Exhibit 2

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY NET SETTLEMENT FUND

It is very important that you read the Class Notice in order to fully understand your rights under this Settlement.

DEADLINE FOR CLAIM FORM SUBMISSION: Submitted online or postmarked by _____.

WE STRONGLY RECOMMEND SUBMITTING YOUR CLAIM FORM ONLINE. IF THAT IS NOT FEASIBLE, PLEASE SUBMIT YOUR CLAIM FORM VIA REGISTERED OR CERTIFIED MAIL AND RETAIN YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

If you validly submit a Claim Form to the Settlement Notice Administrator online or postmarked no later than _____ you may elect to receive the portion of the Hospital/Facility Net Settlement Fund to which you are entitled as a Health Care Facility or authorized Health Care System. A Class Member may file only one Claim Form as a Health Care Facility or a Health Care System on behalf of Health Care Facilities.

By submitting a Claim Form you are agreeing to be subject to the jurisdiction of the United States District Court for the Northern District of Alabama for any proceedings relating to your Claim Form. Capitalized terms used in the Instructions and Claim Form that are not otherwise defined herein are defined in the Settlement Agreement. A copy of the Settlement Agreement can be found on _____.

Relevant Definitions

- "Claimant" - For purposes of the Claim Form for the Hospital/Facility Net Settlement Fund, a Claimant is a Health Care Facility or Health Care System that submits a submits a Claim Form seeking payment from the Health Care Facilities' Settlement Fund.
- "Class Member" is defined in the Settlement Agreement and described in the Class Notice.
- "Health Care Facility" means any facility, such as a hospital, ambulatory surgery center, dialysis center, imaging center or other facility in which health care services are or were delivered to Blue Plan Members.
- "Health Care System" means any association, partnership, corporation or other form of organization that arranges for care to be provided to Blue Plan Members by two or more Health Care Facilities organized under multiple taxpayer identification numbers.

Submit your completed Claim Form online or mail your completed Claim Form to the Settlement Notice Administrator at:

Settlement Notice Administrator
P.O. Box [XXXXX]
Richmond, VA 23260

NOTE: YOU MUST NOTIFY THE SETTLEMENT NOTICE ADMINISTRATOR IMMEDIATELY OF ANY CHANGE IN YOUR ADDRESS, TO AVOID HAVING YOUR MAILED CHECK RETURNED TO THE SETTLEMENT NOTICE ADMINISTRATOR AND DISTRIBUTED IN ACCORDANCE WITH PARAGRAPH 39 OF THE SETTLEMENT AGREEMENT.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY NET SETTLEMENT FUND

SECTION-BY-SECTION INSTRUCTIONS

SECTION A (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

In Section A, please write in the Health Care System or Health Care Facility name and the name of the person completing the Claim Form. If you are representing a Health Care System, attach a list of all the Health Care Facilities for whom you are filing this Claim. Health Care Systems may submit Claim Forms on behalf of multiple Health Care Facilities without providing individual signatures from the Health Care Facilities, if authorized to do so by the Health Care Facilities and the Health Care Facilities do not also submit Claim Forms on their own behalf.

Your list of Health Care Facilities should be set forth on the Rider attached to the Claim Form, and must include all of the following information for each Health Care Facility:

1. Health Care Facility name.
2. Health Care Facility zip code(s).
3. The National Provider Identifier(s) (NPI(s)) associated with the Health Care Facility.
4. The Tax Identification Numbers (TIN(s)) associated with the Health Care Facility.
5. The First Date of Service during the period from July 24, 2008 through October 4, 2024.
6. The Last Date of Service during the period from July 24, 2008 through October 4, 2024.
7. Whether the Health Care Facility Provides Inpatient Services, Outpatient Services or both.
8. The time period for which the Claimant is submitting the claim on behalf of the Health Care Facility.

SECTION B (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

Individual Health Care Facilities and Health Care Systems who submit Claim Forms on behalf of Health Care Facilities are entitled to receive a portion of the Hospital/Facility Net Settlement Fund. The settlement payment attributable to a Health Care Facility will be based upon the allowed amounts determined by all Settling Individual Blue Plans in response to claims for reimbursement for the provision of Covered Services submitted for each Health Care Facility to Settling Individual Blue Plans during the during the time period from July 24, 2008 through October 4, 2024, as reflected in Evidences of Benefits, Remittance Advices, or similar responses to such claims for reimbursement ("Allowed Amounts").

For purposes of determining which box to check in this section:

"Covered Services" means healthcare services, equipment, or supplies covered under an individual's Commercial Health Benefit Product administered by any Settling Individual Blue Plan.

"Commercial Health Benefit Product" means any product or plan providing for the payment or administration of healthcare services (including but not limited to medical, pharmacy, dental, and vision products and services) or expenses through insurance, reimbursement, or other similar healthcare financing mechanism, for Members in the U.S. (however funded, including insured or self-funded) other than a product or plan purchased or offered by a Government Entity, including but not limited to those offered under the Children with Special Health Care Needs Program (CSHCN); Children's Health Insurance Program (CHIP); Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Indian Health Service, Tribal, and Urban Indian Health Plan; Medicaid; Medicare; Medicare Advantage (including but not limited to Medicare Advantage Prescription Drug Plans and Special Needs Plans, including but not limited to Medicare-Medicaid or Dual-Eligible Plans); Medicare Stand-Alone Prescription Drug Plans; Refugee Medical Assistance Program; State Maternal and Child Health Program (MCH); or TriCare.

The Settling Individual Blue Plans are listed in the Settlement Agreement.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY NET SETTLEMENT FUND

SECTION-BY-SECTION INSTRUCTIONS (CONTINUED)

SECTION B (CONTINUED)

You should select only ONE of the options in Section B, as described below:

Option A (the "Default Method") permits a Health Care System or Health Care Facility to submit the information requested in the Rider attached to the Claim Form **EXCEPT FOR** the estimated Allowed Amounts so that the Settlement Notice Administrator can query the claims data available to it to estimate the Health Care System's or Health Care Facility's Allowed Amounts.

IMPORTANT: Please note that Option A (the Default Method) is not available for Health Care Facilities located in Arizona, Iowa, Louisiana, Maryland, New Jersey, South Dakota, Virginia, the District of Columbia and Puerto Rico.

Option B (the "Alternative Method") permits a Health Care System or Health Care Facility to submit its own estimated Allowed Amounts, which will be validated by the Settlement Notice Administrator. Estimated Allowed Amounts must be provided for Health Care Facilities not open prior to January 1, 2015. If the Settlement Notice Administrator is unable to validate the Allowed Amounts you have claimed, you may later be required to submit documentation to support your claimed Allowed Amounts.

IMPORTANT: Please note that, if a Health Care System or Health Care Facility is only able to submit their own estimated Allowed Amounts for certain years and not others during the period from July 24, 2008 through October 4, 2024, it should still do so, and the Provider Plaintiffs' experts will extrapolate the Claimant's Allowed Amounts for the other years during this time period, using the Consumer Price Index for hospital and related services.

The Settlement Notice Administrator will make the final decision on any dispute regarding the eligibility of a Claimant to receive payment from the Hospital/Facility Net Settlement Fund or the amount of any such payment.

If you have any questions, please contact the Settlement Notice Administrator by telephone at _____ or by email at _____.

SECTION C (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

This Section will allow you to select whether you want to receive a settlement payment, if eligible, by check, electronic transfer (ACH or wire), or by digital payment (PayPal, Venmo, Virtual Mastercard).

SECTION D (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

This Section will dictate to whom the payment is addressed. If you submit a Claim Form on behalf of a Health Care System, the payment will be made to the Health Care System for distribution by the Health Care System to individual Health Care Facilities.

SECTION E (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

Read, sign, and date the Certification.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY NET SETTLEMENT FUND

You must read the Class Notice and Claim Instructions before completing this Claim Form.

SECTION A: CLAIMANT INFORMATION - ALL CLAIMANTS MUST COMPLETE THIS SECTION (EITHER THROUGH A HEALTH CARE SYSTEM OR INDIVIDUALLY, BUT NOT BOTH).

Indicate whether the Claimant is a Health Care System or Health Care Facility and complete the information below. Check one only.

☐ HEALTH CARE SYSTEM	If Health Care System, please indicate the number of Health Care Facilities for whom you are filing this claim.	

Health Care System Name	*National Provider Identifier (NPI)*

Name and Title of Person Filing	*Phone Number*

Email Address of Person Filing

Health Care System: Please see Instructions. You must complete the Rider to this Claim Form and provide the required information regarding all Health Care Facilities for which you are filing a claim.

☐ HEALTH CARE FACILITY	*Health Care Facility Name*

National Provider Identifier (NPI)	*Phone Number*

Email Address of Person Filing

Provide the mailing address for the Health Care System or Health Care Facility.

Address 1	*Address 2*

City	*State*	*Zip Code*

SECTION B: ALL CLAIMANTS MUST COMPLETE THIS SECTION

☐ By checking the box to the left, I certify that I have reviewed the Class Notice and that the Health Care System or Health Care Facility identified above is, or includes, a Class Member (as described in the Class Notice).

Check **ONLY ONE** of the boxes below to designate the method that the Claimant wishes to determine the Allowed Amounts that will form the basis of this claim.

Option A (the "Default Method") permits a Health Care System or Health Care Facility to submit the information requested in the attached Rider **EXCEPT FOR** the estimated Allowed Amounts so that the Settlement Notice Administrator can query the claims data available to it to estimate the Health Care System's or Health Care Facility's Allowed Amounts.

Option B (the Alternative Method") permits a Health Care System or Health Care Facility to submit its own estimated Allowed Amounts for the time period from July 24, 2008 through October 4, 2024, which will be validated by the Settlement Notice Administrator.

☐ **Option A (the "Default Method")**

A Health Care System or Health Care Facility that checks Option A must provide all the information requested in the attached Rider **EXCEPT FOR** the estimated Allowed Amounts for each Health Care Facility for which it is submitting a claim.

☐ **Option B (the "Alternative Method")**

A Health Care System or Health Care Facility that checks Option B must provide all the information requested in the attached Rider **INCLUDING** the estimated Allowed Amounts for each Health Care Facility for which it is submitting a claim. Estimated Allowed Amounts must be provided for Health Care Facilities not open prior to January 1, 2015. If the Settlement Notice Administrator is unable to validate the Allowed Amounts you have claimed, you may later be required to submit documentation to support your claimed Allowed Amounts.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY NET SETTLEMENT FUND

SECTION C: ALL CLAIMANTS MUST COMPLETE THIS SECTION

If the Settlement Notice Administrator determines you are eligible for a settlement award, you may choose to receive your payment as a check mailed to the address you provided on the previous page, by electronic transfer (ACH or wire), or by digital payment (virtual Mastercard, PayPal, or Venmo). Claimants with awards greater than $10,000 must choose check, ACH, or wire, and cannot select PayPal, Venmo, or Virtual Mastercard. The Settlement Notice Administrator will issue your entire payment using the single payment method you select, and you may not split your award across multiple payment types.

Select your preferred method of payment and enter the required information. If you elect to receive an electronic or digital payment and the information you enter is incorrect or incomplete, the Settlement Administrator will convert your award to a check payment. Be sure to double check that the payment information you provide is up-to-date and you're the payment details you provide are correct and associated with the correct account.

Select one and complete the required information.

☐ **CHECK PAYMENT**
(For any payment amount; for payments less than $100,000, there may be a fee of up to $25 for this payment method; for payments of $100,000 or more, there may be a fee of up to $100 for this payment method.)

The check will be made payable to the Health Care System or Health Care Facility listed on the previous page.

☐ **ACH PAYMENT**
(For any payment amount; there are no fees associated with this payment method.)

An Automated Clearing House (ACH) payment is a type of electronic bank-to-bank payment and is a way to transfer money between bank accounts, rather than using card networks, wire transfers, or paper checks. ACH Electronic Transfers are quicker than standard checks and typically arrive within 3-5 business days after the initiation of the payment.

Provide the information below to receive an ACH payment.

Account Name: _____

Account Type (Checking/Savings): _____

Bank ACH Routing Number (9 Digits): _____

Account Number (Up to 16 Digits): _____

☐ **WIRE TRANSFER**
(For payment amounts of $250,000 or more; there may be a fee of up to $100 for this payment method.)

A wire transfer is a common way to electronically move money from one bank account to another. Wire transfers are quicker than standard checks, but depending on your bank or financial institution, may arrive within 1-3 business days after the initiation of the payment. *If you choose to receive payment by wire transfer, the Settlement Notice Administrator will deduct from your payment any costs associated with issuing the wire transfer. In addition, your financial institution may charge fees to receive incoming wire transfers.*

Provide the information below and on the next page to receive a wire transfer.

Account Name: _____

Bank Name: _____

Bank ABA Fedwire Routing Number (9 Digits): _____

Account Number (Up to 16 Digits): _____

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CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY NET SETTLEMENT FUND

SECTION C (CONTINUED): ALL CLAIMANTS MUST COMPLETE THIS SECTION

(**WIRE TRANSFER**: CONTINUED FROM PREVIOUS PAGE)

If your wire instructions include an intermediary bank, provide the intermediary bank information below.

Intermediary Bank Name: _____

Intermediary Bank ABA Fedwire Routing Number (9 Digits): _____

If your wire instructions include additional references in order to apply funds, indicate that information below.

Instructions 1: _____

Instructions 2: _____

Instructions 3: _____

☐ **PAYPAL**
(For payment amounts $10,000 or less; there are no fees associated with this payment method.)

The PayPal payment will be issued to the Health Care System or Health Care Facility identified on the first page. Be sure that the email address below is for the PayPal account to which funds are to be paid. There is no charge to receive a PayPal payment and no fees will be deducted from your award.

Email Address Associated with PayPal Account: _____

☐ **VENMO**
(For payment amounts $10,000 or less; there are no fees associated with this payment method.)

The Venmo payment will be issued to Health Care System or Health Care Facility identified on the first page. Be sure that the email address and phone number below is for the Venmo account to which funds are to be paid. There is no charge to receive a Venmo payment and no fees will be deducted from your award.

Email Address Associated with Venmo Account: _____

Phone Number Associated with Venmo Account: _____

☐ **VIRTUAL MASTERCARD**
(For payment amounts $10,000 or less; there are no fees associated with this payment method.)

The Virtual Mastercard will be issued to the Health Care System or Health Care Facility identified on the first page. Be sure that the email address below is for the Health Care System or Health Care Facility. There is no charge to receive a Virtual Mastercard payment and no fees will be deducted from your award.

Email Address: _____

(CLAIM FORM CONTINUES ON NEXT PAGE)

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY NET SETTLEMENT FUND

SECTION D: SUBSTITUTE FORM W-9 - ALL CLAIMANTS MUST COMPLETE THIS SECTION

Enter the Tax Identification Number of the Claimant whose name will appear on any check and related Form-1099.	*Tax Identification Number (TIN)*

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Tax Identification Number for this Claimant; and

2. The Claimant is not subject to backup withholding because the Claimant: (a) is exempt from backup withholding, or (b) has not been notified by the Internal Revenue Service (IRS) that the Claimant is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the Claimant that the Claimant is no longer subject to backup withholding.

NOTE: Backup withholding is extra tax withholding that occurs when a taxpayer has underreported interest or dividends in a previous year. The IRS notifies taxpayers who are subject to backup withholding. If you (the Claimant) have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return, you must cross out item 2 above by placing a line through the section.

SECTION E: ALL CLAIMANTS MUST COMPLETE THIS SECTION

I do declare and certify as follows:

- I am an authorized representative of the Class Member identified above;

- I am not submitting a claim on behalf of any Class Members who have submitted a request to opt out of the Class and Settlement;

- I am not submitting claims on behalf of any Class Members who are submitting separate claims on their own behalf based on the same Covered Services; and

- All of the statements and information provided in this Claim Form are true, correct and complete, to the best of my knowledge.

NOTE: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications in Section C required to avoid backup withholding.

Signature of Claimant	*Date*

Any Claim Form submitted online or postmarked after _____ is not a Valid Claim Form and will be denied by the Settlement Notice Administrator.

Before submitting your Claim Form, please be sure to:
- **Complete Section A – Claimant Information**
- **Complete Section B and the attached Rider listing the Health Care Facilities for which you are submitting this Claim Form and listing the required key information.**
- **Complete Section C.**
- **Complete Section D.**
- **Sign the Certification in Section E.**

WE STRONGLY RECOMMEND SUBMITTING YOUR CLAIM FORM ONLINE. IF THAT IS NOT FEASIBLE, PLEASE SUBMIT YOUR CLAIM FORM VIA REGISTERED OR CERTIFIED MAIL AND RETAIN YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

Claim Forms must be sent to the Settlement Notice Administrator at P.O. Box [XXXXX], Richmond, VA 23260.

If you have any questions, please contact the Settlement Notice Administrator by telephone at _____ or by email at _____.

RIDER FOR HEALTH CARE SYSTEMS AND HEALTH CARE FACILITIES

Health Care System or Health Care Facility Name	
Name and Title of Person Filing	*Phone Number*
Email Address of Person Filing	

List of Health Care Facilities and Key Information For EACH Health Care Facility for Whom You Are Submitting Claims (Please attach additional pages of this form, if necessary)

Health Care Facility Name:

Health Care Facility Type	*Health Care Facility Zip Code*
Billing National Provider Identifier (NPI)	*Billing Tax ID Number (TIN)*
First Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)	*Last Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)*
Does Facility Provide Inpatient Services (IP), Outpatient Services (OP) or Both?	*Time Period for Which Claimant is Submitting Claim on behalf of Health Care Facility (Format: MM/DD/YYYY to MM/DD/YYYY)*

If you selected Option B ("Alternative Method"), complete the Estimated Allowed Amounts from 7/24/2008 through 10/4/2024, including information for each year, Inpatient Services, and Outpatient Services.
If you selected Option A ("Default Method"), you do not need to complete the Estimated Allowed Amounts below.

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Inpatient Services (IP)									
Outpatient Services (OP)									
	2017	2018	2019	2020	2021	2022	2023	2024	
Inpatient Services (IP)									
Outpatient Services (OP)									

To add information for more Health Care Facilities, use the next page. You may print and use extra copies of the next page as many times as needed to submit information for each Health Care Facility. Remember to include all pages with your Claim Form submission. You may also provide the information requested in an Excel spreadsheet by upload through the Settlement Website or by mailing a thumb drive with your Claim Form.

Health Care Facility Name:

Health Care Facility Type	*Health Care Facility Zip Code*
Billing National Provider Identifier (NPI)	*Billing Tax ID Number (TIN)*
First Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)	*Last Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)*
Does Facility Provide Inpatient Services (IP), Outpatient Services (OP) or Both?	*Time Period for Which Claimant is Submitting Claim on behalf of Health Care Facility (Format: MM/DD/YYYY to MM/DD/YYYY)*

If you selected Option B ("Alternative Method"), complete the Estimated Allowed Amounts from 7/24/2008 through 10/4/2024, including information for each year, Inpatient Services, and Outpatient Services.
If you selected Option A ("Default Method"), you do not need to complete the Estimated Allowed Amounts below.

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Inpatient Services (IP)									
Outpatient Services (OP)									
	2017	2018	2019	2020	2021	2022	2023	2024	
Inpatient Services (IP)									
Outpatient Services (OP)									

Health Care Facility Name:

Health Care Facility Type	*Health Care Facility Zip Code*
Billing National Provider Identifier (NPI)	*Billing Tax ID Number (TIN)*
First Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)	*Last Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)*
Does Facility Provide Inpatient Services (IP), Outpatient Services (OP) or Both?	*Time Period for Which Claimant is Submitting Claim on behalf of Health Care Facility (Format: MM/DD/YYYY to MM/DD/YYYY)*

If you selected Option B ("Alternative Method"), complete the Estimated Allowed Amounts from 7/24/2008 through 10/4/2024, including information for each year, Inpatient Services, and Outpatient Services.
If you selected Option A ("Default Method"), you do not need to complete the Estimated Allowed Amounts below.

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Inpatient Services (IP)									
Outpatient Services (OP)									
	2017	2018	2019	2020	2021	2022	2023	2024	
Inpatient Services (IP)									
Outpatient Services (OP)									