In re: NorthShore University HealthSystem Antitrust Litigation

INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR CLAIM FORM

A Third-Party Payor ("TPP") member of the Class or an authorized agent can complete this Claim Form. If both a member of the Class and its authorized agent submit a Claim Form, the Notice and Claims Administrator will only consider the member of the Class's Claim Form. The Notice and Claims Administrator may ask for supporting documents in addition to the documents and information requested below. The Notice and Claims Administrator may reject a claim if the TPP member of the Class or their authorized agent does not provide all requested documents in a timely manner.

If you are a member of the Class submitting a Claim Form on your own behalf, complete "**Section A – COMPANY OR HEALTH PLAN MEMBER OF THE CLASS ONLY**." Do not complete Section B. Complete Sections C-E of the Claim Form and provide any other required information.

If you are an **authorized agent** of one or more members of the Class, complete "**Section B – AUTHORIZED AGENT ONLY**." **Do not submit a Claim Form for any member of the Class unless that member of the Class previously authorized you to submit the Claim Form on their behalf.** Do not complete Section A. Complete Sections C-E of the Claim Form and provide any other required information.

If you are submitting a Claim Form only as an authorized agent of one or more members of the Class, you may submit a separate Claim Form for each member of the Class OR you may submit one Claim Form for all such members of the Class if you provide the required information for each member of the Class for whom you are submitting the form.

If you are submitting Claim Forms on both your own behalf as a member of the Class AND as an authorized agent of one or more members of the Class, you should submit one Claim Form for yourself, completing Section A, and another Claim Form or Forms as an authorized agent for the other member(s) of the Class, completing Section B.

To qualify to receive a payment from the Settlement, you must complete and submit this Claim Form. You can submit your Claim Form by mail or electronically on the Settlement website (www.NorthShoreAntitrustLitigation.com). You may need to provide documents to verify your claim.

If you do not complete and submit your Claim Form postmarked or filed online by **April 4, 2024**, you will not get a payment from this Settlement. Submitting a Claim Form does not guarantee you will get a payment from the Settlement. If the Notice and Claims Administrator rejects or reduces your claim, you may follow the dispute resolution process described on pages 5-6.

CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS

Please provide the following information to support your claim that from February 10, 2000, to December 31, 2015, you (or the member(s) of the Class you represent) purchased or paid directly to NorthShore University HealthSystem (formerly known as Evanston Northwestern Healthcare) ("NorthShore") for inpatient hospital services, its wholly-owned hospitals, predecessors, subsidiaries, or affiliates other than those acquired as a result of the merger with Rush North Shore Medical Center in the United States of America and Puerto Rico:

a) Unique patient identification number or code

b) Date of Service – *e.g.*, 06/01/2012

c) Hospital Location of Service – *e.g.*, Highland Park Hospital, Evanston Hospital, or Glenbrook Hospital

d) Amount Billed (not including dispensing fee) – *e.g.*, $1,500.00

e) Amount Paid by TPP net of co-pays, deductibles, and co-insurance – *e.g.*, $1,200.00

If you are submitting a Claim Form on behalf of multiple members of the Class, also provide the following information for each prescription:

f) Plan or Group Name

g) Plan or Group FEIN – provide group number for each transaction

For your convenience, an exemplar spreadsheet containing these categories is available and can be downloaded from the website, www.NorthShoreAntitrustLitigation.com. Please use this format if possible. Please provide the electronic data in Microsoft Excel, ASCII flat file pipe "|", tab-delimited, or fixed-width format.

Please provide as much of the information requested above as possible. For claims of $300,000 or more, transaction data is mandatory. If your claim is for $300,000 or more, you must provide transaction data to support your claim. The Notice and Claims Administrator may also require you to provide transaction data for claims of less than $300,000. It is important to keep any related transaction data and other documents that support your claim (*e.g.*, invoices) in case the Notice and Claims Administrator requests additional information. If your claim is for less than $300,000, please provide the transaction data with your claim submission now (if you can).

If the Notice and Claims Administrator still has questions about your claim after it is audited, and you did not provide enough information or documents to verify your claim, the Notice and Claims Administrator may reject your claim.

Please contact the Notice and Claims Administrator at 1-800-952-3716 with any questions about the required claims information or documents.

MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY, APRIL 4, 2024

NorthShore University HealthSystem Antitrust Litigation

THIRD-PARTY PAYOR CLAIM FORM

Use Blue or Black Ink Only

Attention: This form should only be filled out on behalf of a Third-Party Payor (or an authorized agent). If you are a Consumer, please fill out the Consumer Claim Form, available at www.NorthShoreAntitrustLitigation.com.

- Complete Section A only if you are filing as an individual TPP member of the Class.
- Complete Section B only if you are an authorized agent filing on behalf of one or more TPP Class Members.

Section A: Company or Health Plan Member of the Class Only

Company or Health Plan Name

Contact Name

Address 1

Address 2

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since February 10, 2000.

☐ Health Insurance Company/HMO ☐ Self-Insured Employee Health or Pharmacy Benefit Plan

☐ Self-Insured Health & Welfare Fund

☐ Other (Explain):

Section B: Authorized Agent Only

As an authorized agent, please check how your relationship with the member(s) of the Class is best described: (You may need to provide documents demonstrating your relationship.)

☐ Third-Party Administrator or Administrative Services Only Provider

☐ Pharmacy Benefits Manager

☐ Other (Explain): _____

Authorized Agent's Company Name

_____

Contact Name

_____

Address _____ Floor/Suite _____

City _____ State _____ Zip Code _____

Area Code - Telephone Number _____ Authorized Agent's Tax Identification Number _____

Email Address

_____

Please list the name and FEIN of every member of the Class (*i.e.,* company or health plan) for whom you were authorized to submit this Claim Form. (Attach additional sheets to this Claim Form as needed.) Alternatively, you may submit the requested list of members of the Class's names and FEINs in an electronic format, such as in an Excel or a tab-delimited text file. Please contact the Notice and Claims Administrator to determine what formats are acceptable.

MEMBER OF CLASS'S NAME	MEMBER OF CLASS'S FEIN

Section C: Purchase Information

Please provide the total amount paid directly to NorthShore for inpatient hospital services, its wholly-owned hospitals, predecessors, subsidiaries, or affiliates other than those acquired as a result of the merger with Rush North Shore Medical Center, from February 10, 2000, to December 31, 2015, in the United States of America and Puerto Rico.

Total Amount Paid:	$

Authorized Agents Only: For each member of the Class for whom you are submitting this Claim Form, please provide the above information for purchases made by the member of the Class's members, employees, insureds, participants, or beneficiaries.

Section D: Proof of Payment and Disputes Regarding Claim Amounts

Please provide as much of the information requested in the "CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS" section in the instructions as possible.

If your claim is for $300,000 or more, you must provide transaction data to support your claim; it is mandatory. The Notice and Claims Administrator may also require you to provide transaction data for claims of less than $300,000. Keep any related transaction data and other documents that support your claim (*e.g.*, invoices) in case the Notice and Claims Administrator requests additional information. If your claim is for less than $300,000, please provide the transaction data with your claim submission now (if you can).

If the Notice and Claims Administrator still has questions about your claim after it is audited, and you did not provide enough information or documents to verify your claim, the Notice and Claims Administrator may reject your claim.

If the Notice and Claims Administrator rejects or reduces your claim and you believe the rejection or reduction is in error, you may contact the Notice and Claims Administrator to request further review. If the dispute concerning your claim cannot be resolved by the Notice and Claims Administrator and Lead Counsel, you may ask the Court to review your claim.

Section E: Certification

I have read and am familiar with the content of the Instructions accompanying this Claim Form. I certify that the information I provided in this Claim Form and in any documents attached by me are true, correct, and complete to the best of my knowledge. I certify that I, or the member(s) of the Class I represent, are located within the United States or Puerto Rico and purchased or paid for inpatient hospital services directly from NorthShore University HealthSystem (formerly known as Evanston Northwestern Healthcare), its wholly-owned hospitals, predecessors, subsidiaries, or affiliates other than those acquired as a result of the merger with Rush North Shore Medical Center from February 10, 2000, to December 31, 2015.

I further certify that I, or the member(s) of the Class I represent, did not ask to be excluded ("opt out") from the Class in this lawsuit and did not submit a claim for the following: (i) Self-insured entities and businesses which paid NorthShore through third-party claims administrators acting on their behalf; (ii) Government entities; (iii) NorthShore and its present and former parents, predecessors, subsidiaries, and affiliates; (iv) Other healthcare services providers and their present and former parents, predecessors, subsidiaries, and affiliates; (v) Other healthcare service providers who purchased or paid for inpatient hospital services directly from NorthShore, its wholly-owned hospitals, predecessors, subsidiaries, or affiliates (other than those acquired from the merger with Rush North Shore Medical Center); or (vi) Certain insurance companies required to arbitrate their claims, and Present and former parents, predecessors, subsidiaries, and/or affiliates of NorthShore.

I further certify that I have provided all the requested information to the extent I have it.

I further certify that I, and the member(s) of the Class I represent, have read and are familiar with the releases stated in paragraph 10 of the Settlement Agreement and understand that by staying in the Class they give up their rights and can no longer sue or participate in any lawsuit against the Defendant in the future about the claims resolved in this lawsuit.

To the extent I was authorized to submit this Claim Form by one or more members of the Class on their behalf, and am submitting this Claim Form as an authorized agent, and to the extent I was authorized to receive any and all amounts from the Settlement Fund that may be allocated to these members of the Class on their behalf, I certify that such authority has been properly vested in me and I will fulfill all duties I may owe the member(s) of the Class. If amounts from the Settlement Fund are distributed to me, and a member of the Class later claims that I did not have the authority to claim and/or receive such amounts on its behalf, I and/or my employer will hold the Class, Lead Counsel, and the Notice and Claims Administrator harmless with respect to any claims made by the member of the Class.

I hereby submit to the jurisdiction of the United States District Court for the Northern District of Illinois, Eastern Division for all purposes connected with this Claim Form, including resolving disputes related to this Claim Form. I acknowledge that if I provided any false information or representations related to this claim, I may be subject to sanctions, including criminal prosecution. If the Notice and Claims Administrator requests additional supporting documents to supplement this Claim Form and the information in it, I agree to provide them.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge, and this Claim Form was signed this _____ day of _____ 2024.

Signature

Position/Title

Print Name

Date

Mail your completed Claim Form, along with any supporting documents as described in the CLAIM INFORMATION AND DOCUMENTATION INSTRUCTIONS on pages 1-2 above, to the address below postmarked no later than **April 4, 2024**, or submit the information online at the website below by that date:

NorthShore Antitrust Litigation
c/o A.B. Data, Ltd.
P.O. Box 170990
Milwaukee, WI 53217
Toll-Free Telephone: 1-800-952-3716
Website: www.NorthShoreAntitrustLitigation.com

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form or complete the online Claim Form. Attach or upload any documents that support your claim.
2. Keep a copy of your Claim Form and supporting documents for your records.
3. If you would also like a receipt acknowledging your Claim Form was received, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.
4. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Notice and Claims Administrator at info@NorthShoreAntitrustLitigation.com or via U.S. Mail at the address above.