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ADVANCED
REIMBURSEMENT
SOLUTIONS

Advanced Reimbursement Solutions, LLC
2801 Centerville Road, First Floor, PMB#550
Wilmington, Delaware 19808
(302) 316-5305

'03/24/2021'

ATTN: Appeals Department
UHC Member Inquiry/Appeals PO Box 740800 Atlanta GA 30374-0800

RE: Failure to Respond to Second-Level Appeal
Tax ID: 82-4510876
Date of Service: 01/21/2020
Fan: RFA-VANJ012120
Billed Charges: $20,572.86

To Whom It May Concern,

Advanced Reimbursement Solutions, LLC ("**ARS**") has been appointed by John D Van Hemert (the "**Beneficiary**") (Subscriber ID:932614470) as their Authorized Representative for pursuing, *inter alia*, the Beneficiary's benefits claim and administrative appeals, as indicated by the enclosed "Authorization of Representation" document (the "**Authorization**"). To date, the total amount paid on this claim is $1266.72.

On 2021-01-14, ARS submitted a second-level appeal to challenge UHC's claims adjudication for one or more of the following adverse benefit determinations: (i) insufficient payment; (ii) improper denial; (iii) a failure to properly adjudicate the claim according to the Beneficiary's health plan; and/or (iv) a failure to properly adjudicate the claim in compliance with the claims processing procedures under the Employee Retrirement Income Security Act of 1974 ("**ERISA**"), 29 C.F.R. § 2560.503-1. To date, UHC has failed or refused to process or respond to the Beneficiary's second-level appeal.

ERISA CLAIMS PROCESSING REQUIREMENTS

AUTHORIZATION OF REPRESENTATION AND SPECIFIC POWER OF ATTORNEY
Relating to Healthcare Benefits

I. IDENTIFYING INFORMATION

Patient Name: John D Vanhemert
Patient Date of Birth: 04/29/1968
Insurance Carrier: UHC
Member ID: 932614470
Group #:199409
Primary Subscriber Name: Shauna M Vanhemert
Primary Subscriber Date of Birth: 03/13/1966
Primary Subscriber Employer: Southwest Airlines Co
Primary Subscriber Employer Address:

II. AUTHORIZATION OF REPRESENTATION

I John D Vanhemert, hereby appoint Advanced Reimbursement Solutions, L.L.C. (ARS) and/or Gregory B. Maxon Maldonado, President of ARS (collectively known as my "Authorized Representative") to act on my behalf, as my Authorized Representative, as permitted under Department of Labor Regulation Section 2560.503-1, in connection with the processing of claims, communicating with the Plan Administrator and/or Fiduciary, and/or appeals relating to services and/or products that I received from my Surgery Center, Physician, Medical Group, Durable Medical Equipment Provider and/or any other medical expenses (collectively known as "Services/Products") I have incurred within two (2) year prior to and after the date of the execution of this authorization.

I authorize my Authorized Representative: (a) to communicate with me through email and/or text message regarding any and all matters related to scheduling my healthcare Services/Products and any and all matters related to billing for my healthcare Services/Products to the email and phone number on file, (b) to submit claims for my healthcare Services/Products to insurance companies, health plans, my employer-sponsored health plan's plan administrator, trust, self-funded plans, third party administrators, re-pricing companies, federal and state payers, and all other types of governmental and commercial payers on my behalf; (c) to pursue appeals of denials or underpayments of claims at all administrative levels, including (but not limited to) informal, internal and external appeals or reviews; (d) to request and receive documentation and information necessary to pursue collection of such claims; (e) to pursue any and all legal action and all legal remedies to which I am entitled regarding such claims including (but not limited to) recovering any underpayments or denials of payments, including claims for interests, penalties, breach of fiduciary duty, and punitive damages; (f) to resolve or settle any claims on my behalf; (g) to receive payments from all governmental and commercial payers on my behalf, and; (h) to retain an attorney to represent my Authorized Representative.

In furtherance of my Authorized Representative pursuing health benefit claims and appeals on my behalf, and any other administrative remedies to which I am entitled, under both state and Federal laws; I authorize my Authorized Representative to receive all information, from any source, to pursue such claims, appeals, and legal actions. Additionally, I authorize the hiring of an attorney, at ARS's, cost, as necessary to pursue benefit claims, appeals of adverse benefit determinations and any applicable legal actions on my behalf. I authorize a copy of all information, correspondence and notifications, including but not limited to Explanations of Benefits, claim denials and approvals, and appeal denials and approvals relating to the Services/Products to be sent to Advanced Reimbursement Solutions, L.L.C., PMB #550, 2801 Centerville Road, First Floor, Wilmington, DE 19808.

This Authorization of Representation is effective as of the date signed below and will expire after claims within the Service Period are fully adjudicated or litigated as permitted under state and federal law. I understand that sometimes I may go to the same provider multiple times. This Authorization and Specific Power of Attorney may be used and relied upon repeatedly and universally until its expiration. I understand that I may revoke this Authorization or the Specific Power of Attorney at any time by informing my Authorized Representative in writing. All correspondence and communications relating to the Services/Products should be directed to my Authorized Representative. Any change in my intent relative to this Authorization will be communicated by me in writing.

J.V. Initial

If any insurance company, health plan, trust, self-funded plan, third party administrator, re-pricing company, federal and state payer, or governmental or commercial payer requires a specific form be filled out to appoint an authorized representative or any other forms related to Protected Health Information, please forward those forms, along with any plan language requiring I use such forms to ARS. The signing of this Authorization of Representation and Specific Power of Attorney evidences my intent to appoint ARS and/or Gregory B. Maxon Maldonado as my authorized representative and my attorney-in-fact.

I understand I have a duty to cooperate with ARS or its retained counsel in the processing of claims, appeals and interactions with my employer, if necessary. Revocation of any of the forms necessary to fully and properly adjudicate a claim may result in all outstanding balances being owed by the beneficiary. A price list of all services billed is available upon written request.

III. SPECIFIC POWER OF ATTORNEY

This specific power of attorney is effective as the date below and will continue to be effective two years from date entered below or when the claim is paid in its entirety, whichever is first. Any third party who receives a copy of this document shall unequivocally accept instructions from my attorney-in-fact as if given directly by me.

To the extent any dispute arises between Authorized Representative, the Third Party Administrator (TPA), the health insurance carrier, and/or my Plan and/or its fiduciaries relating to a Benefit Claim or the manner in which similar claims will be treated by the TPA, including Plan Administrator and/or its fiduciaries now or in the future, it is my intention that the Plan and/or its fiduciaries give Advanced Reimbursement Solutions L.L.C. on my behalf any and all claims, rights, appeals and causes of actions that I could bring pursuant to Employment Retirement Income Security Act (ERISA) and the Patient Protection and Affordable Care Act (PPACA). This SPECIFIC POWER OF ATTORNEY grants the following:

- Ability for ARS, or its agents or representatives to sign, endorse and complete on my behalf any settlement agreements, releases, checks, and/or other documents necessary to properly and completely execute any Authorization of Representation and/or Protected Health Information (PHI) forms and any and all corresponding claims.
- To claim on my behalf any benefits, reimbursements, damages, excise taxes and awards
- Directly communicate with the Plan Administrator of my employer.
- Direct the Third Party Administrator to mail checks directly to ARS for processing
- To edit, complete, and/or fill out any Insurance carrier forms necessary to adjudicate the claim, appeal the claim, or interact with my employer or Insurance carrier

IV ACKNOWLEDGMENTS

By signing this form, I understand that I have been given an opportunity to have an attorney or other advisor review the documents and am knowingly waiving my right to have an attorney or other advisor review the documents. I further agree that a photocopy of this agreement shall be as effective and valid as the original. I also certify that I have read and understand the above statements and that all of my questions have been satisfactory answered.

I understand that if I would like additional time to have an advisor or an attorney review these forms, I have the option to reschedule the procedure(s) or set-up and at my own cost have all documents reviewed and explained to me by my attorney or advisor.

Additionally, I understand that I have a continuous and ongoing duty to timely cooperate with ARS during the processing of my claim and all subsequent appeals. Failure to cooperate with ARS may result in the insurance company fully or partially denying payment of the claim. If a full or partial denial of the claim occurs because I fail to cooperate, I understand that I may be responsible for the full payment of the claim.

This Authorization of Representation and Specific Power of Attorney is effective as of the date signed below and will continue to be effective until claims relating to the Services/Products are paid in their entirety or for two years whichever comes first.

J.V. Initial

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All correspondence and communications relating to the Services/Products should be directed to my Authorized Representative. Any change in my intent relative to this Authorization or Power of Attorney will be communicated by me in writing.

E-SIGNED by John Vanhemert on 2020-01-21 16:36:52 GMT

Signature of Beneficiary/Participant

January 21, 2020

Date

By signing below, Advanced Reimbursement Solutions, L.L.C. and/or Gregory B. Maxon Maldonado hereby accepts the appointment to serve as Authorized Representative and Specific Power of Attorney as described above.

By: Gregory Brian Maxon Maldonado

Gregory B. Maxon Maldonado

UHC is a fiduciary with respect to the Beneficiary's health benefit plan. "[A] person is a fiduciary with respect to a plan to the extent (i) [it] exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . , or (iii) [it] has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A). As a fiduciary of the plan, UHC "shall discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries." ERISA, Section 404(a)(1)(A)(i), *codified at* 29 U.S.C. § 1104(a)(1)(A)(i); *see also* ERISA, Section 403(c)(1), *codified at* 29 U.S.C. § 1103(c)(1) ("[T]he assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.").

With these fiduciary principles in mind, ERISA requires UHC to provide a reasonable opportunity to the Beneficiary and Authorized Representative for a full and fair review of an adverse benefit determination for a medical claim. *See* ERISA Claims Procedure, 29 CFR 2560.503-1(h)(2). When denying or underpaying a claim for medical benefits, UHC is required to "provide adequate notice . . . setting forth the specific reasons for such denial." 29 U.S.C. § 1133; *see also* 29 C.F.R. § 2560.503-1(g). UHC is also required to provide the Beneficiary with a "reasonable opportunity . . . for a full and fair review" of a denial of benefits. *Id.* "In simple English, what [section 1133] calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton v. Lockheed Med. Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). "If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial; if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it." *Id.* UHC is required to "write a denial 'in a manner calculated to be understood by the claimant.'" *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 680 (9th Cir. 2011). Pursuant to these ERISA provisions, UHC was required to provide the following:

(1) reference specific provisions of the Beneficiary's plan documents and any additional documents that define what medical services constitute experimental, investigational, or "medically necessary" services, and provide substantiating documentation as to what standards UHC is referring, as well as an explanation as to how these standards apply to this claim and UHC's subsequent denial of this medical claim;

(2) all documents and methodologies that UHC used in its calculation of the "allowed amount," and reference the specific provisions of the Beneficiary's plan documents that support these calculations;

(3) If the allowed amount was based upon Maximum Non-Network Reimbursement Program ("**MNRP**") or a derivative thereof, such as Webstrat or Berges, reference the specific page in the Beneficiary's plan documents that allow for the use of MNRP;

(4) a copy of UHC's Administrative Service Agreement (the "**ASA**") with the plan sponsor or plan administrator and a reference to the provisions of the ASA that provide for the discretion to re-price out-of-network claims;

(5) all substantiating documentation that defines what constitutes a "global period," and all documentation that explains the denial of payment for the medical services rendered to the Beneficiary; and,

(6) reference to the specific provisions of the Beneficiary's plan documents that define what constitutes "reasonable and appropriate charges," and an explanation of the methodologies used by UHC to calculate the charges for medical services rendered to the Beneficiary.

"Under ERISA, plan administrators must follow certain practices when processing and deciding plan participants' claims. For example, administrators must adhere to various procedures for giving notice, reporting, and claims processing. *See* 29 U.S.C. § 1021(a) (disclosure to all plan participants); *id.* § 1021(b) (reporting requirements); *id.* § 1133 (claims procedures); 29 C.F.R. § 2560.503-1 (same)." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 971 (9th 2006). UHC has now failed or refused to comply with one or more of these requirements.

UHC'S FAILURE TO MAKE TIMELY DETERMINATION

As the Beneficiary's Authorized Representative, ARS has now appealed the Beneficiary's medical claim through the second-level appeal. Under 29 CFR 2560.503-1(i)(2)(iii)(A), UHC was required to respond to the appeal "not later than 30 days after receipt by the plan of the [Beneficiary's] request for review of the adverse determination."

A failure to issue a final decision on the Beneficiary's appeal is not a mere procedural oversight, but rather an "a wholesale and flagrant violation of the requirements of both ERISA and the benefit plan" that "utterly disregards [UHC's] obligations as a plan administrator." *Gordon v. Metro. Life Ins. Co.*, 747 Fed. Appx. 594, 595 (9th Cir. 2019) (emphasis added). Pursuant to 29 C.F.R. 2560.503-1(*l*), the failure of UHC to timely respond to Beneficiary's second-level appeal, or to otherwise comply with ERISA's claims-procedure requirements, means that Beneficiary is deemed to have exhausted all administrative remedies available under the plan and is entitled to pursue a civil action.

ARS demands that UHC remedy this "wholesale and flagrant violation" of ERISA within ten (10) calendar days, or ARS will take all necessary and appropriate action to enforce the Beneficiary's rights under ERISA and the benefit plan. UHC should keep in mind that a failure to respond to the Beneficiary's request for appeal may result in, among other things, a *de novo* review by any court of competent jurisdiction.

Sincerely,

Advanced Reimbursement Solutions, LLC
Authorized Representative for
John D Van Hemert