INSTRUCTIONS REGARDING THE CLAIM FORM FOR THE *SPINEDEX* SETTLEMENT FUND

It is very important that you read the enclosed Notice of Proposed Settlement of Class Action and Final Fairness Hearing ("Notice") in order to fully understand your rights under this Settlement. You have been mailed either a Plan Member or medical provider Claim Form. The Claim Form differs depending on which type of Settlement Class Member you may be.

TO MAKE A CLAIM IN THE SETTLEMENT:

A. IN SECTION A, FILL IN THE INFORMATION REQUESTED REGARDING THE CLAIMANT;

B. IN SECTION B, CHECK THE BOXES NUMBERED 1 THROUGH 4, CERTIFYING THAT YOU ARE A SETTLEMENT CLASS MEMBER WHO MEETS ALL OF THE ELIGIBILITY REQUIREMENTS TO RECEIVE A PAYMENT FROM THE SETTLEMENT FUND;

C. IN SECTION C, YOU MUST COMPLETE A CHART OR CHARTS IDENTIFYING YOUR ESTIMATED RECOGNIZED LOSS;

D. IN SECTION D, FILL IN YOUR TAX IDENTIFICATION NUMBER;

E. IN SECTION E, CERTIFY, SIGN, AND DATE THE CLAIM FORM; AND

F. MAIL IN YOUR COMPLETED CLAIM FORM BY NO LATER THAN MAY 24, 2019.

THE INSTRUCTIONS BELOW GIVE MORE DETAILS ABOUT EACH OF THESE STEPS IN SUBMITTING YOUR CLAIM.

THE DEADLINE FOR CLAIM FORM SUBMISSION: Postmarked by May 24, 2019

YOU SHOULD SEND YOUR CLAIM FORM BY REGISTERED OR CERTIFIED MAIL AND KEEP YOUR RECEIPT AND COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

If you submit a valid Claim Form to the Settlement Administrator postmarked no later than May 24, 2019, you will receive a payment from the Net Settlement Fund to which the Settlement Administrator determines you are entitled. By submitting a Claim Form, you are agreeing to be subject to the jurisdiction of a court of competent jurisdiction for any proceedings relating to your Claim Form. Capitalized terms used in these Claim Form Instructions and Claim Form that are not otherwise defined herein are defined in the Settlement Agreement or the Notice. A copy of the complete Settlement Agreement can be found at: **www.spinedexsettlement.com**.

"Settlement Class" and "Settlement Class Members" are defined in the Settlement Agreement and described in the enclosed Notice.

Mail your completed Claim Form, by May 24, 2019 to the Settlement Administrator at:

Spinedex Class Action Litigation
c/o Settlement Administrator
PO Box 58430
Philadelphia, PA 19102-8430

NOTE: YOU MUST NOTIFY THE SETTLEMENT ADMINISTRATOR IMMEDIATELY OF ANY CHANGE IN YOUR ADDRESS TO AVOID HAVING YOUR MAILED CHECK RETURNED TO THE SETTLEMENT ADMINISTRATOR AND REMITTED TO THE ACADEMIC INSTITUTION PURSUANT TO SECTION III.D. OF THE SETTLEMENT AGREEMENT.

SECTION-BY-SECTION INSTRUCTIONS:

Section A: ALL CLAIMANTS MUST COMPLETE THIS SECTION. Settlement Class Members must include all of the following information:

1. Name of Settlement Class Member (Plan Member or medical provider);
2. Tax I.D. number of Settlement Class Member;
3. Name of representative;
4. Phone number; and
5. Mailing address.

Section B: ALL CLAIMANTS MUST COMPLETE THIS SECTION. To be eligible to receive a payment from the Settlement Fund, you must be a Settlement Class Member and meet certain additional criteria described in the enclosed Notice and in the Settlement Agreement. Claimants must certify their eligibility as follows:

1. Check the box marked "**Settlement Class Member**," certifying that you have reviewed the enclosed Notice and these Claim Form Instructions, and that you are a Settlement Class Member (Plan Member or medical provider) as described and defined in the Notice and in the Settlement Agreement.

2. Check box 2 to certify that you provided or received Out-of-Network Decompression Therapy during the period from March 7, 2002 through April 24, 2019. Plan Members are eligible to receive payment *only if* they certify that they previously paid out of pocket for Decompression Therapy Services in an amount over and above their copay and coinsurance. You must also certify that you are prepared to provide documentation of your payment to the Settlement Administrator if requested. If you are a medical provider with a valid assignment of benefits from a Plan Member, you must certify that you possess such an assignment and are prepared to provide a copy of the assignment to the Settlement Administrator if requested.

3. Check the box marked "**United Denied My Claim**" to certify that you submitted a claim for reimbursement of the Decompression Therapy Services to the United Defendants, and that United issued a "Complete Claim Denial" during the period from March 7, 2002 through April 24, 2019. As described in the enclosed Notice and in the Settlement Agreement, this means that United made no payment whatsoever on your claim.

4. Check the box marked "**Difficulty Appealing United's Decision**" to certify that after the United Defendants denied your claim, you had difficulty understanding and/or completing the procedures for appealing United's decision.

Section C: ALL CLAIMANTS MUST COMPLETE THIS SECTION. In this section, you must complete the chart (or download and complete an additional chart or charts) to determine your Recognized Loss. A chart or charts may be completed only as a Plan Member (Group 1) or a medical provider (Group 2).

You are eligible to claim a Recognized Loss in Group 1 *only* if you are a Plan Member who *paid* to your medical provider any portion of the amount billed by your medical provider above your copayment, coinsurance, or deductible for a Complete Claim Denial of Out-of-Network Decompression Therapy Services received from March 7, 2002 through April 24, 2019.

You are eligible to claim a Recognized Loss in Group 2 *only* if you are a medical provider who provided Out-of-Network Decompression Therapy Services to a Plan Member for which a Complete Claim Denial was received from March 7, 2002 through April 24, 2019. To be eligible for a Recognized Loss in Group 2, the Plan Member must not have paid you for the Out-of-Network Decompression Therapy Services for which you submitted a claim. You are eligible for a Recognized Loss in Group 2 if the Plan Member paid you only a copay, coinsurance, or deductible, or if the Plan Member paid less than the full amount of the claim after accounting for copayments, coinsurance, and deductibles. You are not required to have balance billed the Plan Member to be eligible for a Recognized Loss in Group 2.

For Group 1 and Group 2, 20% of the Recognized Loss will be subtracted to arrive at your eligible payment amount from the Settlement Fund to account for copayments, coinsurance, or deductibles that a Plan Member ordinarily would be responsible for under his/her health plan. All Recognized Losses are rounded to the nearest dollar. If the total amount of valid claims submitted by claimants (Plan Members and medical providers) is greater than the Net Settlement Fund, your Recognized Loss will be paid on a *pro rata* basis.

Section D: ALL CLAIMANTS MUST COMPLETE THIS SECTION. In this Section, you must provide your tax identification number. You must also read the two items in this Section that you are certifying by signing the Claim Form.

Section E: ALL CLAIMANTS MUST COMPLETE THIS SECTION. You must sign and date this Section, which sets forth what you are certifying under penalties of perjury by signing the Claim Form.

IF YOU HAVE QUESTIONS ABOUT THE NET SETTLEMENT FUND OR THE PROCEDURE FOR FILING A CLAIM FORM, CONTACT THE SETTLEMENT ADMINISTRATOR AT 1-844-702-2787.
DO NOT CONTACT THE COURT, THE CLERK OF THE COURT, DEFENDANTS, OR DEFENSE COUNSEL WITH QUESTIONS ABOUT THE SETTLEMENT.