Everett Fire Pension Board Meeting Agenda

May 20, 2026, 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for April 15, 2026

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$704,000.00	
March 2026	$52,239.18	
Remaining budget	**$544,482.92**	**77.34%**
MEDICAL CLAIMS		
Budgeted amount	$2,240,000.00	
March 2026	$83,757.82	
March 2026 HMA fees	$14,006.79	
Remaining budget	**$1,839,765.57**	**82.13%**

3.) Action Items:

Member # 101	Request for reimbursement of $348.27 for Eliquis for AFib while out of the country (HMA only covered 60% since foreign claim).
Member #35	Request for reimbursement of $13,123.37 for three-night stay in hospital while out of the country for diverticulitis.

Fire Pension Board Minutes
City Of Everett
April 15, 2026

DRAFT

The regular meeting of the Fire Pension Board was called to order at 9:30 a.m. on April 15, 2026. Board Members Schwab, Vitalich, Jorve, Neyens, and alternate Oas were present. Board Member Franklin was excused. Ana Mechler, Human Resources; David Hall, Board Attorney; and Rick Gray, Finance were also present.

APPROVAL OF MINUTES

The minutes of the meeting of March 18, 2025, were approved.

BILLS AND PENSION ROLLS

PENSION ROLL		
Budgeted Amount	$704,000.00	
February 2026	$53,789.23	
Remaining budget	**$596,722.10**	**84.76%**
MEDICAL CLAIMS		
Budgeted amount	$2,240,000.00	
February 2026	$96,171.05	
February 2026 HMA fees	$14,006.79	
Remaining budget	**$1,937,530.18**	**86.50%**

Moved by Vitalich, seconded by Neyens, to approve the pension rolls as presented.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

Moved by Vitalich, seconded by Neyens, to approve the medical claims as presented.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

DRAFT

ACTION ITEMS

Member #3 Reimbursement request in the amount of $249.99 for a portable oxygen concentrator.

Moved by Neyens, seconded by Vitalich, to approve the request for Member #3.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

Member # 144 Reimbursement request in the amount of $60 for ointment for rosacea. Request includes approval for up to one year of treatment (which is not covered by HMA).

Moved by Neyens, seconded by Vitalich, to approve the request for Member #144.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

Member #22 Reimbursement request for $2254.80 for 2024 Medicare.

Moved by Neyens, seconded by Vitalich, to approve the request for Member #22.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

DRAFT

OTHER

Member Jack Scherueble passed away.

Discussion ensued regarding member payment timing.

The Board meeting adjourned at 9:43 a.m.

_____
Marista Jorve, Board Secretary

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name [redacted]
(please print)

1. Diagnosis: AFib
2. Prognosis: _____
3. Type of Treatment(s) or Procedure: Eliquis
4. Cost of treatments/service: $ $323.91 + $24.36 conversion bank fees
5. Request to the board for this specific treatment or procedure:

Fire member #101 is requesting reimbursement for $323.91 + bank fees. HMA only covered 60% since it is a foreign claim.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

HMA

Member Reimbursement Claim Form

Instructions

Please use this form if requesting reimbursement for claims related to all medical, dental, and vision services covered by Healthcare Management Administrators (HMA), your third-party Health Plan Administrator. For prescription claims, contact your pharmacy benefits manager (PBM). You will need to complete and submit this form only if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy; however, they are not required to do so.

Please include a copy of your itemized receipt, bill, and/or invoice with your completed claim form. Your submission must contain all necessary information based on the type of service for which you're requesting reimbursement. The minimum necessary information for each type of service is described below in the "Attachments" section.

☒ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

Note: Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will remit payment to the provider, even if you indicate you want reimbursement to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, be sure to provide your providers with your insurance card so they can bill your Plan directly.

Any questions? We are here to help! Contact Customer Care at 800-869-7093.

Submission Information

Please choose one of the following methods below for submitting your claim reimbursement request (pick any option that works for you):

Electronic Submission Options

✓ **Option 1: DocuSign**:
1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Complete Online**
3. Complete and submit the form and a copy of your itemized receipt, bill, and/or invoice through DocuSign

✓ **Option 2: HMA Member Portal**:
1. Login to the member portal at https://memportal.accesshma.com/login
2. In the member portal, click on **Manage Claims & Deductibles**, click on **Submit a Claim**, and follow the prompts - be sure to upload a copy of your itemized receipt, bill, and/or invoice

Paper Submission Options

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Download pdf**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat (it is not recommended to try filling out the form in a web browser or on a mobile device, as the form may not work correctly) or print out the form and fill it out by hand
4. Use one of the submission options below:

   ✓ **Option 1: Fax** the completed form and a copy of your itemized receipt, bill, and/or invoice to: 866-458-5488

   ✓ **Option 2: Mail** the completed form and a copy of your itemized receipt, bill, and/or invoice to:
   HMA
   Attn: Claims Department
   PO Box 85008
   Bellevue, WA 98015-5008

HMA

Member Reimbursement Claim Form

Patient Information

First Name [redacted] **Last Name** [redacted]

Date of Birth [redacted] **Member ID Number**[1] [redacted]

Group/Employer Name CITY OF EVERETT **Group Number**[1] 020188

Service Type

Please select the type of service for which you're requesting reimbursement. If more than one service type applies, you must submit a separate claim form for each. If you're completing this form electronically, your selection here drives which information will be marked as required in the "Attachments" and "Claim Information" sections below.

Service Type Select... DR PRESCRIBE MEDICATION — ELIQUIS

Attachments

Please include all relevant documentation (such as an itemized receipt, bill, and/or invoice) with your submission. The checkboxes below indicate which information your documentation must contain for each service type. **Failure to provide the requested information may cause your claim to be delayed or denied.**

- ☑ **Required for all service types:** Date(s) of service and total amount you were billed for each service rendered / equipment purchased
- ☑ **Required for all service types *except* durable medical equipment (DME) purchased through a store (not purchased through a certified DME vendor):** Patient name, provider full name and mailing address, including city, state, and ZIP code, procedure codes such as CPTs or HCPCs, and one or both of the following: Provider's national provider identifier (NPI) number, provider's tax ID number (TIN)
- ☑ **Required for all service types except DME purchased through a store and massage therapy:** Diagnosis code(s), in ICD format

Claim Information

Please enter all necessary information below or ensure it's listed on the documentation you're attaching with your submission such as an itemized receipt, bill, and/or invoice. **Failure to supply all the required information may cause your claim to be delayed or denied.**

↓ Check each applicable box below if you're including an attachment that contains this information. If so, no need to also write the information below.

- ☐ **Date(s) of Service**[2] 1-15-26 $29.36
- ☐ **Total Billed Amount** $812.09 + BANK CHARGES FOREIGN CUR
- ☐ **Provider Name** BUMRUNGRAD INTERNATIONAL HOSPITAL
- ☐ **Provider Mailing Address** 33 SUKHUMVIT SOI 3 WATTANA
  City BANGKOK **State** THAILAND **ZIP Code** 10110
- ☐ **Procedure or Service Codes (such as CPTs or HCPCs)**[3]
- ☐ **Diagnosis Codes (in ICD format)**[4]
- ☐ **Provider's NPI Number**[5] **and/or Tax ID Number (TIN)**[6] 0107536000994

1 This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".
2 For DME you purchased through a store, this is the purchase date.
3 Procedure/Service Code (CPT/HCPC) is usually a five-digit number that describes the services/products provided.
4 Diagnosis Code (ICD) is usually a three- to seven-character alphanumeric code that indicates the reason for your healthcare treatment.
5 National Provider Identifier (NPI) is a unique 10-digit ID issued to U.S. healthcare providers by the Centers for Medicare and Medicaid Services (CMS). If you don't know your provider's NPI, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.
6 Tax Identification Number (TIN) is a unique 9-digit ID issued by the IRS. If you don't know your provider's TIN, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

HMA

Member Reimbursement Claim Form

Accident Information

Is This Claim Due to an Accident? ⊘ No (skip to next section) ○ Yes (fill out this section)

Accident Date _____ **Accident Location** ○ Home ○ Work ○ School ○ Auto ○ Other _____

How Did the Accident Happen? _____

Are You Filing a Claim with Labor & Industries (L&I), Homeowner/Auto Insurance, or Any Other Party? ○ Yes ○ No

Signature

Note: It's a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

By signing below, I indicate the following:

- ☑ I certify that the information I provided on this form is true and complete to the best of my knowledge.
- ☑ I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.
- ☑ I understand that my claim for [redacted] ed or even denied if I haven't provided all the information

[redacted]

SELF

Relationship to Patient (If you are the patient, put "Self")

[redacted]

2-22-26

Date

Bangkok Bank
ธนาคารกรุงเทพ

BUMRUNGRAD HOSPITAL
33 SUKHUMVIT SOI 3 BKK
OPD-A

HOST:BBL_HOST
TID:50152190 BATCH:000073
MID:000002220032072 TRACE:008525
REF:000011008525 APP.CODE:015343

VISA CARD Exp.****
**********9558 (C)
15 JAN 2026 13:20:32
SALE
TOTAL THB 25,485.00

SIGNATURE IS NOT REQUIRED

[redacted]

I ACKNOWLEDGE SATISFACTORY
RECEIPT OF RELATIVE GOODS/SERVICE

*** NO REFUND ***

com.arke2 v.K1.18.32
---CUSTOMER COPY---

เสร็จแล้วกรุณาเก็บสลิปนี้ไว้เพื่อตรวจสอบในภายหลัง ธนาคารกรุงเทพ Bangkok Bank

120-9 (VAT) (1-09/67) โปรดอย่าพับสลิป โปรดหลีกเลี่ยงการสัมผัสโดยตรงกับแหล่งความร้อน เช่น แสงแดด หรือเครื่องถ่ายเอกสาร ก่อนใช้ก่อน 09/70 SFS

Bumrungrad International HOSPITAL

Patient Name: [redacted]

HN: 800753418
Printed Date: 15 Jan 2026 13:19
Visit No: O0007458458
Visit Date: 15-Jan-2026

Includes uncommitted charges
Includes closed charges
The charges are grouped by days
Grouped by Item group, Item
Package charges are excluded

OPD Charges Detail

Description	Unit Price	Quantity	Total Amount	Discount	Total Net
Drug and Parenteral Nutrition / ค่ายาและสารอาหารทางเส้นเลือด			**23,800.00**	**0.00**	**23,800.00**
Medication / ค่ายา					
Eliquis 5 mg tablet	170.00	140.00	23,800.00	0.00	23,800.00
Nursing or Midwifery Charge / ค่าบริการพยาบาลของผู้ประกอบวิชาชีพการพยาบาลหรือการผดุงครรภ์			**190.00**	**0.00**	**190.00**
OPD Nursing Charge / ค่าบริการพยาบาลผู้ป่วยนอก					
OPD Nursing Service (General)	190.00	1.00	190.00	0.00	190.00
Other Hospital Charges / ค่าบริการอื่น ๆ			**495.00**	**0.00**	**495.00**
Hospital Service Charge / Hospital Service Charge					
OPD Hospital Charges	495.00	1.00	495.00	0.00	495.00
Physician Fee / ค่าตรวจรักษาทำโปรของผู้ประกอบวิชาชีพ			**1,000.00**	**0.00**	**1,000.00**
Outpatient Care / ตรวจรักษาการณีผู้ป่วยนอก					
OPD New patient level 2	1,000.00	1.00	1,000.00	0.00	1,000.00

Bumrungrad International

สองหมื่นห้าพันสี่ร้อยแปดสิบห้าบาทถ้วน
Twenty-five thousand four hundred eighty-five baht only

Total Net Amount: 25,485.00

33 สุขุมวิท ซอย 3 กรุงเทพฯ 10110
33 Sukhumvit 3, Bangkok 10110
Tel. +66 (0) 2066 8888

Bumrungrad Hospital Public Company Limited, 33 Sukhumvit Soi 3, Wattana, Bangkok 10110
Tel.02-066 8888 Fax: 02-011-5100 Accounting Dept. Tel: 02-011 5075 Fax: 02-011-5090

V5.1 Created on 15 Jan 2026 13:19 by Sirikul Rungsangchol
www.bumrungrad.com

Please recycled paper and ink

OPD Receipt Original

RCO-2026-00032230

Bumrungrad International HOSPITAL

HN: 800753418
Patient Name: [redacted]
Payor: Self-pay

Receipt No: RCO-2026-00032230
Receipt Date: 15-Jan-2026 13:20
Visit No: O0007458458
Visit Date: 15-Jan-2026 12:57

Description	Total Amount	Discount	Net Amount
Drug and Parenteral Nutrition ค่ายาและสารอาหารทางเส้นเลือด	23,800.00	0.00	23,800.00
Nursing or Midwifery Charge ค่าบริการพยาบาลของผู้ประกอบวิชาชีพการพยาบาลหรือการผดุงครรภ์	190.00	0.00	190.00
Other Hospital Charges ค่าบริการอื่น ๆ	495.00	0.00	495.00
Physician Fee ค่าตรวจรักษาทั่วไปของผู้ประกอบวิชาชีพ	1,000.00	0.00	1,000.00

เพื่อความปลอดภัยของผู้ป่วย โรงพยาบาลขอสงวนสิทธิ์ในการรับคืนยาและเวชภัณฑ์
For patient safety purposes, the hospital reserves the right not to accept return medicines / medical supply.

Payments	
Credit Card	25,485.00
สองหมื่นห้าพันสี่ร้อยแปดสิบห้าบาทถ้วน Twenty-five thousand four hundred eighty-five baht only	
Cashier Signature:	
Sirikul Rungsangchol	

Total Amount:	25,485.00
Total Discount Amount:	0.00
Net Amount:	25,485.00
Outstanding Amount:	0.00
Payment Amount:	25,485.00

Thank you for using Bumrungrad International. Your satisfaction is our primary concern.
Appointments and information : www.bumrungrad.com

Contact Center
Phone: +66 (0) 2066 8888 Fax: +66 (0) 2011 5100
Billing Questions: Weekdays: 9:00 am - 5:30 pm
Phone: +66 (0) 2011 5075 Fax: + 66 (0) 2011 5091
Email: billing@bumrungrad.com

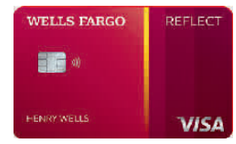
33 สุขุมวิท ซอย 3 กรุงเทพฯ 10110
33 Sukhumvit 3, Bangkok 10110 Thailand
Tel. +66 (0) 2066 8888
Fax. +66 (0) 2011 5100
www.bumrungrad.com

Share your experiences with us

บริษัท โรงพยาบาลบำรุงราษฎร์ จำกัด (มหาชน)
Bumrungrad Hospital Public Company Limited
เลขประจำตัวผู้เสียภาษี (Tax ID) 0107536000994

Created on 15-Jan-2026 13:20 By Sirikul Rungsangchol
Printed on 15 Jan 2026 13:20 by Sirikul Rungsangchol

Please do not write on this area



Wells Fargo Online®: **wellsfargo.com**
24-hour Customer Service: 1-800-642-4720
We accept all relay calls, including 711
Outside the US call collect: 1-925-825-7600

Send general inquiries to:
Wells Fargo, PO Box 10347, Des Moines IA 50306-0347

Payment

Payment Due Date	02/12/2026
Minimum Payment	$25.00
New Balance	$836.45

$0 - $25.00 will be deducted from your account and credited as your automatic payment on 02/12/26. The automatic payment amount will be reduced by all payments posted on or before this date.

Late Payment Warning: If we do not receive your Minimum Payment by 02/12/2026, you may have to pay a late fee up to $40.

Minimum Payment Warning: If you make only the minimum payment each period, you will pay more in interest and it will take you longer to pay off your balance. For example:

If you make no additional charges using this card and each month you pay ...	You will pay off the New Balance shown on this statement in about ...	And you will end up paying an estimated total of ...
Only the minimum payment	5 years	$1,604
$35	3 years	$1,254 (Savings of $350)

If you would like information about credit counseling services, refer to **www.justice.gov/ust/list-credit-counseling-agencies-approved-pursuant-11-usc-111** or call **1-866-484-6322**.

Account Summary

[redacted]

+ Purchases, Balance Transfers & Other Charges	$812.09
+ Fees Charged	**$24.36**
+ Interest Charged	**$0.00**
= New Balance	$836.45

Transactions

Card Ending in	Trans Date	Post Date	Reference Number	Description	Credits	Charges

Payments

[redacted]

TOTAL PAYMENTS FOR THIS PERIOD

Purchases, Balance Transfers & Other Charges

9550	01/15	01/15	7436514QZ02PA8S24	BUMRUNGRAD HOSPITAL BANGKOK TH		812.09
			- 01/15	TH BAHT		
			- 01/15	25485.00 X 0.03186541		

TOTAL PURCHASES, BALANCE TRANSFERS & OTHER CHARGES FOR THIS PERIOD **$812.09**

NOTICE: SEE REVERSE SIDE FOR IMPORTANT INFORMATION ABOUT YOUR ACCOUNT

Continued

5596 YKG 1 7 11 260118 0 PAGE 1 of 3 1 0 3531 8100 C1IF O1DP5596

Detach and mail with check payable to **Wells Fargo.** For faster processing, include your account number on your check.

Account Number [redacted]
Payment Due Date [redacted]

[redacted]

Amount Enclosed $ [redacted]

[redacted]

WELLS FARGO CARD SERVICES
PO BOX 51193
LOS ANGELES CA 90051-5493

YKG
516

IMPORTANT INFORMATION ABOUT YOUR ACCOUNT

1. What are your billing rights?

Addressing Errors and Transaction Disputes

If you believe that your bill is wrong ("error") or you need more information about a transaction on the statement, contact us as soon as possible. We must hear from you within 60 days after we sent you the first bill that your error appeared on.

In order to keep your billing rights, you must write to us. While you can call us at the phone number listed on your statement or contact us in another way, doing so will not preserve your billing rights.

Follow these steps when contacting us:

1. Write a letter ("Written Notice") about the error or transaction question you have. Include the following details:

Written Notice Topic	Details to Include
Errors	• Your name • Your account number • Dollar amount of the suspected error • Description of the error and why you believe it is wrong
Transaction Questions	• Your name • Your account number • Description of the transaction in question

2. Mail your Written Notice to the following address:
   Wells Fargo Bank, N.A.
   P.O. Box 522
   Des Moines, IA 50306-0522

Bill Payments During an Investigation

- **Suspected Error Amounts**
  While we are investigating your suspected error amount, you do not have to pay that amount. But you must still pay the rest of your bill that is not part of the error. We also cannot report you as late or take any action to collect your suspected error amount during our investigation.
- **Automatic Bill Payments**
  You can stop authorized automatic payments for your credit card bill on the amount you believe is an error. To do so, we must receive your Written Notice within three business days before the scheduled automatic payment happens.

Addressing Quality of Goods – Special Rule for Credit Card Purchases

If you purchased a good or service with your credit card and have a problem with the quality, you may not have to pay your remaining amount on the good or service. To qualify, you must have tried in good faith to correct the problem with the merchant. If we own or operate the merchant, or we mailed you an advertisement for the property or services, then we will cover all purchases. Otherwise, the following three details must apply in order to have this protection:

1. The purchase must cost more than $50.
2. You must have made the purchase in your home state or within 100 miles of your mailing address.
3. You must have a balance left on the charge you are disputing. For example, the good cost $1000, and you already paid $700,leaving $300 left to pay.

2. How do we use your credit information?

We may provide information about your account to consumer reporting agencies. You have the right to dispute the accuracy of information that we report. To do so, take these steps:

1. Write a letter to us that describes the specific information that is not correct or that you are disputing, as well as any supporting documents.
2. Mail your letter to us at the following address:
   Wells Fargo Bank, N.A.
   P.O. Box 393
   Minneapolis, MN 55480-0393

If the information relates to identity theft, you will need to provide us with an identity theft report.

3. When do we process payments?

We process payments in different ways depending on whether you make Conforming– or Non-Conforming Payments.

Conforming Payments

"Conforming Payments" are payments that you either:

- Mail to us using the enclosed payment coupon to the payment address listed on your statement or
- Make via the "Transfer" tab or "Make a Payment" link on the Wells Fargo Online Banking credit card Account Activity tab at: www.wellsfargo.com.

When We Receive the Payment	When We Credit Your Account
In the mail by 5:00 p.m. local time	The date that we receive your payment
In the mail after 5:00 p.m. local time	The next day
Through our Website or Mobile App	We will disclose this detail when you make your transaction.

Non-Conforming Payments

"Non-Conforming Payments" are payments that you make in any other way, such as:

- Certified mail
- FedEx or UPS
- Envelopes with addresses that are not clear enough to read

Non-Conforming Payments may not receive credit for up to five days after the date that we receive it.

Payments Made on Last Day of Statement Cycle

When you make payments to your account on the last day of the statement cycle, we apply those payments on that day. However, these payments may not appear on your monthly billing statement or credit report until the next statement cycle.

We cannot accommodate a check with a future date on it (postdated check). If you mail a postdated check, it will be processed on the date we receive it (regardless of the date on the check). To schedule a future-dated payment, sign on to the Wells Fargo Mobile App or wellsfargo.com or call us.

4. What does a check payment authorize?

When you pay with a check, you authorize us to do either of the following:

- Use your check information to make a one-time electronic fund transfer from your account. In this scenario, we may withdraw the funds from your account as soon as the same day we receive your payment. You also will not get your check back from your financial institution.
- Process the payment as a check transaction.

5. How do you pay your Account with an amount less than you owe?

If you want to pay your account for less than the full amount you owe, mail your request to us at:
Wells Fargo Bank, N.A.
P.O. Box 10311
Des Moines, IA 50306-0311
Please note: These payments do not erase your full debt.

6. How do we calculate your balance?

We use a method called "average daily balance (including new purchases)." For more information, refer to your Credit Card Account Agreement or call our toll-free Customer Service number located on the front of this statement.

7. How can you avoid paying interest on purchases?

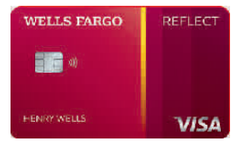
Your Payment Due Date is at least 25 days after each billing period closes. You must pay your entire balance each month to avoid interest charges. We begin charging interest on cash advances and balance transfers on the transaction date.

8. How can you manage your account?

To manage your account details — including card payments, alerts, and address changes — **visit wellsfargo.com** or call the customer service number that appears on your account statement.

9. Will customer service monitor your calls with us?

We may record or monitor any calls you have with customer service.



Transactions (continued from previous page)

Card Ending in	Trans Date	Post Date	Reference Number	Description	Credits	Charges

Fees Charged

[redacted]	01/15	01/15	7436514QZ02PA8S24	FOREIGN CURRENCY CONVERSION FEE		24.36
	TOTAL FEES CHARGED FOR THIS PERIOD					**$24.36**

Interest Charged

	INTEREST CHARGE ON PURCHASES	0.00
	INTEREST CHARGE ON CASH ADVANCES	0.00
TOTAL INTEREST CHARGED FOR THIS PERIOD		**$0.00**

2026 Totals Year-to-Date

TOTAL FEES CHARGED IN 2026	$24.36
TOTAL INTEREST CHARGED IN 2026	$0.00

Interest Charge Calculation

[redacted]

[redacted]					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Wells Fargo News

Help take control of your finances with a Wells Fargo Personal Loan.
Whether it's managing debt, making a large purchase, improving your home, or paying for unexpected expenses, a personal loan may be able to help. See personalized rates and payments in minutes with no impact to your credit score.
Get started at wellsfargo.com/personalloan.

Do we have your correct mobile phone number?
Don't miss suspicious-activity notifications, time-sensitive information, or critical account updates. Make sure we can reach you if we detect unusual activity on your account, or need to contact you to verify transactions. Sign in or log on to **wellsfargo.com/online-banking** and verify your mobile phone number on the **Contact Information** page.

Continued

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Healthcare Management Administrators
PO Box 85016
Bellevue, WA 98015-5016

HMA

Explanation of Benefits

THIS IS NOT A BILL

[redacted]

Customer Care	
Have Questions?	www.accesshma.com
Toll Free:	(800)869-7093
Hours:	Monday - Friday 6 AM to 6 PM PST
Group Name:	CITY OF EVERETT
Group #:	020188
Member ID:	[redacted]
Date:	March 29, 2026

HI [redacted]

This Explanation of Benefits (EOB) gives you information about how an insurance claim submitted by you or your healthcare provider (such as a doctor, hospital, or pharmacy) was handled on your behalf. There is a lot of information packed into this document:

The Summary of Activity shows the amount billed by your healthcare provider, any discounts that were applied, the amount your health plan paid, and any balance you owe to your provider (which you may have already paid).

The Detailed Claim Breakdown section breaks everything down for you.

The My Spend and Family Spend sections show how much of the claim was applied to your deductible. It also shows the remaining amount needed to meet your deductible, as well as where you are with your out-of-pocket maximum for the year.

Each time you receive an EOB, review it closely and compare it to the bill or statement from your healthcare provider. If you have any questions, contact us at the phone number provided in the box at the top of this page.

Monthly Explanation of Benefits
This is not a Bill

SUMMARY OF ACTIVITY

This covers claims processed between 01/15/26-01/15/26

Total Billed Amount	$809.78	This is the total amount of charges during this period.
Discount & Adjustments	$0.00	Healthcare Management Administrators negotiates discounts with health care professionals and facilities to help you save money.
Amount Not Covered	$323.91	This is the portion of your bill that is not covered by your plan. You may or may not need to pay this amount. We'll cover that information for you in the Detailed Claim Breakdown.
What Your Plan Paid	$485.87	This is the total amount your plan paid during this period.
What You Pay	$809.78	This is the amount you owe after your discount and what your plan paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. You may or may not have already paid this amount.
You Saved	$0.00	This is a total of your discount and what your plan paid.

Claim #: 8951328802
Patient: [redacted]

Provider: FOREIGN CLAIMS

Date & Type of Service	Amount Billed	Not Covered	Rmk Code	Member Discount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At	Plan Payment
01/15/26-01/15/26 OUTPATIENT SERVICES	$809.78	$323.91	1A PW	$0.00	$485.87	$0.00	$0.00	$485.87	100%	$485.87
Column Totals	$809.78	$323.91		$0.00	$485.87	$0.00	$0.00	$485.87		

Patient Responsibility: $323.91

Other Carrier Adjustments $0.00
Total Plan Payment Amt $485.87

Remark Code Description	
1A	MEMBER SUBMITTED CLAIM. REIMBURSEMENT, IF ANY, IS ENCLOSED.
PW	MAXIMUM ALLOWABLE CHARGE BASED ON A PERCENTAGE OF THE BILLED AMOUNT.

Foreign Language Assistance

SPANISH (Español): Para obtener asistencia en español, por favor póngase en contacto con el número de teléfono que aparece arriba.
TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjį' niká'a'doowołgo, t'áá shǫǫdi hódahdi béésh bee hane'é binumber bikáá'ígíí bish'į' hodíílnih.

Important Information

What if I need help understanding a denied claim? Contact us at (800) 869-7093 if you need help understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Complete and send in the Request for Appeal within 180 days of this notice. The form is available online at https://www.accesshma.com/member-forms or call us to have one mailed to you.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. If you wish to designate someone to act as your authorized representative, please complete the Appointment of Authorized Representative section of the Appeal Form available online at https://www.accesshma.com/member-forms

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by calling (800) 869-7093.

Can I provide additional information about my claim? Yes, you may supply additional information. Please send documentation (medical records, clinical notes, from your treating physician(s), etc.) that you wish to have considered as part of your appeal to: Healthcare Management Administrators, PO Box 85016, Bellevue, WA 98015, ATTN: Appeals Department

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us. All requests need to be submitted in writing. You may complete the Authorization to Disclose Protected Health Information form online at https://www.accesshma.com/member-forms or mail it to us at: Healthcare Management Administrators, PO Box 85016, Bellevue, WA 98015, ATTN: Appeals Department

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-3272. Additionally, a consumer assistance program may be able to assist you. Please note that not all states have Consumer Assistance programs available. If one is available in your area, we have included that information for you on this document. For the most current program available in your area, please go online to: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc

Healthcare Management Administrators, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Electronic Payment Clearinghouse
Healthcare Management Administrators
PO Box 85008
Bellevue, WA 98015-8508

The Huntington National Bank
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO.: 398058050
DRAFT DATE: 03/27/2026

PAYABLE THROUGH DRAFT Four Hundred Eighty-Five And 87 / 100 Dollars**********

AMOUNT
******$485.87*******

VOID AFTER 150 DAYS

TO THE ORDER OF [redacted]

⑈398058050⑈ ⑆044115126⑆ 0166950861 2⑈

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name [redacted]
(please print)

1. Diagnosis: Diverticulitis

2. Prognosis: Lifetime

3. Type of Treatment(s) or Procedure: 3 night hospital stay

4. Cost of treatments/service: $ 13,123.37

5. Request to the board for this specific treatment or procedure:

Fire #35 member had a 3 night hospital stay in Mexico. Total bill was $32,808.42. HMA covered $19,685.05. Member is requesting a reimbursement for the difference totaling $13,123.37.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

GRUPO MÉDICO JOYA - HOSPITAL JOYA NUEVO VALLARTA SA DE CV

BLVD. FRANCISCO MEDINA ASCENCIO 2760, ZONA HOTELERA NORTE, 48333 PUERTO VALLARTA, NAYARIT

GRUPO MÉDICO JOYA

FOLIO: NV21262 [redacted] CUARTO: HABITACION ESTANDAR 202 F. INGRESO: 06/12/2025 SEGURO:

F. EGRESO: 09/12/2025 F. NACIMIENTO: [redacted]

MÉDICO: ALDO CURIEL CURIEL

ORIGINAL *HOSPITAL FEES*

HOSPITALIZACION

FECHA	CANT.	DESCRIPCIÓN	PRECIO / U	SUBTOTAL	IVA	TOTAL
06/12/2025	1.000	AGUJA HIPODERMICA 18G X 38MM ROSA	$5.01	$5.01	$0.80	$5.81
06/12/2025	1.000	CLORURO DE SODIO 0.9% DE 100 ML SOLUCION FRASCO	$21.53	$21.53	$3.44	$24.97
06/12/2025	2.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$56.04	$8.97	$65.01
06/12/2025	1.000	HARTMANN DE 1000 ML SOLUCION FRASCO	$34.93	$34.93	$5.59	$40.52
06/12/2025	2.000	METRONIDAZOL	$24.71	$49.42	$7.91	$57.33
06/12/2025	1.000	PARACETAMOL	$70.10	$70.10	$11.22	$81.32
06/12/2025	1.000	HIOSCINA	$31.16	$31.16	$4.99	$36.15
06/12/2025	1.000	PARACETAMOL	$70.10	$70.10	$11.22	$81.32
06/12/2025	1.000	COMODO DESECHABLE PARA PACIENTE	$38.02	$38.02	$6.08	$44.10
06/12/2025	1.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$11.32	$1.81	$13.13
06/12/2025	1.000	ORINAL DESECHABLE PARA PACIENTE	$24.38	$24.38	$3.90	$28.28
06/12/2025	5.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$140.10	$22.42	$162.52
06/12/2025	1.000	TEGADERM IV ADVANCED 6.5CMX7CM	$22.71	$22.71	$3.63	$26.34
06/12/2025	2.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$41.82	$6.69	$48.51
06/12/2025	1.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$20.91	$3.35	$24.26
06/12/2025	2.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$56.04	$8.97	$65.01
06/12/2025	1.000	JERINGA 3ML CON AGUJA 21G X 32MM VERDE	$9.40	$9.40	$1.50	$10.90
06/12/2025	1.000	CHLORAPREP ONE - STEP 1.0 ML CON APLICADOR	$28.09	$28.09	$4.49	$32.58
06/12/2025	1.000	JERINGA 3ML CON AGUJA 21G X 32MM VERDE	$9.40	$9.40	$1.50	$10.90
06/12/2025	1.000	TOALLAS ALCOHOLADAS	$4.48	$4.48	$0.72	$5.20
06/12/2025	1.000	CEFTRIAXONA	$35.59	$35.59	$5.69	$41.28
06/12/2025	1.000	CEFTRIAXONA	$35.59	$35.59	$5.69	$41.28
06/12/2025	1.000	JERINGA 20ML SIN AGUJA	$11.32	$11.32	$1.81	$13.13
07/12/2025	1.000	HIOSCINA	$31.16	$31.16	$4.99	$36.15
07/12/2025	2.000	METRONIDAZOL	$24.71	$49.42	$7.91	$57.33
07/12/2025	1.000	JERINGA 5ML CON AGUJA 21G X 32MM VERDE	$9.05	$9.05	$1.45	$10.50
07/12/2025	1.000	HARTMANN DE 1000 ML SOLUCION FRASCO	$34.93	$34.93	$5.59	$40.52
07/12/2025	1.000	HIOSCINA	$21.93	$21.93	$3.51	$25.44
07/12/2025	3.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$33.96	$5.43	$39.39
07/12/2025	1.000	JERINGA 3ML CON AGUJA 21G X 32MM VERDE	$9.40	$9.40	$1.50	$10.90
07/12/2025	1.000	HIOSCINA	$21.93	$21.93	$3.51	$25.44
07/12/2025	1.000	METRONIDAZOL	$24.71	$24.71	$3.95	$28.66
07/12/2025	1.000	JERINGA 3ML CON AGUJA 21G X 32MM VERDE	$9.40	$9.40	$1.50	$10.90
07/12/2025	2.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$22.64	$3.62	$26.26
07/12/2025	1.000	MONITOR SIGNOS VITALES / BLOOD PRESSURE MONITOR	$93.62	$93.62	$14.98	$108.60
07/12/2025	2.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$22.64	$3.62	$26.26
07/12/2025	1.000	HIOSCINA	$31.16	$31.16	$4.99	$36.15
07/12/2025	6.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$168.12	$26.90	$195.02
07/12/2025	3.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$84.06	$13.45	$97.51
07/12/2025	2.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$41.82	$6.69	$48.51
07/12/2025	1.000	CHLORAPREP ONE - STEP 1.0 ML CON APLICADOR	$28.09	$28.09	$4.49	$32.58
07/12/2025	1.000	TEGADERM IV ADVANCED 6.5CMX7CM	$22.71	$22.71	$3.63	$26.34
07/12/2025	1.000	CLORURO DE SODIO 0.9% DE 100 ML SOLUCION FRASCO	$21.53	$21.53	$3.44	$24.97
07/12/2025	1.000	CEFTRIAXONA	$35.59	$35.59	$5.69	$41.28
07/12/2025	1.000	TEGADERM IV ADVANCED 6.5CMX7CM	$22.71	$22.71	$3.63	$26.34
07/12/2025	1.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$20.91	$3.35	$24.26
07/12/2025	1.000	PARACETAMOL	$70.10	$70.10	$11.22	$81.32

GRUPO MÉDICO JOYA - HOSPITAL JOYA NUEVO VALLARTA SA DE CV

BLVD. FRANCISCO MEDINA ASCENCIO 2760, ZONA HOTELERA NORTE, 48333 PUERTO VALLARTA, NAYARIT

GRUPO MÉDICO JOYA

FOLIO: NV21262 [redacted] CUARTO: HABITACION ESTANDAR 202 F. INGRESO: 06/12/2025 SEGURO:

F. EGRESO: 09/12/2025 F. NACIMIENTO: [redacted]

MEDICO: ALDO CURIEL CURIEL

ORIGINAL

07/12/2025	1.000	PROTECTOR PARA CAMA ULTRASORB 58CM. X 91CM.	$47.23	$47.23	$7.56	$54.79
07/12/2025	1.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$20.91	$3.35	$24.26
07/12/2025	1.000	CEFTRIAXONA	$35.59	$35.59	$5.69	$41.28
07/12/2025	3.000	TOALLAS ALCOHOLADAS	$4.48	$13.44	$2.15	$15.59
07/12/2025	1.000	PROTECTOR DE CAMA	$18.23	$18.23	$2.92	$21.15
07/12/2025	1.000	EQ BOMBA DE INFUSION	$70.43	$70.43	$11.27	$81.70
07/12/2025	2.000	PARACETAMOL	$70.10	$140.20	$22.43	$162.63
07/12/2025	1.000	CATETER INTRAVENOSO 20 GA AUTOGUARDABLE PERIFERICO	$32.32	$32.32	$5.17	$37.49
07/12/2025	1.000	PARACETAMOL	$70.10	$70.10	$11.22	$81.32
07/12/2025	3.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$84.06	$13.45	$97.51
07/12/2025	2.000	BANDITA REDONDA 2.5CM X 3.2CM	$4.89	$9.78	$1.56	$11.34
07/12/2025	1.000	TOALLAS ALCOHOLADAS	$4.48	$4.48	$0.72	$5.20
08/12/2025	1.000	MONITOR SIGNOS VITALES / BLOOD PRESSURE MONITOR	$93.62	$93.62	$14.98	$108.60
08/12/2025	2.000	METRONIDAZOL	$24.71	$49.42	$7.91	$57.33
08/12/2025	1.000	PROTECTOR PARA CAMA ULTRASORB 58CM. X 91CM.	$47.23	$47.23	$7.56	$54.79
08/12/2025	1.000	PARACETAMOL	$70.10	$70.10	$11.22	$81.32
08/12/2025	2.000	PARACETAMOL	$70.10	$140.20	$22.43	$162.63
08/12/2025	1.000	METRONIDAZOL	$24.71	$24.71	$3.95	$28.66
08/12/2025	1.000	HIOSCINA	$21.93	$21.93	$3.51	$25.44
08/12/2025	1.000	KETOROLACO	$21.47	$21.47	$3.44	$24.91
08/12/2025	1.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$20.91	$3.35	$24.26
08/12/2025	1.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$20.91	$3.35	$24.26
08/12/2025	3.000	EQUIPO SET SECUNDARIO FILTRO DE 15 MICRAS EN CAMARA DE GOTEO.	$37.48	$112.44	$17.99	$130.43
08/12/2025	2.000	JERINGA 5ML CON AGUJA 21G X 32MM VERDE	$9.05	$18.10	$2.90	$21.00
08/12/2025	6.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$168.12	$26.90	$195.02
08/12/2025	1.000	HARTMANN DE 1000 ML SOLUCION FRASCO	$34.93	$34.93	$5.59	$40.52
08/12/2025	1.000	HIOSCINA	$21.93	$21.93	$3.51	$25.44
08/12/2025	1.000	CLORURO DE SODIO 0.9% DE 100 ML SOLUCION FRASCO	$21.53	$21.53	$3.44	$24.97
08/12/2025	1.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$20.91	$3.35	$24.26
08/12/2025	2.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$22.64	$3.62	$26.26
08/12/2025	1.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$11.32	$1.81	$13.13
08/12/2025	2.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$22.64	$3.62	$26.26
08/12/2025	1.000	CEFTRIAXONA	$35.59	$35.59	$5.69	$41.28
08/12/2025	1.000	CEFTRIAXONA	$35.59	$35.59	$5.69	$41.28
08/12/2025	1.000	EQ BOMBA DE INFUSION	$70.43	$70.43	$11.27	$81.70
09/12/2025	2.000	CEFUROXIMA	$243.07	$486.14	$77.78	$563.92
09/12/2025	1.000	TOALLAS ALCOHOLADAS	$4.48	$4.48	$0.72	$5.20
09/12/2025	3.000	FLEBOTEK QUIRURGICO PARA VENOCLISIS	$28.02	$84.06	$13.45	$97.51
09/12/2025	2.000	DEXKETOPROFENO	$378.30	$756.60	$121.06	$877.66
09/12/2025	1.000	EQ BOMBA DE INFUSION	$70.43	$70.43	$11.27	$81.70
09/12/2025	1.000	BANDITA REDONDA 2.5CM X 3.2CM	$4.89	$4.89	$0.78	$5.67
09/12/2025	1.000	PARACETAMOL	$218.57	$218.57	$34.97	$253.54
09/12/2025	1.000	MONITOR SIGNOS VITALES / BLOOD PRESSURE MONITOR	$93.62	$93.62	$14.98	$108.60
09/12/2025	1.000	JERINGA 10ML CON AGUJA 21G X 32MM VERDE	$11.32	$11.32	$1.81	$13.13
09/12/2025	1.000	METRONIDAZOL	$138.94	$138.94	$22.23	$161.17
09/12/2025	1.000	JERINGA 3ML CON AGUJA 21G X 32MM VERDE	$9.40	$9.40	$1.50	$10.90
09/12/2025	2.000	TRIMEBUTINA / SIMETICOMA / GALACTOSIDASA	$368.21	$736.42	$117.83	$854.25
			$3,999.41	$6,027.36	$964.38	$6,991.74

URGENCIAS

FECHA	CANT.	DESCRIPCIÓN	PRECIO / U	SUBTOTAL	IVA	TOTAL
06/12/2025	1.000	BRAZALETE DE IDENTIFICACION ADULTO BLANCO	$9.14	$9.14	$1.46	$10.60
06/12/2025	1.000	HARTMANN DE 500 ML SOLUCION FRASCO	$25.65	$25.65	$4.10	$29.75
06/12/2025	1.000	TEGADERM IV ADVANCED 6.5CMX7CM	$22.71	$22.71	$3.63	$26.34

GRUPO MÉDICO JOYA - HOSPITAL JOYA NUEVO VALLARTA SA DE CV

BLVD. FRANCISCO MEDINA ASCENCIO 2760, ZONA HOTELERA NORTE, 48333 PUERTO VALLARTA, NAYARIT

GRUPO MÉDICO JOYA

FOLIO: NV21262 CUARTO: HABITACION ESTANDAR 202 F. INGRESO: 06/12/2025 SEGURO:
[redacted] F. EGRESO: 09/12/2025 F. NACIMIENTO: [redacted]
MÉDICO: ALDO CURIEL CURIEL

ORIGINAL

06/12/2025	1.000	SALA DE EMERGENCIA	$1,094.22	$1,094.22	$175.08	$1,269.30
06/12/2025	1.000	PARACETAMOL	$101.72	$101.72	$16.28	$118.00
06/12/2025	1.000	MONITOR SIGNOS VITALES / BLOOD PRESSURE MONITOR	$93.62	$93.62	$14.98	$108.60
06/12/2025	1.000	METRONIDAZOL	$24.71	$24.71	$3.95	$28.66
06/12/2025	1.000	LEVOFLOXACINO	$192.03	$192.03	$30.72	$222.75
06/12/2025	1.000	JERINGA 5ML CON AGUJA 21G X 32MM VERDE	$9.05	$9.05	$1.45	$10.50
06/12/2025	1.000	HIOSCINA	$31.16	$31.16	$4.99	$36.15
06/12/2025	1.000	HARTMANN DE 500 ML SOLUCION FRASCO	$25.65	$25.65	$4.10	$29.75
06/12/2025	1.000	BRAZALETE DE IDENTIFICACION COLOR NARANJA	$9.14	$9.14	$1.46	$10.60
06/12/2025	1.000	EQUIPO SET SECUNDARIO FILTRO DE 15 MICRAS EN CAMARA DE GOTEO.	$37.48	$37.48	$6.00	$43.48
06/12/2025	4.000	EQUIPO SET SECUNDARIO FILTRO DE 15 MICRAS EN CAMARA DE GOTEO.	$37.48	$149.92	$23.99	$173.91
06/12/2025	1.000	EQUIPO SET PRIMARIO PLUM FILTRO DE 15 MICRAS EN CAMARA DE GOTEO	$130.72	$130.72	$20.92	$151.64
06/12/2025	1.000	EQ BOMBA DE INFUSION	$70.43	$70.43	$11.27	$81.70
06/12/2025	1.000	CONECTOR MICROCLAVE CLEAR DE 2 VIAS C/EXTENSION 20 CM	$84.49	$84.49	$13.52	$98.01
06/12/2025	1.000	CLORURO DE SODIO 0.9% DE 50 ML SOLUCION FRASCO	$20.91	$20.91	$3.35	$24.26
06/12/2025	1.000	CHLORAPREP ONE - STEP 1.0 ML CON APLICADOR	$28.09	$28.09	$4.49	$32.58
06/12/2025	1.000	CATETER INTRAVENOSO 18 GA AUTOGUARDABLE PERIFERICO	$35.90	$35.90	$5.74	$41.64
06/12/2025	1.000	BRAZALETE DE IDENTIFICACION COLOR VERDE	$9.14	$9.14	$1.46	$10.60
06/12/2025	5.000	TOALLAS ALCOHOLADAS	$4.48	$22.40	$3.58	$25.98
			$2,097.92	$2,228.28	$356.52	$2,584.80

HABITACION

FECHA	CANT.	DESCRIPCIÓN	PRECIO / U	SUBTOTAL	IVA	TOTAL
06/12/2025	1.000	HABITACION	$1,327.09	$1,327.09	$212.33	$1,539.42
07/12/2025	1.000	HABITACION	$1,327.09	$1,327.09	$212.33	$1,539.42
08/12/2025	1.000	HABITACION	$1,327.09	$1,327.09	$212.33	$1,539.42
			$3,981.27	$3,981.27	$636.99	$4,618.26

LABORATORIO

FECHA	CANT.	DESCRIPCIÓN	PRECIO / U	SUBTOTAL	IVA	TOTAL
06/12/2025	1.000	BIOMETRIA HEMATICA	$81.08	$81.08	$12.97	$94.05
06/12/2025	1.000	PROCALCITONINA CUANTIFICADA (PCT)	$365.52	$365.52	$58.48	$424.00
06/12/2025	1.000	TIEMPO DE TROMBOPLASTINA PARCIAL	$84.22	$84.22	$13.48	$97.70
06/12/2025	1.000	TIEMPO DE PROTROMBINA	$92.10	$92.10	$14.74	$106.84
06/12/2025	1.000	QUIMICA SANGUINEA (3)	$108.80	$108.80	$17.41	$126.21
06/12/2025	1.000	PRUEBAS FUNCIONALES HEPATICAS 2	$233.51	$233.51	$37.36	$270.87
06/12/2025	1.000	PROTEINA C REACTIVA	$106.70	$106.70	$17.07	$123.77
06/12/2025	1.000	UROCULTIVO-HOSPITALARIO	$290.15	$290.15	$46.42	$336.57
06/12/2025	1.000	PERFIL DE ELECTROLITOS	$236.98	$236.98	$37.92	$274.90
06/12/2025	1.000	GASOMETRIA ARTERIAL	$261.25	$261.25	$41.80	$303.05
07/12/2025	1.000	BIOMETRIA HEMATICA	$81.08	$81.08	$12.97	$94.05
07/12/2025	1.000	PERFIL DE ELECTROLITOS	$236.98	$236.98	$37.92	$274.90
07/12/2025	1.000	PROCALCITONINA CUANTIFICADA (PCT)	$365.52	$365.52	$58.48	$424.00
07/12/2025	1.000	PROTEINA C REACTIVA	$106.70	$106.70	$17.07	$123.77
07/12/2025	1.000	CULTIVO DE HECES	$186.41	$186.41	$29.83	$216.24
07/12/2025	1.000	QUIMICA SANGUINEA (3)	$108.80	$108.80	$17.41	$126.21
08/12/2025	1.000	PROCALCITONINA CUANTIFICADA (PCT)	$365.52	$365.52	$58.48	$424.00
08/12/2025	1.000	BIOMETRIA HEMATICA	$81.08	$81.08	$12.97	$94.05
08/12/2025	1.000	GASOMETRIA VENOSA	$261.25	$261.25	$41.80	$303.05
08/12/2025	1.000	PROTEINA C REACTIVA	$106.70	$106.70	$17.07	$123.77
08/12/2025	1.000	PERFIL DE ELECTROLITOS	$236.98	$236.98	$37.92	$274.90
08/12/2025	1.000	QUIMICA SANGUINEA (3)	$108.80	$108.80	$17.41	$126.21
09/12/2025	1.000	PERFIL DE ELECTROLITOS	$236.98	$236.98	$37.92	$274.90
09/12/2025	1.000	PROTEINA C REACTIVA	$106.70	$106.70	$17.07	$123.77
09/12/2025	1.000	QUIMICA SANGUINEA (3)	$108.80	$108.80	$17.41	$126.21

GRUPO MÉDICO JOYA - HOSPITAL JOYA NUEVO VALLARTA SA DE CV

BLVD. FRANCISCO MEDINA ASCENCIO 2760, ZONA HOTELERA NORTE, 48333 PUERTO VALLARTA, NAYARIT

GRUPO MÉDICO JOYA

FOLIO: NV21262 CUARTO: HABITACION ESTANDAR 202 F. INGRESO: 06/12/2025 SEGURO:
[redacted] F. EGRESO: 09/12/2025 F. NACIMIENTO: [redacted]
MEDICO: ALDO CURIEL CURIEL

ORIGINAL

09/12/2025	1.000	BIOMETRIA HEMATICA	$81.08	$81.08	$12.97	$94.05
09/12/2025	1.000	PROCALCITONINA CUANTIFICADA (PCT)	$365.52	$365.52	$58.48	$424.00
			$5,005.21	$5,005.21	$800.83	$5,806.04

IMAGENOLOGIA

FECHA	CANT.	DESCRIPCIÓN	PRECIO / U	SUBTOTAL	IVA	TOTAL
06/12/2025	1.000	TOMOGRAFIA ABDOMINAL CONTRASTADA	$794.03	$794.03	$127.04	$921.07
06/12/2025	1.000	TOMOGRAFIA DE TORAX SIMPLE	$742.30	$742.30	$118.77	$861.07
08/12/2025	1.000	TOMOGRAFIA ABDOMINAL CONTRASTADA	$794.03	$794.03	$127.04	$921.07
			$2,330.36	$2,330.36	$372.85	$2,703.21

SERVICIOS DE ENFERMERIA

FECHA	CANT.	DESCRIPCIÓN	PRECIO / U	SUBTOTAL	IVA	TOTAL
06/12/2025	1.000	NS INITIAL INTRAVENOUS INFUSION HYDRATION	$124.58	$124.58	$19.93	$144.51
06/12/2025	1.000	NS INJECTION IV	$44.02	$44.02	$7.04	$51.06
06/12/2025	1.000	NS IV START	$87.20	$87.20	$13.95	$101.15
09/12/2025	1.000	NS IV LINE REMOVAL	$87.20	$87.20	$13.95	$101.15
09/12/2025	1.000	NS NURSE FAC DISCHARGE DAY	$242.37	$242.37	$38.78	$281.15
			$585.37	$585.37	$93.65	$679.02

TOTALES POR CONCEPTO / TOTAL BY CONCEPT

CONCEPTO	SUBTOTAL	IVA	TOTAL
HOSPITALIZACION	$6,027.36	$964.38	$6,991.74
URGENCIAS	$2,228.28	$356.52	$2,584.80
HABITACION	$3,981.27	$636.99	$4,618.26
LABORATORIO	$5,005.21	$800.83	$5,806.04
IMAGENOLOGIA	$2,330.36	$372.85	$2,703.21
SERVICIOS DE ENFERMERIA	$585.37	$93.65	$679.02
	$20,157.85	$3,225.22	$23,383.07

MEDICAL FEES US DOLLARS

SERVICIOS MEDICOS

FECHA	CODIGO	DESCRIPCIÓN	TOTAL
06/12/2025	99284	EMERGENCY DEPARTMENT VISIT MODERATE LEVEL OF MEDICAL DECISION MAKING - EMERGENCIES	$678.00
06/12/2025	99222	INITIAL HOSPITAL INPATIENT OR OBSERVATION MODERATE LEVEL MEDICAL CARE - DR. ALDO CURIEL - MEDICINA INTERNA	$871.40
06/12/2025	99222	INITIAL HOSPITAL INPATIENT OR OBSERVATION MODERATE LEVEL MEDICAL CARE - MEDICO STAFF	$626.10
06/12/2025	99253	INPATIENT CONSULTATION, LOW LEVEL MEDICAL DECISION - DR. ENRIQUE ROSALES - CIRUGIA GENERAL	$871.40
06/12/2025	97802	MEDICAL NUTRITION; INITIAL ASSESSMENT AND INTERVENTION - LIC. IRMA NOEMI HERNANDEZ - NUTRICION	$190.11
07/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - DR. ALDO CURIEL - MEDICINA INTERNA	$776.60
07/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - DR. ENRIQUE ROSALES - CIRUGIA GENERAL	$776.60
07/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - MEDICO STAFF	$626.10
08/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - DR. ALDO CURIEL - MEDICINA INTERNA	$776.60
08/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - DR. ENRIQUE ROSALES - CIRUGIA GENERAL	$776.60
08/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - MEDICO STAFF	$626.10
09/12/2025	99239	HOSPITAL INPATIENT DISCHARGE DAY MANAGEMENT MORE THAN 30 MIN - DR. EDSON ROBLES - MEDICINA INTERNA	$417.04
09/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - DR. ALDO CURIEL - MEDICINA INTERNA	$776.60
09/12/2025	99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE LEVEL MEDICAL CARE - MEDICO STAFF	$626.10
			$9,425.35

GRUPO MÉDICO JOYA - HOSPITAL JOYA NUEVO VALLARTA SA DE CV

BLVD. FRANCISCO MEDINA ASCENCIO 2760, ZONA HOTELERA NORTE, 48333 PUERTO VALLARTA, NAYARIT

GRUPO MÉDICO JOYA

FOLIO: NV21262 CUARTO: HABITACION ESTANDAR 202 F. INGRESO: 06/12/2025 SEGURO:
[redacted] F. EGRESO: 09/12/2025 F. NACIMIENTO: [redacted]
MÉDICO: ALDO CURIEL CURIEL

TOTAL HONORARIOS / TOTAL MEDICAL FEES

CONCEPTO	HONORARIOS MÉDICOS / MEDICAL FEES	$9,425.35 USD

ORIGINAL

TOTAL HOSPITAL / TOTAL HOSPITAL	$23,383.07
TOTAL HONORARIOS / TOTAL MEDICAL FEES	$9,425.35
TOTAL FINAL	**$32,808.42 USD**

US DOLLARS

THIS DOCUMENT CONTAINS SECURITY FEATURES - SEE BACK FOR DETAILS

Copy of HMA Check

Electronic Payment Clearinghouse
Healthcare Management Administrators
PO Box 85008
Bellevue, WA 98015-8508

The Huntington National Bank
Westerville, OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO.: 400862883
DRAFT DATE: 04/24/2026

PAYABLE THROUGH DRAFT Nineteen Thousand Six Hundred Eighty-Five And 05 / 100 Dollars**********.

AMOUNT
******$19,685.05*******

VOID AFTER 150 DAYS

TO THE ORDER OF [redacted]

Kristopher T. Ke

DUPEPROOF ICON MUST BE VISIBLE

⑈400862883⑈ ⑆044115126⑆ 0166950861 2⑈

Insfamed signin 2025 GMC Denali!

BANK OF AMERICA

Client Receipt

Thank you for banking with us today.

To help protect you and us from losses if a check(s) is returned unpaid, all deposits are subject to a hold review at any time. It's important you know that deposit holds can result in a reduction of your available balance. For more information, please refer to your Deposit Agreement & Disclosures at bankofamerica.com/deposits/resources/deposit-agreements.go.deposit.

Please save this receipt until you see the transaction completed on your statement. Transactions are credited subject to verification, collection, and the terms of your account. Keep in mind, transactions made in a financial center on non-business days (Saturday, Sunday, and bank holidays) aren't processed until the next business day we're open.

Visit bankofamerica.com to learn more about how you can receive money fast through electronic payment methods like direct deposit, Zelle®, ACH, and wires.

05/01/2026 15:43 Assoc: 712

WA Center: 0059501 Seq#: 120
Trans:Deposit Acct#: ********2641
Trans Total: $19,685.05
Chk Amt: $19,685.05

Transaction Posts On: 05/01/2026
Available Balance: $68,720.48

Done

VISA approval 5/1/26

Receipt - APPROVED

Passage Health International
5900 N. Andrews Ave, Suite 802,, Fort Lauderdale, FL 33309

Date
May 1 2026 3:58:20 PM PST

Type
Credit Card - Sale

First Name
[redacted]

Last Name
[redacted]

Authorization Amount
$22,808.42

Authorization Code
73420D

Name on Card
[redacted]

Card Type
VISA

Card Number
[redacted]

Card Entry Mode
Keyed

Response Message Code
Approval (00) 000

Mode
Issuer

GRUPO MEDICO JOYA

HOSPITAL JOYA RIVIERA

GRUPO MÉDICO JOYA

OUT OF COUNTRY MEDICAL INVOICE

INVOICE No.: C-83398

DATE: 1/14/2026

Foreign Provider Identification - EIN: 98-1906290 & NPI: 1417814336

INSURANCE & PATIENT INFORMATION	
BILL TO : Healthcare Management Administrators PO Box 85008 Bellevue, WA 98015 United States ORIGINAL	PATIENT : [redacted] D.O.B.: [redacted] POLICY No.: 9HP000115128 GROUP No.: 020188 ICD-10: K57.32 D.O.S.: 12/6/2025 - 12/9/2025 Dx.: Diverticulitis of sigmoid colon CASE No.: NONE

PAYMENT INFORMATION: REF# C-83398	
Submit Payment By Check To: Hospital Joya Riviera c/o Passage Health International Attn: International Billing Office PO BOX 11597 Fort Lauderdale Florida 33339 USA	***By Wire Transfer To: Bank of America Acct Name: PASSAGE HEALTH INTERNATIONAL Account No.: 229047101905 ABA No.: 063100277 (paper & electronic) ABA No.: 026009593 (wires) Swift Code from USA: BOFAUS 3 N Swift Code from Overseas: BOFAUS 6 N Bank Address: 1745 E Sunrise Blvd Ft. Lauderdale FL 33304 USA

*** For Wire Transfers, please reference the above invoice number in the memo or reference field. This ensures accurate processing and timely resolution of the claim.***

INTERNATIONAL BILLING DEPARTMENT CONTACT INFORMATION:

FOR BILLING INQUIRIES CALL: USA 1 (954) 903-7445 / FAX 1 954 376 6163 / EMAIL : info@internationalbillingoffice.com

Correspondence Only: Hospital Joya/ 5900 N Andrews Ave. Suite 802, Fort Lauderdale, Florida 33309

EMERGENCY MEDICAL SERVICES RENDERED OVERSEAS - MEXICO

DESCRIPTION OF CHARGES	TOTAL
Facility Charges - Emergency Room / Inpatient Admission	$ 23,383.07
Professional Charges - Emergency Room / Inpatient Admission	$ 9,425.35
FOREIGN EMERGENCY CLAIM — U.S. Dollars	
TOTAL AMOUNT IN U.S. DOLLARS	$ 32,808.42
PATIENT DEPOSIT IN U.S. DOLLARS	$ (10,000.00)

PLACE OF SERVICE: OVERSEAS (HOSPITAL JOYA RIVIERA)

Paseo de los Cocoteros # 55, Nautico Turistico, 63732, Nuevo Vallarta, Nayarit, Mexico

PAYMENT NOTE:

We appreciate your prompt attention to this invoice. As a reminder, insurance companies are generally expected to process claims promptly and fairly to avoid any inconvenience for the member, including the posibility of direct billing. Thank you for your cooperation.

Received: 1/26/2026

Visa Transaction 5/1/26

Receipt from Ft Lauderdale Intl.

yahoo/mail Inbox (6,987)

Search

arunch, specials, mimosas & a p...

Charles Schwab & ... 9:30 AM
Your account eStatement is avail...
Schwab eStatement notification ...

TEMU
Temu Clearance Sale

Karen Fowler 9:23 AM
Need to find another time
Hello Dotty! I have a training on T...

Patient Care Team 9:21 AM
Complete your RET - Burlington ...
Complete your brief assessment ...

USPS Informed ... 7:21 AM
Your Daily Digest for Mon, 5/4 is r...
COMING TO YOU SOON Hi, Dor...

[redacted]

Early Bird Books 3:09 AM
Your Ebook Deals for Monday ...

the amount of **$22,606.42.**

Please note that it typically takes **3–5 business days** for the payment to be reflected in our system. Once the payment is posted, the case will be automatically closed.

I truly appreciate your prompt payment and cooperation in resolving this matter.

Once the payment has been fully received and [redacted] account is officially closed; I will send you a confirmation email.

Thank you again for your assistance.

Best regards,

ibo International billing office

Nancy Shay
International Claim Specialist
International Billing Office
5900 N Andrews Ave Ste 802
Fort Lauderdale, FL 33309

T: +1 954 3537 465 ext 253 | D: +1 954 3768 103

Expand Delete Move to Forward Reply More

32 08 42
19685.05
#13,123.37

Intl. Billing Office. Tel.: 1 954-903-7445 Fax: 1 954-376-6163 e-mail: info@internationalbillingoffice.com

PATIENT CONSENT & AUTHORIZATION TO RENDER MEDICAL SERVICES

** PRINT ONLY (Information provided must be legible)

PATIENT INFORMATION:

Full Name: [redacted]

Address: [redacted]

City: [redacted]

Date of Birth: (MM/DD/YYYY) [redacted]

Telephone No.: [redacted]

* Please provide a photocopy of your Passport, and Identification Card.

INSURANCE INFORMATION:

Insurance Co. Name: City of Everett Telephone No.: 800 8697093

Policy/ID No.: 9HP00015128 Group No.: 020188

Main Subscriber (Full Name) [redacted]

Date of Arrival to Mexico (MM/DD/YYYY) 12-02-2025

Estimated Date of Departure: (MM/DD/YYYY) 12-09-2025

* Please provide a photocopy of your insurance card / policy and any other evidence of Health Insurance Coverage (Secondary Insurance / Travel Insurance)

EMERGENCY CONTACT (NEXT OF KIN):

Full Name: [redacted]

Address: [redacted]

City: [redacted]

Telephone: [redacted]

PRENATAL: [redacted]

Telephone: [redacted]

IMPORTANT: WITHOUT COMPLETE INFORMATION, YOUR INSURANCE COMPANY WILL NOT PAY FOR THIS CLAIM AND YOU WILL BE RESPONSIBLE FOR ALL SERVICES RENDERED. YOUR INSURANCE MAY REQUIRE YOU TO COMPLETE ADDITIONAL CLAIM FORMS

PATIENT CONSENT AND AUTHORIZATION:

I authorize any holder of medical or other information about me to be released to the insurance carriers (or their Business Associates(s)) for the purpose of this insurance claim. I request that payment of authorized benefits be made on my behalf. Authorization is also given to the subscriber's insurer (or Business Associate) in any country to collect, use or release any medical, protected health information or other personal information that they deem necessary to provide services or to adjudicate this claim. I assign the benefits payable for medical services to GRUPO MEDICO JOVA, Physician furnishing the services and its billing administrator Passage Health International. I understand that I am financially responsible for any amounts applied to the deductible, co-insurance, copayment, or maximum out of pocket as well as any non-covered services or charges not paid by my insurance. The claim is being submitted on my behalf to the medical provider and permission to render medical services is hereby given.

X [redacted] DATE: 12-08-2025

PATIENT OR AUTHORIZED REPRESENTATIVE ONLY MM/DD/YYYY

JOYA

INTERNATIONAL BILLING OFFICE
PO BOX 11661. FORT LAUDERDALE, FL 33339.

Provider / Billing Administrator Designation of Authorized Representative Agreement

The following people or companies have the right to act as my Designated Authorized Representative. A Designated Authorized Representative is a person whom you appoint to act as your representative in carrying out a grievance or appeal, including any external review rights available to you.

[redacted]

Patient Full Nam[redacted]ard.
Patient Address: [redacted]
Patient Date of B[redacted]

By this Designation of Authorized Representative, I intend to authorize **GRUPO MEDICO JOYA** ("Provider") or its designee **Passage Health International** ("Billing Administrator") to act as my authorized representative in pursuing a grievance, appeal, external review, or request documents regarding the medical claim(s) for the above provider from date of services and onward.

The aforementioned entities and any of their employees, officers, contractors, subcontractors conducting business on behalf of the entities have the right to receive my information. They must be 18 years of age or older.

I authorized the release and use of the following information by my insurance carrier on my behalf:
Check box: ☒ All my information, or if partial specify: _____. This can in[redacted], a diagnosis, claims, doctors and other healthcare providers and financial information (e.g., billing and banking): INITIALS [redacted]

Provider or its billing administrator is given the right by me to: (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts and law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial action and pursue claim(s) or cause of action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, plan administrator, travel insurance product or underwriter of such product. The provider or its billing administrator, as my designated representative, may sue any such health care benefit plan, employee benefit plan, plan administrator, insurance company, or travel insurance in my name with derivative standing at provider's expense. INITIALS [redacted]

I understand that as result of this authorization, any such health care benefit plan, employee benefit plan, plan administrator, insurance company, or travel insurance product may disclose and release all information concerning benefit eligibility, claim status, claim approval or denial, reasons in connection with the above reference health care claim(s) [redacted]nated authorized representative named above. This also includes billing and banking information disclosure. INITIALS [redacted]

I understand and agree that my health information may contain medical, pharmacy, dental, vision, mental health[redacted] abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease, and health care program information. INITIALS [redacted]

I understand that alcohol / substance abuse rec[redacted]ected by law and cannot be disclosed without my written consent unless otherwise provided for in the laws. INITIALS [redacted]

I have read the contents of this form, I understand, agree, and allow my Insurance Carrier to use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to my Insurance Carrier. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or entities who receives it. If this happens, it may no longer be protected under HIPAA privacy rule. I am entitled to a copy of this form. A photocopy of this agreement is considered valid, the same as if it were the original. INITIALS _____

Signature of Patient, Subscriber or Guardian

[redacted]

Date

08 - 12 - 2025

If the person signing this authorization is not the patient, describe below relationship to the patient (i.e., Parent, Guardian, Policy Holder, or Legal representative only) if you are the legal representative, a copy of a power of attorney must be provided for the records.

Spouse

Relationship to Patient if Applicable

[redacted]

Full Name of Authorized Person if Applicable

From Hospital Joya Puerto Vallarta

JOYA

ACKNOWLEDGEMENT OF PAYMENT AND DEPOSIT

Dear Patient or Financial Responsible Party:

GRUPO MEDICO JOYA is a private medical facility. You are required to pay for all services rendered to you during your stay at our medical facility prior to your discharge. If you have a valid insurance policy that provides worldwide emergency benefits, we will do our best to work with your insurance company in setting up direct billing on your behalf. Direct billing to your insurance company is a courtesy service and not an entitlement. Please note that we are submitting your claim on your behalf.

If we honor direct billing to your insurance company, you are still required to provide a deposit to the medical facility regardless of whether you are covered 100%. The required deposit amount due will be at the sole discretion of the medical facility based on the level of care you are expected to receive. You will be given a receipt for your payment, and the amount paid will be reflected on your invoice to the insurance company as "patient deposit".

** If you are unable to fulfill the request for a deposit, please notify the admission coordinator immediately. Please kindly note that we reserve the right to provide services to you. **

- Deposit toward invoice $ 10,000 USD

THIS AMOUNT DOES NOT CONSTITUTE FULL PAYMENT OF THE CLAIM

Please note that any deposit made at the time of service does not constitute full payment of the claim. However, if we receive full payment from the insurance company, you will receive a refund within 5 business days from our international billing office in Florida via a bank check to the mailing address provided at the time of service.

Be aware that any coinsurance, deductible, maximum out-of-pocket amounts you may have as part of your health benefit plan must be met prior to any insurance reimbursement. You may also be responsible for any non-covered amount deemed patient responsibility.

It is **GRUPO MEDICO JOYA's** intention to make our best efforts to collect from your insurance carrier, and we will work through our international billing office (see "insurance notification / claim follow-up" form) to ensure that you receive the maximum allowable health benefits, as described in your policy.

IMPORTANT: In order to avoid processing delays on your claim, do not attempt to submit this document for reimbursement **BEFORE** the hospital claim has been processed in its entirety by the insurance company.

During your care, you may receive a cost estimate from your treating physician and/or hospital. It is important to note that the medical providers providing treatment may be independent from the hospital and are providing an estimate of the portion of care you receive, and it may not reflect the entire episode of care. The final bill may take up to 30 days after your discharge to be generated and could have a large disparity between the physicia

[redacted]

Acknowledged Signature:

Patient Full Name:

Financial Party (if different to patient):

Date: 12-08-2025

Tel: + 1 954 903 7445 / E-mail: info@internationalbillingoffice.com

(A copy of this notice must be provided to patient or responsible party)

DO NOT DISREGARD – PLEASE READ THIS DOCUMENT
(SEE MEDICAL CLAIM ATTACHED)

Attn: Claims Department

IMPORTANT

January 14, 2026

Healthcare Management Administrators
PO BOX 85008
Bellevue, WA 98015

CLAIM IS BEING SUBMITTED ON BEHALF OF THE PATIENT

Re: Claim for services rendered by Hospital Joya Riviera
Health Insurance Identification Number: 9HP000115128
Patient Name: [redacted]
Date of Services: 12/6/2025 – 12/9/2025

Dear Sir/Madam,

Please be advised that this is an overseas medical claim, including an invoice and an itemized bill for services rendered. It is essential that this claim is NOT placed in the correspondence file. **This is a non-U.S. standard medical claim and must be processed accordingly.**

The Patient has assigned Passage Health International as their Authorized Representative for matters related to the processing of this claim. **As the Patient's Authorized Representative, we now submit this claim for your review on behalf of the Patient.** The signed Designation of Authorized Representative Agreement has been included in this submission packet for your review.

The attached medical invoice for the above patient pertains to services rendered outside of the United States at an overseas medical provider. **Please note that billing requirements such as the HCFA/CMS 1500, UB-04, DRG, and CPT codes are specific to U.S. medical providers and do not apply to international claims.**

We request that you process this foreign medical claim without requiring these U.S. standard forms, as the foreign provider does not possess the technical expertise nor is required to adhere to

the standards established by the U.S. Healthcare Finance Administration. Requesting such forms and codes is inappropriate for processing this overseas emergency medical claim.

This claim concerns emergency services provided by a foreign provider. U.S. standards, Medicare fee schedules, and CMS guidelines do not apply. Foreign providers are not classified as participant or non-participant providers under CMS guidelines and cannot be part of an administrative review processes designed for U.S. providers. In most cases, foreign providers cannot supply the requested U.S. billing information.

Furthermore, no insurance policy provisions, statutes, or laws require foreign providers to use specific U.S. billing forms or comply with U.S. laws and regulations. We know that policyholders routinely provide proof of loss for reimbursement and that you process their claims without requiring these U.S. billing forms. We are also aware of numerous similar claims that have been fully processed under your policies without needing U.S. standard forms.

If you are not prepared to pay for emergency services rendered by providers outside of the United States you should not instruct the members to "go to the nearest emergency room or urgent care facility" if they "experience an emergency medical condition while traveling outside of the service area" and you should modify the language in the member handbook to make it patently clear that emergency services received outside of the United States will require the member to absorb any and all balance billing.

We strongly believe that a reputable insurer like yourself would not apply standards arbitrarily or inconsistently. It is well established that good faith insurers seek ways to accept and promptly pay claims, while bad faith insurers unlawfully find ways to delay, diminish, disapprove, and deny payment.

Should you require any additional supporting documentation to process this overseas claim, please contact us accordingly. Otherwise, we look forward to the prompt settlement of the outstanding claim.

Sincerely,

International-Billing Office Claims Department

JOVA

INTERNATIONAL BILLING OFFICE
PO BOX 11661. FORT LAUDERDALE, FL 33339.

Patient Full Name: [redacted]

I, the undersigned, understand that **GRUPO MEDICO JOVA** (the "provider") and Passage Health International (the "billing administrator") shall attempt to process all claims through my insurance carrier/payor on my behalf. I understand and agree that should my insurance carrier/payor fail to pay all monies owed to the Provider or send payment directly to me, I shall be responsible for paying all monies owed to the Provider and/or its billing administrator.

I hereby assign and convey directly to the provider and its billing administrator as my Designated Authorized Representative "DAR", any payment, right to payment, all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I authorize the provider and its billing administrator to release all medical information necessary to process my claims. Further, I authorize my plan administrator fiduciary, insurer or its Business Associate, and/or attorney to release to the provider any and all Plan documents, summary benefit descriptions, medical claims and records, Protected Health Information, insurance policies, and/or settlement information upon written request from the provider, the billing administrator, or its attorneys in order to claim such medical benefits. (A separate DAR form is being provided).

In addition to the assignment of medical benefits and/or insurance reimbursement above, I also assign and/or convey to the provider and its designee any legal or administrative claim or cause of action arising under any group health plan, employee benefits plan, health insurance, or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the provider (including any right to pursue those legal or administrative claims or causes of action). This constitutes an express and knowing assignment of my rights in accordance with ERISA Title 29 U.S.C. for breach of fiduciary claims and other legal and/or administrative claims.

I intend by this assignment of benefits to convey to the provider or its designee all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the provider or their designated representative, including any rights to any settlement, insurance, or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). Provider or its assigned designee is given the right by me to: (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts and law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial action and pursue claims or causes of action or rights against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The provider, as my assignee and designated representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance company in my name with derivative standing at the provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (Health Care Reform Legislation), ERISA, Medicare, or applicable federal and state laws. A photocopy of this Assignment is to be considered valid, the same as if it were the original.

If I or my insurance company on my behalf fail to pay all monies owed for services provided by the provider, the provider and/or its assignees may seek a judgment against me for any monies owed. The undersigned agrees to pay for all costs of collection, including reasonable attorneys' fees (including attorney fees on appeal), incurred by the provider or its billing administrator in enforcing payment. The patient irrevocably agrees that the courts of Florida shall have exclusive jurisdiction to settle any dispute or claim (including non-contractual disputes or claims) brought by the Patient arising out of or in connection with this agreement or its subject matter or formation". "Each party irrevocably agrees, for the sole benefit of provider and/or billing administrator that, subject as provided below, the State and Federal Courts of Florida in the United States of America shall have non- exclusive jurisdiction over any dispute or claim (including non-contractual disputes or claims) brought by provider and/or the billing administrator arising out of or in connection with this agreement or its subject matter or formation. Nothing in this clause shall limit the right of provider and its billing administrator to take proceedings against the patient in any other court of competent jurisdiction, nor shall the taking of proceedings in any one or more jurisdictions preclude the taking of proceedings in any other jurisdiction, whether concurrently or not, to the extent permitted by the law of such other jurisdiction.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

[redacted] 12-08-2025

Signature of Patient or Responsible Party/Guardian | Print Name if Guardian or Different from Patient | Date