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MUST BE POSTMARKED NO LATER THAN **MAY 24, 2019**

CLAIM FORM FOR *SPINEDEX* SETTLEMENT FUND

PLAN MEMBERS

For Office Use Only

You must read the enclosed Notice of Proposed Settlement of Class Action and Final Fairness Hearing ("Notice") and Claim Form Instructions **before** completing this Claim Form.

The capitalized terms used in this Claim Form are defined in the Notice or in the Settlement Agreement.

SECTION A: CLAIMANT INFORMATION – ALL CLAIMANTS MUST COMPLETE THIS SECTION

_____ _____

Name of Settlement Class Member (Plan Member) *Tax I.D. number of Settlement Class Member*

_____ (___ ___ ___) ___ ___ ___ -- ___ ___ ___ ___

Name of representative *Phone*

_____

Mailing address (street, apartment, P.O. box, suite, or office number, as applicable)

_____ _____ _____

City *State* *Zip code*

SECTION B: CERTIFICATION AS SETTLEMENT CLASS MEMBER WHO IS ELIGIBLE TO RECEIVE PAYMENT – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

To be eligible to receive payment from the Settlement Fund, you must be a Settlement Class Member and meet certain additional criteria described in the enclosed Notice and Claim Form Instructions and in the Settlement Agreement. By checking the boxes numbered 1 through 4 below, you certify that you meet those requirements:

1. □ **Settlement Class Member**. By checking the box to the left, I certify that I have reviewed the enclosed Notice and Claim Form Instructions, and that I am a Settlement Class Member as described and defined in the enclosed Notice and in the Settlement Agreement.

2. □ **Received Decompression Therapy**. By checking the box to the left, I certify that I am a Plan Member who received Out-of-Network Decompression Therapy Services from a medical provider during the period from March 7, 2002 through April 24, 2019. I further certify that I paid out of pocket for those services in an amount over and above my copay and coinsurance, and that I am prepared to provide documentation of payment to the Settlement Administrator if requested.

3. □ **United Denied My Claim**. By checking the box to the left, I certify that during the period from March 7, 2002 through April 24, 2019, I submitted a claim for reimbursement of Out-of-Network Decompression Therapy Services to the United Defendants. I further certify that the United Defendants issued a Complete Claim Denial that I received from March 7, 2002 through April 24, 2019, making no payment whatsoever on my claim.

4. □ **Difficulty Appealing United's Decision**. By checking the box to the left, I certify that after the United Defendants denied my claim for Decompression Therapy Services, I had difficulty understanding and/or completing the procedures for appealing that decision under the terms of my Plan.

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SECTION C: ESTIMATION OF RECOGNIZED LOSS – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

To be eligible to receive a payment from the Settlement Fund, you must complete the chart (or download and complete an additional chart or charts) below to determine your Recognized Loss. A chart on this form may be completed only as a Plan Member (Group 1).

IF YOU ARE A MEDICAL PROVIDER (GROUP 2), DO NOT COMPLETE THIS FORM. Visit the website for the correct form.

GROUP 1
(To be completed by Plan Members only)

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 submitted from March 7, 2002 through April 24, 2019.

Date of Decompression Therapy	Name of provider and patient	Name of private sector employer-sponsored health plan	Amount that you paid to your medical provider
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __

Chart continues on next page.

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Date of Decompression Therapy	Name of provider and patient	Name of private sector employer-sponsored health plan	Amount that you paid to your medical provider
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __
__ __ / __ __ / __ __ __ __	Name of provider Name of patient		$__ __ , __ __ __ __ . __ __

Additional chart available at www.SpinedexSettlement.com

Total:

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

On the line below, enter the tax identification number of the claimant whose name will appear on any check and related Form-1099.

_____
Tax identification number

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. The IRS does not require your consent to any provision of this document other than the certifications in Section D that are required to avoid backup withholding.

SECTION E: CERTIFICATION – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

I do declare and certify, under penalties of perjury, as follows:

- I am a Settlement Class Member.
- All of the statements and information provided in this Claim Form are true, correct, and complete to the best of my knowledge.
- I understand that the IRS does not require my consent to any provision of this document other than the certifications in Section D that are required to avoid backup withholding.

_____	_____	_____
Signature	Printed name	Date

Claims should be sent to the Settlement Administrator at:
Spinedex Class Action Litigation
c/o Settlement Administrator
PO Box 58430
Philadelphia, PA 19102-8430

YOU MUST COMPLETE AND SIGN THIS CLAIM FORM, AND THE ENVELOPE RETURNING YOUR CLAIM FORM MUST BE MAILED TO THE SETTLEMENT ADMINISTRATOR WITH A POSTMARK DATE *NO LATER THAN* MAY 24, 2019.

IF YOUR SIGNED CLAIM FORM IS NOT MAILED TO THE SETTLEMENT ADMINISTRATOR BY THIS DEADLINE, YOU WILL BE DEEMED TO HAVE WAIVED YOUR RIGHT TO RECEIVE ANY PAYMENT FROM THE SETTLEMENT FUND.

YOUR CLAIM FORM SHOULD BE SENT VIA REGISTERED OR CERTIFIED MAIL AND YOU SHOULD KEEP YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

If you have any questions, please call 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.