B** on page 2.)

_____Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency and your health plan agrees that you do, you will get an **expedited** appeal. An expedited appeal will be decided in about one week. It could take longer if your health plan needs more time to get your medical records. An emergency means that waiting 90 days for a "yes" or "no" decision **could put your life or physical or mental health in real danger**.

Do you still think you have an emergency? If so, you can ask TennCare for an **expedited** appeal by calling 1-800-878-3192. Your **doctor** can also ask for this kind of appeal for you. But the law requires your doctor to have **your permission (OK) in writing.** Write **your name, your date of birth, your doctor's name, and your permission for them to appeal for you** on a piece of paper. Then fax or mail it to TennCare (see **There are 3 ways to file an appeal** for our address and fax number). What if you don't send us your OK and your doctor asks for an expedited appeal? TennCare will send you a page to fill out, sign and send back to us.

After you give your OK in writing, your doctor can help by completing a "Provider's Expedited Appeal Certificate". Your doctor can get the page from TennCare's website. **Go to tn.gov/tenncare.** Click "Providers," and then click "Miscellaneous Provider Forms." Your doctor should fax this certificate and your medical records to TennCare. TennCare **and** your health plan will then look at your appeal and decide if it should be expedited. **If it should be**, you will get a decision on your appeal in about one week. Remember, it could take longer if your health plan needs more time to get your medical records.

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

Health Plan Misconduct preventing needed care, causing injury, jeopardizing health & safety. Provide Full & Fair Review of: "An Example of Misconduct Committed by Plan Fiduciaries And Their Contracted Partners & An Appeal for Rehabilitative Treatment.

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans. Name of health plan you want ~~_____~~

Part B. Need care or medicine. What kind - be specific Rehabilitative Treatment of Disabilities

What's the problem? X Can't get the care or medicine at all.
_____ Can't get as much of the care or medicine as I need.
_____ The care or medicine is being cut or stopped.
_____ Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? ____Yes____No If yes, doctor's name_____
Have you asked your health plan for this care or medicine? X Yes____No If yes, when? 2019-date
What did they say? Misconduct; See Letter/Appeal
Did you get a letter about this problem? ____Yes____No If yes, the date of the letter_____
Who was the letter from?_____
Are you getting this care or medicine from TennCare now? _____Yes X No
Do you want to see if you can keep getting it during your appeal? _____Yes____No
Does your doctor say you still need it? X Yes____No If yes, doctor's name Review Letter/Appeal
If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine_____Name of doctor, drug store, or other place that gave you the care or medicine_____Their phone number (____) _____ - _____
Their address_____
Did you **pay for the care or medicine and want to be paid back?**____Yes____No
If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.
If you didn't pay, ***are you getting a bill?*** _____Yes____No *If yes, and you think TennCare should pay,* you must send a copy of a **bill.** Tell us the date you first got a bill (if you know).

How to file your medical appeal

Make a copy of the completed pages to keep.

Then, **mail** these pages and other facts to:

TennCare Member Medical Appeals
P.O. Box 593
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability.
If you think you've been treated unfairly, call TennCare Connect for free at **1-855-259-0701.**

STATE OF TENNESSEE

DIVISION OF TENNCARE

TennCare Member Medical Appeals

P.O. Box 000593 Nashville,
Tennessee 37202-0593

Appeal Authorization Form

Patient's Printed Name Sean Smith

Patient's Date of Birth [redacted]1986

Doctor's Printed Name Uncertain

Yes, I would like to request a Fair Hearing from TennCare for.

Full & Fair Review & Help Now, or Fair Hearing in Court Later
You, TennCare, Decide
(Drug, item, or service)

X Different issue

☐ I give my doctor permission to file a fair hearing request on my behalf.

☐ I want to keep getting the services I've been getting until my appeal is over. I understand that my health plan will look at my case and decide if I can keep getting this care during my appeal.

Sean P. Smith 11.16.2023

Signature of Patient **Date**

6402 Baird Lane Bartlett TN 38135

Address

901 522-5775

Phone Number