MUST BE POSTMARKED ON OR BEFORE APRIL 1, 2019

Lehman v. Health Net of California, Inc.
c/o GCG
P.O. Box 10573
Dublin, Ohio 43017-7273

LVH

APPEAL FORM

Rebecca Lehman, et al. vs. Health Net of California, Inc., et al.,
Los Angeles Superior Court Case No. BC567361

INSTRUCTIONS

If you disagree with your claim's denial and would like to appeal, please complete this form.

For more information about the settlement, you can visit www.NetworkSettlement.com, or call toll-free at 1 (888) 264-1304.

SUBMIT APPEAL FORM TO CLAIMS ADMINISTRATOR:

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APPEALS THAT MAY BE SUBMITTED

"Out-of-Pocket Expenses" that you may submit an appeal for include:

(1) Amounts that you paid for medical services provided by Out-of-Network Medical PPO Professional(s) in 2014 that would otherwise have been covered services.

(2) Amounts that you have not paid but that have been the subject of active collection efforts within the last 90 days.

"Out-of-Pocket Expenses" do not include:

(1) Your in-network cost sharing responsibility (if any) on the claim had it been processed as in-network (for example, your in-network deductible and co-pay/coinsurance).

(2) Expenses that have been covered or reimbursed by any third-party payor, entity, health care service plan, insurance contract, or from the proceeds of any judgment or settlement.

(3) Expenses that have been released, written off, discharged, or barred, or for which the medical professional has ceased collection efforts.

REQUIRED DOCUMENTATION

For medical bills you have already paid, you must submit documentation: (1) identifying the medical service(s) provided in 2014 by an Out-of-Network Medical Professional(s) for which you seek payment, and (2) the amount you paid for the medical service(s).

Along with your completed appeal form, please submit documentation, especially any information not previously submitted:

1. Identifying the medical service provided in 2014 by an Out-of-Network Medical PPO Professional(s) for which you seek payment.

   i. This information may be provided on this appeal form by providing the date of the service and a brief description of the service provided; or

   ii. You may provide a bill for services from the medical professional which includes the date of service or an Explanation of Benefits ("EOB") you received from Health Net.[1]

and,

2. Providing proof of the amount you paid for the medical service on or before April 9, 2018:

   i. Cancelled check(s) that correspond to a bill for covered service(s); or

   ii. Receipts from the medical professional(s); or

   iii. Credit card statements reflecting your payment to the medical professional(s);or

   iv. A written communication from the medical professional(s) acknowledging receipt of a payment for a specific amount on or before April 9, 2018.

[1] If you do not have a copy of your EOB, you may call 1 (888) 264-1304 to request one.

For medical bills you have <u>not</u> already paid but that have been the subject of active collection efforts within the last 90 days, you must submit the following documentation to show that a bill has not been paid in full and has not been written off by the collection agency or medical professional(s):

1. A written communication or a bill for services from the medical professional(s) dated on or after January 9, 2018 demanding payment of unpaid medical bills;

<u>or</u>

2. A collection notice dated on or after January 9, 2018.

Health Net and the Claims Administrator will review all information on this appeal form. Appeals with incomplete or inaccurate information will be rejected.

<u>REQUIRED INFORMATION</u>

To ensure that your claim form is properly processed, please provide the following information. All information submitted will be subject to verification. Your claim form WILL NOT BE processed unless you provide this information:

Claimant's Name:

Claimant's Health Net ID Number:

Claimant's Daytime Telephone Number: ( ) -

Claimant's Date of Birth: / /

If your address has changed or corrections need to be made to the address on file (which is pre-printed on page 1), please provide the following information:

Name:

Address:

City: State: ZIP:

Your Telephone Number: ( ) -

Please provide the basis of the appeal for each medical service for which you seek reimbursement. You may make copies of this page to accommodate additional medical services. **Please also include the required documentation listed above with your appeal form.**

Professional's Name:

Professional's Address:

City: State: ZIP:

Date of Service: / / Amount You Paid:

Please briefly summarize the basis of your appeal in the box below:

Professional's Name:

Professional's Address:

City: State: ZIP:

Date of Service: / / Amount You Paid:

Please briefly summarize the basis of your appeal in the box below::

Professional's Name:

Professional's Address:

City: State: ZIP:

Date of Service: / / Amount You Paid:

Please briefly summarize the basis of your appeal in the box below:

I attest that the foregoing is true and correct to the best of my knowledge.

Signature of Claimant or Representative: Date: / /

Printed Name of Claimant: