IN THE CIRCUIT COURT OF THE 15th JUDICIAL CIRCUIT IN AND FOR PALM BEACH COUNTY, FLORIDA.

WEST BOCA MEDICAL CENTER, INC., d/b/a WEST BOCA MEDICAL CENTER,
a Florida corporation,

Plaintiff,

vs.

BEST ROOFING SERVICES, LLC,
a Florida limited liability company,

Defendant.
_____/

CIVIL DIVISION

CASE NO:

COMPLAINT FOR BENEFITS

COMES NOW, PLAINTIFF, WEST BOCA MEDICAL CENTER, INC., d/b/a WEST BOCA MEDICAL CENTER, by and through its undersigned attorney files this Complaint for Benefits against BEST ROOFING SERVICES, LLC. As grounds therefore and in support thereof PLAINTIFF states as follows:

JURISDICTION AND VENUE

1. This is an action for benefits due under an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 et seq.
2. This Court has concurrent jurisdiction pursuant to 29 U.S.C. §1132(e)(1).
3. Venue is proper in Palm Beach County because the medical services at issue were rendered in this County.

PARTIES

4. Plaintiff is a licensed hospital in the State of Florida and provided medically necessary inpatient hospital services to a participant/beneficiary of Defendant's employee health benefit plan.

5. Defendant BEST ROOFING SERVICES, LLC sponsors and maintains a self-funded employee welfare benefit plan governed by ERISA (the "Plan").
6. The Plan is administered by EVHC, which has confirmed in writing that it serves as third-party administrator for Defendant's single-employer self-funded plan (***Exhibit "D"***).
7. As Plan Sponsor and/or Plan Administrator, Defendant is responsible for payment of covered benefits due under the Plan.

FACTUAL ALLEGATIONS

8. From July 13, 2022 through July 18, 2022, Plaintiff rendered medically necessary inpatient hospital services for labor and delivery to a participant/beneficiary of the Plan.
9. The patient is identified herein as **"C.F."** to protect patient privacy. Defendant administered the claim at issue and is fully aware of the identity of the participant/beneficiary referenced herein.
10. The total billed charges for the hospitalization were **$106,711.58**. A true and correct copy of the itemized bill (redacted to protect patient privacy) is attached as ***Exhibit "B".***
11. At the time of admission, C.F. executed a written Consent for Treatment and Assignment of Benefits in favor of Plaintiff. A true and correct copy (redacted to protect patient privacy) is attached as ***Exhibit "A".***
12. The Assignment expressly assigns to Plaintiff:
    - All insurance and plan benefits for the hospitalization;
    - All rights and interests in insurance benefits;
    - The right to receive Plan documents and information;
    - The right to appeal denials or underpayments; and
    - The right to pursue legal remedies and receive all monetary or equitable relief available under applicable law, including ERISA.
13. Plaintiff timely submitted its claim for payment under the Plan.
14. The Plan issued an Explanation of Benefits acknowledging coverage but paid only **$11,767.96**, with $500.00 applied to patient responsibility (which was paid), leaving an unpaid balance of **$94.443.62**. A true and correct copy of the Explanation of Benefits (redacted to protect patient privacy) is attached as ***Exhibit "C".***
15. The Explanation of Benefits reflects that approximately $94,443.62 of Plaintiff's billed

charges were reduced as an "adjustment."

16. In correspondence dated March 9, 2023, EVHC confirmed that it administers Defendant's self-funded Plan and stated that the claim was processed pursuant to Plan guidelines. A true and correct copy of that correspondence is attached as ***Exhibit "D".***
17. Plaintiff appealed the underpayment through the Plan's internal review procedures.
18. The Plan upheld its underpayment and failed to remit additional benefits due.
19. All administrative remedies required under the Plan have been exhausted or are deemed exhausted.

COUNT I

Claim for Benefits Under ERISA §502(a)(1)(B)

(29 U.S.C. §1132(a)(1)(B))

20. Plaintiff realleges paragraphs 1–19.
21. Under the terms of the Plan, Defendant is obligated to pay benefits due for covered inpatient hospital services.
22. The services rendered by Plaintiff were covered services under the Plan.
23. Defendant failed to pay the full benefits due under the Plan and underpaid Plaintiff's claim.
24. As a direct and proximate result of Defendant's failure to pay benefits due, Plaintiff has been damaged in the amount of **$94,443.62,** plus prejudgment interest.

WHEREFORE, Plaintiff demands judgment against Defendant for:

a. Benefits due in the amount of $94,443.62;

b. Prejudgment interest;

c. Reasonable attorney's fees and costs pursuant to 29 U.S.C. §1132(g); and

d. Such other and further relief as the Court deems just and proper.

COUNT II

Equitable Relief Under ERISA §502(a)(3)

(29 U.S.C. §1132(a)(3))

(Pled in the Alternative)

25. Plaintiff realleges paragraphs 1–24.

26. To the extent that relief under ERISA §502(a)(1)(B) is deemed unavailable or inadequate, Plaintiff seeks appropriate equitable relief under ERISA §502(a)(3).
27. Defendant is required to administer the Plan in accordance with its written terms and ERISA.
28. Plaintiff seeks equitable remedies, including surcharge or other appropriate equitable relief, to redress Defendant's failure to pay benefits due.

WHEREFORE, Plaintiff demands equitable relief as permitted under ERISA, together with attorney's fees and costs, and such further relief as the Court deems proper.

Respectfully submitted,

Law Offices of Lorne S. Cabinsky, P.A.
Attorney for Plaintiff
3020 NE 32nd Avenue, Suite 201B
Fort Lauderdale, FL 33308
(954) 563-6900
(954) 563-6901 fax

/s/Lorne S. Cabinsky
Lorne S. Cabinsky, Esquire
Florida Bar No.: 331510
lc@lcabinskylaw.com - primary
dvazquez@lcabinskylaw.com - secondary

EXHIBIT "A"

WEST BOCA Medical Center

WBOBO1001

CONSENT FOR TREATMENT AND CONDITIONS FOR ADMISSION

Consent to Medical and Related Health Care: I consent to the admission to the hospital and consent to treatment and procedures that my doctor thinks are needed during this hospitalization or while I am an outpatient or emergency department patient. These may include emergency treatment or services, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, and other hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that I will have an opportunity to separately consent to certain medical procedures and treatments. I also understand that the delivery of health care services is not an exact science and diagnosis, and treatment may involve risks of injury or even death. No guarantees are made to me regarding the result of examination or treatment in this hospital. The hospital has my permission to use any human tissue and/or cells removed during my hospital care for future diagnostic study, teaching or research purposes.

Teaching: Students, residents, postgraduate fellows, nursing and other clinical students may participate in my care as a part of the clinical education or research program of the hospital under appropriate supervision. Unless I notify the hospital that I do not want to participate in these educational programs, I agree that trainees may participate in and/or provide care to me while I am a patient at the hospital.

Medical and Allied Health Care Providers: All physicians, surgeons and various other independent practitioners caring for patients in the hospital, including emergency department physicians, radiologists, pathologists, anesthesiologists, and other attending or consulting physicians (collectively, "Physicians") are independent practitioners. They are not employees or agents of the hospital. Each patient's physicians are responsible for diagnosis of the patient's condition, establishing a plan of care, obtaining the patient's informed consent for medical or surgical treatment, performing diagnostic and therapeutic procedures and for ordering hospital services rendered for the patient by hospital personnel. It is the responsibility of the hospital to carry out the instructions of physicians through its nurses and other support staff.

Physicians may choose to hire physician assistants and nurse practitioners to assist them with medical care. Physician assistants and nurse practitioners employed by Physicians are not employees or agents of the hospital and their supervising Physicians are solely responsible for these physician assistants and nurse practitioners.

I consent to the provision of services by Physicians and independent practitioners and agree that they are solely responsible for their care and direction to hospital staff. Further, I release the Hospital from any and all liability for the acts or omissions of these Physicians or independent practitioners.

My initials at the end of this paragraph confirm that I have read the three paragraphs above; understand and agree to the terms of these paragraphs; am the patient, the patient's legal representative, or am duly authorized by the patient to accept these terms; and will receive a copy thereof.

Patient initials: CA

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted] C[redacted]
AT: GROSS MARIO
WEST BOCA MEDICAL CENTER

Maternity Patients: If I deliver an infant(s) while a patient of this hospital, I agree that this same Condition of Services applies to the infant(s). I acknowledge that I will receive a written copy disclosing my rights as a maternity care patient (if any).

Personal Property: As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any money, jewelry, documents, coats and other garments, dentures, eyeglasses, hearing aids, prosthetics, or any articles of unusual value and/or small size (unless placed in the fireproof safe), and will not be liable for loss or damage to any other personal property unless deposited with the hospital for safekeeping. The hospital's maximum liability for loss of any personal property deposited with the hospital for safekeeping is limited to five hundred dollars ($500.00) unless I receive a written receipt for a greater amount from the hospital.

Consent for Clinical Imaging or Photograph: I understand that some hospital procedures include use of videotape or other imaging as a part of their standard care. I consent to the use of photography during medical and surgical procedures. The hospital may use these images for treatment, scientific, educational or medical research purposes. I further consent to routine photography related to patient care, including newborns. The term "photograph" includes video and still photography, in digital or any other format, and any other means of recording or reproducing images.

Emergency or Laboring Patients: If I come to the hospital emergency department in labor or for an emergency, I understand that I have the right, to receive a medical screening examination performed by a doctor or other qualified medical professional to determine whether I am suffering from an emergency medical condition and, if such a condition exists, to receive stabilizing treatment within the capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance or I am not entitled to Medicare or Medicaid benefits.

Workers Compensation:

I am seeking treatment for an injury or illness that occurred while I was at my place of employment or performing work for my employer: ☑ No ☐ Yes

If yes, on what date did the accident or illness occur: _____

If yes, please provide the name and address of your employer:

_____

If yes, please provide the name and telephone number of your supervisor:

_____

If you know your employer's Worker's Compensation Carrier, please provide the name and/or contact information:

_____

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted], C[redacted]
AT: GROSS MARIO
WEST BOCA MEDICAL CENTER

Payment for Medical and Related Care: I understand payment is due when services are provided. I agree to promptly pay for all hospital services in accordance with the regular rates and terms of the hospital, including its charity care, financial aid, discount payment, and/or alternative payment arrangements policies, if applicable. I understand the hospital will provide an estimate of what I owe based upon the information I provide and information from my insurance or other third party, as applicable. The estimate may include my co-payment, co-insurance and/or deductible, all of which is due and payable at the time of service. I understand that I may receive a bill for any amounts due that are not collected at time of service. If I default on this agreement to pay for services and my account is referred to a third-party for debt collection, I will pay actual collection-related expenses, including attorney fees, and any other fees permitted by law. I understand the hospital may request and use data from third-parties, such as credit reporting agencies, to verify demographic data or evaluate financial options. I understand my physicians and surgeons, including the radiologists, pathologists, emergency physicians, and anesthesiologists will send me a separate bill for their services and I will receive separate bills from each of the providers who care for me during my hospital visit. I agree that if there is an overpayment or excess balance on this account, the overpayment or excess balance may be applied to any other outstanding account(s) for which I am financially obligated.

Notice of Electronic Check Conversion: If I provide a check as payment, I authorize the hospital to use information from my check to make a one-time electronic funds transfer (EFT) from my account or to process the payment as a check transaction. If the hospital uses information from a check to make an EFT, the funds may be withdrawn from my checking account the same day.

Assignment of Benefits: I assign and hereby authorize direct payment to the hospital of all insurance and plan benefits for this hospitalization or for these outpatient services. Completely and without any limitations or reservations, I assign to the hospital, along with any attorneys or agents acting on the hospital's behalf, all of my rights to and interest in all insurance benefits or proceeds for services delivered by the hospital. Without limiting the generality of the foregoing, this assignment extends to all of my rights to (1) request and receive documents and other information from any entity or person, including those governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); (2) appeal any denial or underpayment of benefits or coverage; and (3) pursue any legal remedies in any forum and receive all relief (monetary or equitable) available under applicable law, including all provisions of ERISA. If I am a Medicare beneficiary, I request that payment of authorized benefits be made in my behalf to the hospital for any service furnished to me by the hospital, and I certify that the information given by me in applying for payment under the Medicare program, Title XVIII of the Social Security Act, is correct. I authorize release of any information needed to act on this request. In the event that my current Medicare inpatient days are exhausted or become exhausted during my stay at the hospital, I authorize the hospital to bill and receive payment for benefits under my Lifetime Reserve days, to the extent available and applicable. As to all insurance and plan benefits, including Medicare, if the hospital is authorized to bill for services rendered by physicians or other providers, I assign payment to the hospital for the services rendered by these physicians or other providers. If I receive payment from an insurer or health plan for the hospital's services, I will promptly send that payment to the hospital. I agree that the insurer's or health plan's payment to the hospital pursuant to this authorization and request will discharge the insurer's or health plan's obligations to the extent of that payment. I understand that I am financially responsible for any hospital or other charges not paid according to this. I understand that services not covered through my benefits, as well as any applicable co-payments and deductibles, are my responsibility. I understand that payment for amounts not covered because of an inactive insurance card, no insurance, no insurance card, or insurance the hospital is not a participating provider for (out-of-network) are my responsibility.

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted] C[redacted]
AT: GROSS MARIO
WEST BOCA MEDICAL CENTER

Advanced Directives:

Patient has an advanced directive or living will: ☑ No ☐ Yes

If yes, copy provided? ☐ No ☐ Yes

Patient has Medical Durable Power of Attorney: ☑ No ☐ Yes

If yes, copy provided? ☐ No ☐ Yes

Patient has designated a Health Care Surrogate: ☑ No ☐ Yes

If yes, copy provided? ☐ No ☐ Yes

Name of designated Health Care Surrogate: _____

Phone Number: _____

I would like to receive further information about Living Wills and other advanced directives: ☑ No ☐ Yes

Acknowledgment of the Notice of Privacy Practices: I am aware of the notice of privacy practices that describes how this hospital may use and disclose patient health information. The notice of privacy practice includes information on how my name may be included in the hospital directory so that I can receive visitors and phone calls, unless I object to being included in the directory. I acknowledge receipt of the hospital's Notice of Privacy Practices if I have not received it within the last year or if the document has changed since I was last registered at the hospital.

Patient Rights and Responsibilities: I received Patient Rights and Responsibilities information explaining my rights and my responsibilities as a patient in this hospital, including how to file a complaint and grievance.

Release of Information: The hospital will obtain my consent and authorization to release medical information, except in those circumstances when the hospital is permitted or required by law to release information. I consent to the release of my information to third-parties for education or research activities. I consent to the release of medical information to entities that provide care in post-acute settings. In accordance with the Safe Medical Device Act of 1990, if a permanent medical device is implanted, I authorize the hospital to notify the manufacturer of my name, address, telephone number and Social Security Number, if available, as well as other information about the implantation.

I authorize the hospital to disclose all or any part of my record to any entity which is or may be liable to the hospital or me for all or part of the hospital's or hospital-based physicians' charges for the services provided to me, including, without limitation, hospital or insurance companies, workers' compensation carriers, welfare funds, my employer, or medical utilization review organization designated by the foregoing.

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted], C[redacted]
AT: GROSS MARIO
WEST BOCA MEDICAL CENTER

Clinical Trial or Research:

I am currently participating in a clinical trial: ☑ No ☐ Yes

The services that I will be having done during this hospital visit are part of my clinical trial: ☐ No ☐ Yes

I have a copy of my signed information consent with me: ☐ No ☐ Yes

If yes, we would like to make a copy of this consent for your file.

What is the name of the hospital or doctor's office where this study is taking place? _____

Please provide the name of your study doctor: _____

Please provide the name of the nurse or research coordinator: _____

Consent to Contact:

I consent and authorize the hospital, any physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, debt collectors, and other contracted staff (any or all of these is referred to as "Provider") to use automated telephone dialing systems, text messaging systems and electronic mail to (1) provide messages (including pre-recorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to the health care law, health care coverage, care follow-up, and other healthcare information or (2) provide telemarketing messages (including pre-recorded messages) during a call or via text message that delivers a "health care" message made by, or on behalf of, a "covered entity" or its "business associate," as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103.

Telephone messages may be played by a machine automatically when the telephone is answered, whether answered by me or someone else. These messages may also be recorded by my answering machine. I give the Provider permission to call or send a text message to any telephone number I give the Provider and to play pre-recorded messages or send text messages with information about my transactions over the phone, and understand that such information may not be encrypted or secure.

I promise that, unless I indicate otherwise, I own or customarily use the telephone numbers I give the Provider. I also promise to notify the Provider in writing within 30 days if I change phone number(s). I understand that Provider will continue to use the number I provide unless I provide notice of a change, and, therefore, failure to notify Provider may result in missed or delayed communications.

I also give the Provider permission to communicate such information to me via electronic mail, and understand that such information may not be encrypted or secure.

I agree that the Provider will not be liable to me for any calls or electronic communications, even if information is communicated to an unintended recipient (including, for example, contacts to a

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted], C[redacted]
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WEST BOCA MEDICAL CENTER

previous number that I have not notified the Provider is no longer used by me).

I understand that, when I receive such calls or electronic communications, I may incur a charge from the company that provides me with telecommunications, wireless and/or Internet services. I agree that the Provider has no liability for such charges.

I understand that consent to receive calls/messages is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and received a copy of this form. I am the patient, the patient's legal representative, or am authorized by the patient as the patient's general agent to act on his or her behalf to accept the terms of this form. I understand and accept the terms of this Consent for Treatment and Conditions for Admission form. If I have any questions, I have had an opportunity to ask questions about anything I don't understand. I also confirm that I have received a copy of the Notice of Privacy Practice and am the patient, the patient's legal representative, or am authorized by the patient as the patient's general agent to accept its terms.

Patient/Parent or Legal Guardian Signature

7/10/2022 12:16 PM
Date / Time

self
Relationship to Patient

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted], C[redacted]
AT: GROSS MARIO
WEST BOCA MEDICAL CENTER

Declaration of a Minor:

To be signed only in the instance in which a minor is seeking treatment without a parent or legal guardian present and meets at least one of the criteria below.

I. I am 18 years of age or older;

II. I am legally emancipated, married, or have been married;

III. I am unwed, pregnant, and seeking medical or surgical care or services related to my pregnancy;

IV. I am an unwed mother seeking medical or surgical care or services for my child;

V. I have been adjudicated as an adult and am in the care of the Department of Corrections;

VI. I am receiving treatment for a sexually transmitted disease;

VII. I am receiving treatment for substance abuse; or

VIII. I am 13 years of age or older and receiving outpatient crisis intervention services and treatment that does not include medication, somatic therapy, aversive stimuli, or substantial deprivation.

Patient/Parent or Legal Guardian Signature

Date / Time

Relationship to Patient

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted], C[redacted]
AT: GROSS MARIO
WEST BOCA MEDICAL CENTER

Financial Responsibility Agreement by Person other than the Patient or the Patient's Legal Representative: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Payment for Medical or Related Care (Paragraph 8) and Assignment of Benefits (Paragraph 10).

Person Accepting Financial Responsibility Signature

Date / Time

Relationship to Patient

Translator: I have accurately and completely read the document to the patient or patient's representative in the language requested by the patient or patient's representative.

Translator

Date / Time

DOB: [redacted]
AGE: [redacted]
SEX: [redacted]
ACCT#: [redacted] MR#: [redacted]
AD: 07/13/2022 PN: F[redacted], C[redacted]
AT: GROSS MARIO
WEST BOCA MEDICAL CENTER

EXHIBIT "B"

REV CODE	HCPCS	BILLING DESCRIPTION		QTY	AMOUNT	CHARGE NUMBER	SERVICE DATE
0122		SEMI-PRIV 01661		1	4,992.00	002500044	07/13/2022
0122		SEMI-PRIV 01661		1	4,992.00	002500044	07/14/2022
0122		SEMI-PRIV 01661		1	4,992.00	002500044	07/15/2022
0122		SEMI-PRIV 01081		1	4,992.00	002500044	07/16/2022
0122		SEMI-PRIV 01081		1	4,992.00	002500044	07/17/2022
0250	A9150	APAP 500 ES TB	+	2	6.00	005300014	07/14/2022
0250	J3490	DINOPROSTON10MG		2	5,710.00	005338320	07/14/2022
0250	J3590	ASTROGLID66.5TS	+	2	602.00	005330250	07/15/2022
0250	J8499	IBUPROF600MG TB	+	2	130.00	005305919	07/17/2022
0250	J8499	IBUPROF600MG TB	+	3	195.00	005305919	07/18/2022
0300	U0003	IA SARSCOV2 AMP PRB HTT		1	51.31	007250084	07/10/2022
0300	U0005	SARSCOV2 AMP HTT 48HR		1	.01	007250097	07/10/2022
0300	85025	CBC W/AUTO DIFF		1	553.00	004105028	07/14/2022
0300	85025	CBC W/AUTO DIFF		1	553.00	004105028	07/18/2022
0300	85027	CBC AUTO		1	607.00	004100056	07/17/2022
0300	86850	RBC AB SCRN		1	552.00	004106016	07/14/2022
0300	86900	BLD TYPE ABO		1	339.00	004106080	07/14/2022
0300	86901	BLD TYPE RH (D)		1	360.00	004106100	07/14/2022
0360		SURG LVIII INT3		1	6,695.00	003101218	07/16/2022
0360		SURG LVIII EA15		3	6,987.00	003101219	07/16/2022
0370		ANESTH INT 30M		1	1,896.00	003703560	07/16/2022
0370		ANESTH EA ADD15		3	2,532.00	003703561	07/16/2022
0636	J0690	CEFAZOL500PMXIJ		8	248.00	005318977	07/16/2022
0636	J1100	DEXAMETHAS1MGIJ		4	48.00	005319864	07/16/2022
0636	J1200	DIPHENHYDR 50MG		1	19.00	005320117	07/16/2022
0636	J1885	KETOROLAC 15MG		4	76.00	005321633	07/16/2022
0636	J1885	KETOROLAC 15MG		2	38.00	005321633	07/17/2022
0636	J2274	MORPH PF 10MGIJ		1	194.00	005327712	07/16/2022
0636	J2405	ONDANSETRO1MGIJ		8	72.00	005322936	07/15/2022
0636	J2590	OXYTOC 10U LR		3	357.00	005323038	07/15/2022
0636	J2590	OXYTOC 10U LR		3	357.00	005323038	07/16/2022
0636	J2590	OXYTOCIN 10U IJ		10	2,590.00	005323045	07/16/2022
0636	J2795	ROPIVACAIN1MGIJ		400	800.00	005324052	07/15/2022
0636	J3010	FENTANYL.1MG IJ		1	10.00	005327501	07/15/2022
0636	J3010	FENTANYL.1MG IJ		1	10.00	005327501	07/16/2022
0636	J7120	L RINGERS 1LIVF		2	86.00	005412550	07/15/2022
0636	S0020	BUPIV.75%PF30ML		1	39.26	005318716	07/15/2022
0710		RECOVERY INT 30		1	2,824.00	003101222	07/16/2022
0710		RECOVERY ADD 15		6	7,200.00	003101223	07/16/2022
0720		LBR CPX 1ST HR		1	961.00	003101208	07/14/2022
0720		LBR CPX ADD HR		17	12,206.00	003101209	07/14/2022
0720		LBR CPX ADD HR		24	17,232.00	003101209	07/15/2022
0720		LBR CPX ADD HR		12	8,616.00	003101209	07/16/2022

TOTAL 106,711.58

EXHIBIT "C"

EVHC
PO Box 2820
Clinton, IA 52733-2920

EVHC

Questions? Contact us:
Toll-Free: 800-311-3842

Website: http://www.myevhc.com

C[redacted] F[redacted]
[redacted]

BEST ROOFING
Group Number: ECMNH

Consolidated Family Explanation of Benefits

This is not a Bill

C[redacted] F[redacted]

Patient's Name / Type of Service	Service Date(s)	Billed Charges	Discount Amount	Other Adjustments	Other Plan Payment	Patient Responsibility After Payment: Ineligible	Co-Pay	Deductible	Co-Ins	Plan Benefit	Plan Paid At	Reason Codes
F[redacted] C[redacted]												
Claim #: 080622-105-19 Pat. Acct. #: [redacted] Provider: WEST BOCA MEDICAL CENTER INC Network:												Issued:10/19/22
HOSPITAL SERV	07/10/2022	24,990.00	0.00	22,000.51	0.00	0.00	0.00	0.00	0.00	2,866.49	100%	ADJ AM1
HOSPITAL SERV	07/10/2022	6,843.00	0.00	5,576.30	0.00	0.00	0.00	0.00	0.00	765.70	100%	ADJ AM1
HOSPITAL SERV	07/10/2022	3,015.32	0.00	2,668.67	0.00	0.00	0.00	0.00	0.00	346.65	100%	ADJ AM1
HOSPITAL SERV	07/10/2022	13,682.00	0.00	12,109.07	0.00	0.00	0.00	0.00	0.00	1,572.93	100%	ADJ AM1
HOSPITAL SERV	07/10/2022	4,426.00	0.00	3,916.95	0.00	0.00	0.00	0.00	0.00	509.05	100%	ADJ AM1
HOSPITAL SERV	07/10/2022	39.26	0.00	34.75	0.00	0.00	0.00	0.00	0.00	4.51	100%	ADJ AM1
INJECTION	07/10/2022	248.00	0.00	219.49	0.00	0.00	0.00	0.00	0.00	28.51	100%	ADJ AM1
INJECTION	07/10/2022	48.00	0.00	42.49	0.00	0.00	0.00	0.00	0.00	5.51	100%	ADJ AM1
INJECTION	07/10/2022	19.00	0.00	16.82	0.00	0.00	0.00	0.00	0.00	2.18	100%	ADJ AM1
INJECTION	07/10/2022	114.00	0.00	100.90	0.00	0.00	0.00	0.00	0.00	13.10	100%	ADJ AM1
INJECTION	07/10/2022	194.00	0.00	171.70	0.00	0.00	0.00	0.00	0.00	22.30	100%	ADJ AM1
INJECTION	07/10/2022	72.00	0.00	63.73	0.00	0.00	0.00	0.00	0.00	8.27	100%	ADJ AM1
INJECTION	07/10/2022	3,304.00	0.00	2,924.16	0.00	0.00	0.00	0.00	0.00	379.84	100%	ADJ AM1
INJECTION	07/10/2022	800.00	0.00	708.03	0.00	0.00	0.00	0.00	0.00	91.97	100%	ADJ AM1
INJECTION	07/10/2022	20.00	0.00	17.71	0.00	0.00	2.29	0.00	0.00	0.00	0%	ADJ AM1
INJECTION	07/10/2022	86.00	0.00	76.12	0.00	0.00	9.88	0.00	0.00	0.00	0%	ADJ AM1
HOSPITAL SERV	07/10/2022	10,024.00	0.00	8,871.61	0.00	0.00	487.83	0.00	0.00	664.56	100%	ADJ AM1
HOSPITAL SERV	07/10/2022	39,816.00	0.00	34,529.61	0.00	0.00	0.00	0.00	0.00	4,486.39	100%	ADJ AM1
	Totals:	155,711.58	0.00	94,443.52	0.00	0.00	500.00	0.00	0.00	$11,767.96		

The allowed amount of Plan benefits for medical claims are limited under the terms of the Plan Document (available upon request) to Permitted Payment Levels for the provided goods and services, notwithstanding the amount of the billed charges. Benefit determinations may be appealed in accordance with the terms of the Plan.

Patient Responsibility $500.00

Payee:WEST BOCA MEDICAL CENTER INC Amount: 11,767.96

Reason Code Descriptions:

ADJ THIS REFLECTS AN ADJUSTMENT TO A PREVIOUS CLAIM. PLEASE REFER TO THE ORIGINAL EOB FOR AN EXPLANATION OF PAYMENT OR DENIAL.

AM1 PAYMENT TENDERED ON BEHALF OF PLAN/PARTICIPANT/PATIENT IN SATISFACTION AND FULL SETTLEMENT OF ALL CHARGES FOR FACILITY MEDICAL BILLS/CLAIMS SUBMITTED ON STATED ACCOUNT.

Please see your Summary Plan Description for a more detailed explanation of your plan benefits, exclusions, and maximums.
The dollars displayed on this statement are as of the Print Date and are subject to change.

EXHIBIT "C"

March 9, 2023

West Boca Medical Center
Attention: Appeal Claims Representative
2166 State Rd 7
Boca Raton FL 33428-1842

Employee/ Patient Name: C[redacted] F[redacted] / [redacted]
Identification Number: [redacted]
Employer Name: Best Roofing
Date of Service: 07 16 2022 – 07 18 2022
Provider Name: West Boca Medical Center Inc.
Claim Charge: $11842.00

Dear Disputed Claims Dept.:

This is in response to your correspondence received regarding the payment for services rendered on the above-mentioned date of service.

EVHC is a licensed third party administrator for the single employer self-funded plan sponsored by Best Roofing and is only authorized to process claims in accordance with the specific plan guidelines provided by the Plan Administrator; EVHC.

The claim in question processed in accordance with the contractual agreement with the provider and Advanced Medical Pricing Solutions (AMPS), a Cost-Plus Model for the application of Referenced Based Reimbursement (RBR) pricing methodology. If there are any discrepancies with the allowed amounts for any charges in question, please contact AMPS by calling (800) 425-9373. If additional pricing is received, it will be considered a new claims submission and will be considered under all terms of the plan. Therefore, at this time, it must be maintained that the original processing of the claim in question was appropriate and no adjustments are warranted.

If you have any questions, please contact our Customer Service Department.

Sincerely,

Claims Department