

Settlement Administrator  
PO Box 3240  
Portland, OR 97208-3240

*The Shane Group, Inc. v. Blue Cross Blue Shield of Michigan*  
No. 2:10-cv-14360  
U.S. District Court for the Eastern District of Michigan

**CONSUMER CLAIM FORM**

If you are an individual who paid a general acute care hospital in Michigan for healthcare services at any time between January 1, 2006 and June 23, 2014, you are a member of the Settlement Class in a lawsuit against Blue Cross Blue Shield Michigan (“BCBSM”) and are entitled to submit a claim to share in the Settlement money. You do not need to be a BCBSM customer to be eligible. A list of the relevant hospitals is attached to this form.

If you wish to submit a claim, complete this form and mail it, postmarked on or before **November 3, 2018**, to the address below. You may also complete the Claim Form electronically at [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com) on or before **November 3, 2018**. If you submitted a claim in 2014 for the earlier settlement in this lawsuit, that claim will be processed for the new Settlement, and you do not need to submit another claim.

Your claim will be reviewed to determine whether or not you are entitled to payment and the amount of any payment. More information, including details on how payments are determined, is available at [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com) or by writing, emailing, or calling the Settlement Administrator. Questions about your claim can be sent to the Settlement Administrator at the address below or by emailing [info@MichiganHospitalPaymentsLitigation.com](mailto:info@MichiganHospitalPaymentsLitigation.com), or calling (877) 846-0588.

You may not share in the Settlement Fund if you exclude yourself from the Settlement. BCBSM, related corporate entities, and BCBSM’s officers, directors, employees, agents, and attorneys are not eligible to share in the Settlement money and are excluded from the Settlement Class. Under the terms of the Amended Settlement Agreement, the Class also does not include any person or entity who released BCBSM from liabilities related to the contract clauses at issue in this case.

**Please mail your claim to:** Settlement Administrator  
PO Box 3240  
Portland, OR 97208-3240

**Questions?**

Call Toll-Free (877) 846-0588 or Visit [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com)

**SECTION A: CLAIMANT INFORMATION**

First Name:

MI:

Last Name:

Grid for First Name (18 boxes)

Grid for MI (1 box)

Grid for Last Name (18 boxes)

(Please write the Claimant Name as you would like it to appear on the check, if eligible for payment.)

Street Address:

Grid for Street Address (28 boxes)

City:

State:

ZIP Code:

Grid for City (18 boxes)

Grid for State (2 boxes)

Grid for ZIP Code (5 boxes)

Telephone Number:

Grid for Telephone Number (3-3-4 format)

Email Address:

Grid for Email Address (30 boxes)

(By providing an email address, you are authorizing the Settlement Administrator to provide you with information relevant to your claim via email.)

The Settlement Administrator will use this information for all communications relevant to this claim (including the check, if eligible for payment). If your contact information changes, you **MUST** notify the Settlement Administrator in writing at the mailing or email address above.

**SECTION B: REPRESENTATIVE CONTACT INFORMATION**

Please indicate whether you are filing on your own behalf as a Class Member or as the authorized representative of someone else who is a Class Member:

I am the Class Member named in Section A above.  
(If so, you may skip the rest of this section.)

I am filing on behalf of the Class Member named in Section A above.

If you are filing on behalf of a Class Member, state your relationship to the Class Member (e.g., family member, attorney, etc.):

Grid for relationship (28 boxes)

Representative Name:

Grid for Representative Name (28 boxes)

Street Address:

Grid for Street Address (28 boxes)

City:

State:

ZIP Code:

Grid for City (18 boxes)

Grid for State (2 boxes)

Grid for ZIP Code (5 boxes)

Telephone Number:

Grid for Telephone Number (3-3-4 format)

Email Address:

Grid for Email Address (30 boxes)

(By providing an email address, you are authorizing the Settlement Administrator to provide you with information relevant to your claim via email.)

Questions?

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## **SECTION C: YOUR HOSPITAL HEALTHCARE PAYMENTS**

To make a claim, you must complete and sign this form, stating all eligible hospital healthcare payments that you wish to be included in your claim by completing **either** Claim Table A **or** Claim Table B below, but **not** both.

Use Claim Table A below if you have records that show the amounts you paid the hospital for your hospital visits. Claim Table A requires you to state the amount you paid the hospital for each hospital visit.

Use Claim Table B below if you do not have records that show the amounts you paid the hospital for your hospital visits, and you wish to accept a payment based on a default amount of your hospital payments instead of the actual amount of your hospital payments. Claim Table B can be completed without knowing the amounts you paid the hospital for your hospital visits. The default amount is \$50 per outpatient hospital visit and \$414 per inpatient hospital visit. These are the payment amounts that you will be credited with in calculating your pro rata share of the Settlement money. These are **not** the amounts you will receive from the Settlement. The amount you receive, if your claim is valid, will be substantially less.

If you submitted a claim form for the earlier settlement, and:

- The amount of purchases you claimed is less than or equal to \$50, you will be credited for this Settlement with \$50 in purchases.
- The amount of purchases you claimed is greater than \$50 but less than \$414, you will be credited for this Settlement with \$414 in purchases.
- The amount of purchases you claimed is more than \$414, you will be credited for this Settlement with the amount of purchases you claimed.

### **Instructions for Completing Claim Table A**

If you have records that show the amounts you paid the hospital for your hospital visits, you should complete Claim Table A below, following these instructions.

Please list each hospital from the following list that you paid for healthcare services, the date(s) the hospital provided the services, the amount(s) you paid to the hospital, and the insurance company, if any, that provided insurance coverage for your hospital care. You may include only payments for hospital healthcare services provided between January 1, 2006 and June 23, 2014. You may include all payments that you (and **not** your insurer) made to the hospital. These could be co-payments, co-insurance payments, deductible payments, or other payments you made to the hospital. You may include amounts you paid to the hospital even if an insurer or self-insured entity reimbursed you.

Do not include the following:

- Purchases from a hospital pharmacy
- Payments that you made to your insurer or any entity other than a hospital
- Payments that your insurer or any other entity made to the hospital

If you are submitting your claim online, you can either fill out Claim Table A on the website or attach a spreadsheet or other file containing the information required by Claim Table A.

If you are submitting your claim by mail and need additional room, you may attach additional pages. Please number all additional pages to ensure review.

Your claim will be reviewed to determine whether or not you are entitled to a payment. Submission of a claim does not guarantee that you will receive a payment, and does not guarantee that the full amount of purchases claimed will be accepted.

**You may be asked for more information at a later time to validate your claim. For example, you may be asked for hospital invoices, payment checks, and/or credit card statements. You should save any proof of your hospital purchases that you may have. Your claim may be rejected if any requested information is not provided.**

If you complete Claim Table A, do not complete Claim Table B.

**Questions?**

Call Toll-Free (877) 846-0588 or Visit [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com)

## CLAIM TABLE A

(Please list separate visits on separate rows.)

<u>Hospital</u> <small>(use code from list)</small>	<u>Date(s) of Hospital Services</u> <small>(mm/dd/yyyy)</small>	<u>Amount You Paid to the Hospital</u> <small>(in dollars)</small>	<u>Insurance Company</u> <small>(use code from list)</small>
<b>Total:</b>			

**When completing the above table, please use the corresponding code from the below chart for the hospital and insurance company affiliated with each claimed purchase.**

**Questions?**

**Call Toll-Free (877) 846-0588 or Visit [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com)**

## Instructions for Completing Claim Table B

If you do not have records that show the amounts you paid the hospital for your hospital visits, and you wish to accept a default amount, instead of the actual amount, of your hospital payments, you should complete Claim Table B below, following these instructions.

Please list each hospital from the following list that you paid for healthcare services, the year the hospital provided the services, whether you received inpatient or outpatient services, and the insurance company, if any, that provided insurance coverage for your hospital care. You may include only hospital visits between January 1, 2006 and June 23, 2014.

If you are submitting your claim online, you can either fill out Claim Table B on the website or attach a spreadsheet or other file containing the information required by Claim Table B.

If you are submitting your claim by mail and need additional room, you may attach additional pages. Please number all additional pages to ensure review.

Your claim will be reviewed to determine whether or not you are entitled to a payment. Submission of a claim does not guarantee that you will receive a payment.

**You may be asked for more information at a later time to validate your claim. For example, you may be asked for hospital invoices, payment checks, and/or credit card statements. You should save any proof of your hospital purchases that you may have. Your claim may be rejected if any requested information is not provided.**

If you complete Claim Table B, do not complete Claim Table A.

**Questions?**

**CLAIM TABLE B**  
(Please list separate visits on separate rows.)

<u>Hospital</u> (use code from list)	<u>Year of Hospital Services</u>	<u>Inpatient or Outpatient</u>	<u>Insurance Company</u> (use code from list)
<b>Total:</b>			

**When completing the above table, please use the corresponding code from the below chart for the hospital and insurance company affiliated with each claimed purchase.**

**Questions?**

Call Toll-Free (877) 846-0588 or Visit [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com)

**Section D: YOUR SHARE OF THE SETTLEMENT MONEY, IF ANY**

Your share of the settlement money, if any, will depend on the hospital(s) you paid, the date(s) the hospital provided the services, the amount of your payment(s), and the number of others who submit a valid Claim Form, and the amount of their hospital payments. For more information, please review the Plan of Allocation, which is located on the website [www.MichiganHealthcarePaymentsLitigation.com](http://www.MichiganHealthcarePaymentsLitigation.com) as an exhibit to the Amended Settlement Agreement, or contact the Settlement Administrator at:

**Settlement Administrator**  
**PO Box 3240**  
**Portland, OR 97208-3240**  
Email Address: [info@MichiganHospitalPaymentsLitigation.com](mailto:info@MichiganHospitalPaymentsLitigation.com)

**Section E: CONFIDENTIALITY**

All information you submit will be kept confidential by the Settlement Administrator and Class Counsel. It will not be used for any purpose other than administering your claim and determining the amount, if any, of your payment. It will not be disclosed to BCBSM, the Plaintiffs, or any entity other than the Settlement Administrator and Class Counsel, and potentially the Court, under seal, if the Court needs to resolve a dispute concerning your claim. All documents you provide will be destroyed after all claims are finally resolved.

**Section F: RELEASE**

If you are a Settlement Class Member and do not timely and validly request to be excluded from the Settlement, and the Settlement receives Final Approval, you will release and discharge forever all Released Claims against BCBSM and related entities and individuals, whether or not you submit a Claim Form. For more information, see Paragraphs 58-59 of the Amended Settlement Agreement, available at [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com).

**Section G: CLAIMANT CERTIFICATION AND SIGNATURE**

**I hereby certify under penalty of perjury that:**

1. The information I provided in this Claim Form is true and accurate to the best of my knowledge, information, and belief.
2. I am a member of the Settlement Class and did not request to be excluded from the Settlement; or, I have been authorized by the Claimant to file a claim on his or her behalf, and the Claimant is a member of the Settlement Class and did not request exclusion.
3. I have read and agree to the Release in Paragraphs 58-59 of the Amended Settlement Agreement.
4. I understand that I may be asked to provide additional information to validate my claim, and that my claim may be denied if I am unable to provide the requested information.
5. I have not assigned or transferred (or purported to assign or transfer) or submitted any other claim for the same hospital payments and have not authorized any other person or entity to do so and know of no other person or entity having done so on the Claimant's behalf.
6. In the event that the Claimant later claims that I did not have the authority to claim or receive payments from the Settlement Fund on its behalf, I and/or my employer will indemnify and hold the parties, their counsel, and the Settlement Administrator harmless with respect to such claims.

Signature

Date   -   -    
MM DD YY

Type/Print Name:

Claimant Name (if different than above):

**ACCURATE PROCESSING OF CLAIMS MAY TAKE SIGNIFICANT TIME.  
THANK YOU IN ADVANCE FOR YOUR PATIENCE.**

**Questions?**

Call Toll-Free (877) 846-0588 or Visit [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com)

Code	Hospital Name
01-25	Allegan General Hospital
02-18	Allegiance Health
03-31	Alpena Regional Medical Center
04-40	Ascension Borgess-Lee Memorial Hospital
05-33	Ascension Borgess Medical Center
06-32	Ascension Borgess-Pipp Hospital
07-42	Ascension Genesys Regional Medical Center
08-50	Ascension Providence Hospital and Medical Centers
09-40	Ascension Providence Park Hospital–Novi
10-47	Ascension St. John Hospital and Medical Center
11-59	Ascension St. John Macomb-Oakland Hospital–Macomb Center
12-41	Ascension St. John North Shores Hospital
13-43	Ascension St. John River District Hospital
14-58	Ascension St. Mary's of Michigan Medical Center–Saginaw
15-59	Ascension St. Mary's of Michigan Medical Center–Standish
16-36	Ascension St. Joseph Hospital–Tawas
17-28	Aspirus Grand View Hospital
18-26	Aspirus Keweenaw Hospital
19-27	Aspirus Ontonagon Hospital
20-32	Baraga County Memorial Hospital
21-23	Bell Memorial Hospital
22-18	Botsford Hospital
145-20	Bronson Battle Creek
23-26	Bronson LakeView Hospital
75-26	Bronson Methodist Hospital
24-27	Bronson Vicksburg Hospital
25-24	Caro Community Hospital
26-25	Charlevoix Area Hospital
27-28	Cheboygan Memorial Hospital
76-37	Chippewa County War Memorial Hospital
28-41	Community Health Center of Branch County
29-32	Community Hospital–Watervliet
30-24	Covenant Medical Center
77-19	Crittenton Hospital
31-31	Deckerville Community Hospital
32-35	Dickinson County Memorial Hospital
78-38	DMC–Children's Hospital of Michigan
79-62	DMC–Detroit Receiving Hospital and University Health Center
80-59	DMC–Harper University Hospital & Hutzel Women's Hospital
81-34	DMC–Huron Valley Sinai Hospital
82-27	DMC–Sinai-Grace Hospital

Code	Insurance Provider
A-1	Aetna PPO
B-2	BCBSM Non-HMO (inpatient claims only)
C-3	HAP HMO (inpatient claims only)
D-4	HAP PPO
E-5	Priority PPO
F-6	Priority HMO
G-7	None of the Above

Code	Hospital Name
83-29	Doctors' Hospital of Michigan
33-28	Eaton Rapids Medical Center
84-28	Forest Health Medical Center
85-20	Garden City Hospital
34-32	Harbor Beach Community Hospital
35-36	Hayes Green Beach Memorial Hospital
36-28	Helen Newberry Joy Hospital
86-27	Henry Ford Cottage Hospital
87-19	Henry Ford Hospital
88-26	Henry Ford Macomb Hospital
89-40	Henry Ford Macomb Hospital–Warren Campus
90-35	Henry Ford West Bloomfield Hospital
91-29	Henry Ford Wyandotte Hospital
37-31	Hills & Dales General Hospital
92-33	Hillsdale Community Health Center
93-16	Holland Hospital
94-21	Hurley Medical Center
38-21	Huron Medical Center
39-41	Kalkaska Memorial Health Center (Munson)
95-22	Karmanos Cancer Center
96-42	Lakeland Hospitals at Niles and St. Joseph
40-44	Mackinac Straits Hospital and Health Center
41-27	Marlette Regional Hospital
42-32	Marquette General Health System
43-27	McKenzie Memorial Hospital
97-35	McLaren Bay Regional Medical Center
98-43	McLaren Central Michigan Community Hospital
99-56	McLaren Ingham Regional Medical Center (Greater Lansing)
100-38	McLaren Lapeer Regional Medical Center
101-45	McLaren Mount Clemens Regional Medical Center
102-43	McLaren Northern Michigan Regional Hospital
103-35	McLaren POH Regional Medical Center
104-31	McLaren Regional Medical Center
105-29	Mecosta County Medical Center

Questions?



106-28	Memorial Healthcare (Owosso)
44-41	Memorial Medical Center of West Michigan
107-30	Mercy Memorial Hospital System
45-22	Metro Health Hospital
46-35	MidMichigan Medical Center–Clare
47-37	MidMichigan Medical Center–Gladwin
48-37	MidMichigan Medical Center–Gratiot
50-37	MidMichigan Medical Center–Midland
51-27	Munising Memorial Hospital
52-22	Munson Medical Center
108-31	North Ottawa Community Hospital
53-24	Northstar Health System
109-25	Oakland Regional Hospital
110-16	Oaklawn Hospital
111-26	Oakwood Annapolis Hospital
112-25	Oakwood Heritage Hospital
113-42	Oakwood Hospital & Medical Center–Dearborn
114-33	Oakwood Southshore Medical Center
115-24	OSF St. Francis Hospital
54-25	Otsego Memorial Hospital
55-39	Paul Oliver Memorial Hospital (Munson)
56-17	Pennock Hospital
116-19	Port Huron Hospital
57-24	Portage Health Hospital
117-33	ProMedica–Bixby Medical Center
58-36	ProMedica–Herrick Medical Center
59-18	Scheurer Hospital
60-30	Schoolcraft Memorial Hospital
61-28	Sheridan Community Hospital
62-31	South Haven Community Hospital
118-36	Southeast Michigan Surgical Hospital
119-28	Sparrow Carson City Hospital
63-25	Sparrow Clinton Hospital
64-17	Sparrow Hospital
65-23	Sparrow Ionia Hospital
120-27	Spectrum Health–Butterworth
121-31	Spectrum Health Gerber Memorial
66-32	Spectrum Health Kelsey Hospital
67-35	Spectrum Health Reed City Hospital
122-31	Spectrum Health United Hospital
123-35	Spectrum Zeeland Community Hospital
124-36	Straith Hospital for Special Surgery
125-16	Sturgis Hospital
68-20	Three Rivers Health

126-34	Trinity Chelsea Community Hospital
127-33	Trinity Mercy Hospital–Cadillac
128-33	Trinity Mercy Hospital–Grayling
129-26	Trinity MHP–Hackley Campus
130-24	Trinity MHP–Mercy Campus
69-35	Trinity MHP Mercy–Lakeshore Campus
131-34	Trinity St. Joseph Mercy–Ann Arbor
132-35	Trinity St. Joseph Mercy–Livingston
133-32	Trinity St. Joseph Mercy–Oakland
134-35	Trinity St. Joseph Mercy–Port Huron
135-31	Trinity St. Joseph Mercy–Saline
136-30	Trinity St. Mary Mercy–Livonia
137-43	Trinity St. Mary's Health Care–Grand Rapids
138-36	University of Michigan Health System
139-33	VA–Aleda E Lutz Medical Center
140-33	VA–Ann Arbor Healthcare System
141-33	VA–Battle Creek Medical Center
142-34	VA–Iron Mountain Medical Center
143-35	VA–John D. Dingell Medical Center
144-35	West Branch Regional Medical Center
70-26	West Shore Medical Center
71-40	William Beaumont Hospital–Grosse Pointe
72-36	William Beaumont Hospital–Royal Oak
73-31	William Beaumont Hospital–Troy
74-17	None of the Above

Questions?

09-CA8356 Call Toll-Free (877) 846-0588 or Visit [www.MichiganHospitalPaymentsLitigation.com](http://www.MichiganHospitalPaymentsLitigation.com)

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