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 July 29, 2025.

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 July 29, 2025 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 at www.BCBSProviderSettlement.com.

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 26443
Richmond, VA 23261

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.

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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.

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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, CareFirst's service area in Virginia, the District of Columbia and Puerto Rico, as well as Health Care Facilities that were not open prior to January 1, 2015.

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 use the Consumer Price Index for hospital and related services to backcast the Allowed Amounts for prior years, forecast the Allowed Amounts for later years and interpolate, assuming linear growth, the Allowed Amounts for years in between years with Allowed Amounts.

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 (888) 452-3095 or by email at Administrator@BCBSProviderSettlement.com.

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.