

SETTLEMENT AGREEMENT

dated as of

May 21, 2003

by and among

AETNA INC.,

THE REPRESENTATIVE PLAINTIFFS,

THE SIGNATORY MEDICAL SOCIETIES

AND CLASS COUNSEL

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List of Exhibits:

Exhibit A	Form of Claim Form
Exhibit B	List of Class Counsel
Exhibit C	Form of Compliance Dispute Review Form
Exhibit D	Form of Final Order and Judgment
Exhibit E	Form of Mailed Notice
Exhibit F	Form of Preliminary Approval Order
Exhibit G	Form of Published Notice
Exhibit H	Section 7 Time Periods
Exhibit I	Current Pre-Certification List
Exhibit J	Foundation Term Sheet

SETTLEMENT AGREEMENT

This Settlement Agreement (the “**Agreement**”) is made and entered into as of the date set forth on the signature pages hereto by and among the Representative Plaintiffs (on behalf of themselves and each of the Class Members who have not validly and timely requested to Opt-Out of this Agreement), by and through their counsel of record in In re Managed Care Litigation, MDL Docket No. 1334, Company and those medical societies identified on the signature pages hereto (such medical societies are herein collectively referred to as the “**Signatory Medical Societies**”) (the Representative Plaintiffs, the Class Members who have not validly and timely requested to Opt-Out of this Agreement, Company and the Signatory Medical Societies are herein collectively referred to as the “**Parties**”). The Parties intend this Agreement to resolve, discharge and settle the Released Claims, fully, finally and forever according to the terms and conditions set forth below.

WITNESSETH:

WHEREAS, by Order filed June 13, 2000, the United States District Court for the Southern District of Florida (the “**Court**”) assigned each action that has been assigned MDL Docket No. 1334 to one of two tracks: a “**Subscriber Track**” and a “**Provider Track**”;

WHEREAS, the Provider Track includes all actions under MDL Docket No. 1334 brought by health care providers or Physician Groups who participated in Company’s health insurance plans or otherwise treated Company’s insureds, or by representatives of said providers or Physician Groups;

WHEREAS, by Order filed October 23, 2000, the Judicial Panel on Multidistrict Litigation transferred and consolidated the Provider Track actions for pretrial purposes before the Court;

WHEREAS, on September 19, 2002, the Representative Plaintiffs filed Plaintiffs’ Second Amended Consolidated Class Action Complaint (hereinafter the “**Complaint**”);

WHEREAS, on September 26, 2002, the Court issued its Order Granting Provider Track Class Certification;

WHEREAS, Company denies the material factual allegations and legal claims asserted in the Complaint, including without limitation any and all charges of wrongdoing or liability arising out of any of the conduct, statements, acts or omissions alleged, or that could have been alleged, in the Complaint including without limitation the allegations that the Representative Plaintiffs and/or other Class Members have suffered damages; that Company improperly manipulated claim procedures or fraudulently misrepresented the criteria for insurance coverage determination, treatment decisions, and payments; that Company

conspired with or aided and abetted wrongful conduct of any other person; and that the Representative Plaintiffs and/or other Class Members were harmed by the conduct alleged in the Complaint;

WHEREAS, Company has asserted a number of defenses to the claims set forth in the Complaint that Company believes are meritorious; nonetheless, Company has a desire to make more transparent, simplify and otherwise improve the system through which it conducts business with Representative Plaintiffs and has concluded that further conduct of the Action would be protracted and expensive and that it is desirable that the Action be fully and finally settled in the manner and upon the terms and conditions set forth in this Agreement;

WHEREAS, the Representative Plaintiffs believe that the claims asserted in the Action have merit; provided that Class Counsel recognize and acknowledge the expense and length of continued proceedings that would be necessary to prosecute the Action against Company through trial and appeals;

WHEREAS, Class Counsel also have taken into account the uncertain outcome and the risk of any class action, especially in complex actions such as the Action, as well as the difficulties and delays inherent in such Action, and Counsel for the Representative Plaintiffs believe that the settlement set forth in this Agreement confers substantial benefits upon the Representative Plaintiffs and the other Class Members;

WHEREAS, based on their evaluation of all of these factors, and recognizing that Company's compliance with the terms of this Agreement is beneficial to Class Members and that such compliance does not and shall not violate any legal right of Class Members, the Representative Plaintiffs and their counsel have determined that this Agreement is in the best interests of themselves and the other Class Members;

WHEREAS, the Signatory Medical Societies have determined that it is in their best interests to obtain the benefits afforded to such Signatory Medical Societies by the applicable provisions of this Agreement, and, in exchange therefor, to make the commitments and agreements contained herein, including without limitation those contained in § 13;

WHEREAS, the Parties acknowledge that the implied duty of good faith and fair dealing is applicable to each Party's obligations under this Agreement.

NOW, THEREFORE, IT IS HEREBY STIPULATED AND AGREED by and among the Representative Plaintiffs (for themselves and all Class Members who have not validly and timely requested to Opt-Out of this Agreement), by and through their respective counsel or attorneys of record, and Company, that, subject to the approval of the Court, the Action and the Released Claims shall be finally and fully resolved, compromised, discharged and settled under the following terms and conditions:

1. Definitions.

As used in this Agreement, the following terms have the meanings specified below:

- 1.1. “**Action**” means Shane v. Humana, Inc., et al., Master File No. 00-1334-MD-MORENO.
- 1.2. “**Active Physician**” means a Class Member who is a Physician and who is not a Retired Physician.
- 1.3. “**Active Physician Amount**” shall have the meaning assigned to that term in §8.4(b) of this Agreement.
- 1.4. “**Affiliate**” means with respect to any Person, any other Person controlling, controlled by or under common control with such first Person. The term “control” (including without limitation, with correlative meaning, the terms “controlled by” “under common control with”), as used with respect to any Person, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and Policies of such Person, whether through the ownership of voting securities or otherwise.
- 1.5. “**Agreement**” shall have the meaning assigned to that term in the preamble of this Agreement.
- 1.6. “**Attorneys’ Fees**” means the funds for attorney’s fees and expenses that may be awarded by the Court to Class Counsel.
- 1.7. “**Bar Order**” means an order of the Court barring the assertion of claims against the Released Parties for contribution, indemnity or other similar claims by the non-settling defendants in the Action or other Persons in the form included as part of the Final Order and Judgment.
- 1.8. “**Billing Dispute**” shall have the meaning assigned to that term in § 7.10(a) of this Agreement.
- 1.9. “**Billing Dispute External Review Board**” shall have the meaning assigned to that term in § 7.10 of this Agreement.
- 1.10. “**Business Day**” means any day on which commercial banks are open for business in New York City.
- 1.11. “**Cash Amount**” shall have the meaning assigned to that term in § 17(a) of this Agreement.

- 1.12. “**Certification**” shall have the meaning assigned to that term in § 15 of this Agreement.
- 1.13. “**Claim Deadline**” shall have the meaning assigned to that term in § 8.5(a) of this Agreement.
- 1.14. “**Claim Form**” means a document in substantially the form attached hereto as Exhibit A.
- 1.15. “**Class**” means any and all Physicians, Physicians Groups and Physician Organizations who provided Covered Services to any Plan Member or any individual enrolled in or covered by a plan offered or administered by any Person named as a defendant in the Complaint or by any of their respective current or former subsidiaries or affiliates, in each case from August 4, 1990 through the Preliminary Approval Date.
- 1.16. “**Class Counsel**” means those Persons set forth on Exhibit B attached hereto.
- 1.17. “**Class Member**” means any Person who is a member of the Class.
- 1.18. “**Clean Claim**” means a claim for Covered Services that (a) is timely received by Company, (b) has a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (c) (i) when submitted via paper has all the elements of the UB-92 or CMS-1500 (or successor standard) forms or (ii) when submitted via an electronic transaction, uses only permitted standard code sets (e.g., CPT®-4, ICD-9, HCPCS) and has all the elements of the standard electronic formats, as required by applicable Federal authority and state regulatory authority (except where such state authority is preempted by applicable Federal authority), (d) is a claim for which Company is the primary payor or Company’s responsibility as a secondary payor has been established by agreement of Company or by order no longer subject to appeal or review (in the context of coordination of benefits), and (e) contains no defect or error.
- 1.19. “**CMS**” means the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration).
- 1.20. “**CMS-1500**” means the health care provider claim form number 1500 created by CMS, as such form exists on the date

of this Agreement and as it may be amended, modified or superceded thereafter during the term of this Agreement.

- 1.21. “**Company**” means Aetna Inc. and each of its Subsidiaries.
- 1.22. “**Complaint**” shall have the meaning assigned to that term in the recitals of this Agreement.
- 1.23. “**Compliance Dispute**” means (i) any claim that Company has failed in any manner to carry out any of its obligations under § 7 of this Agreement and (ii) any claim of the type described in §13(e)(2) of this Agreement that is not also any of the following: (A) a Released Claim, (B) a Retained Claim, (C) a Billing Dispute;(D) a claim for which the Medical Necessity External Review Process is available, or (E) a claim challenging a Medical Necessity determination arising out of administration of benefits for a Self-Funded Plan as to which the Plan Sponsor has not elected to participate in Company’s Medical Necessity External Review Process.
- 1.24. “**Compliance Dispute Claim Form**” means a document in substantially the same form as Exhibit C, attached hereto.
- 1.25. “**Compliance Dispute Facilitator**” means the person who, pursuant to § 12.1(a) of this Agreement, shall first hear Compliance Disputes.
- 1.26. “**Compliance Dispute Review Officer**” means the person chosen pursuant to § 12 of this Agreement and charged with the administration of Certifications and Compliance Disputes under this Agreement.
- 1.27. “**Conclusion Date**” shall have the meaning assigned to that term in § 7 of this Agreement.
- 1.28. “**Court**” shall have the meaning assigned to that term in the recitals of this Agreement.
- 1.29. “**Coverage Policy Bulletin**” means an established policy or other formal statement developed by Company with respect to clinical services, with particular attention to new technologies and new treatment approaches and procedures, that the Company applies to determine whether, and under what circumstances, a specific medical service or supply for which coverage is requested is a Covered Service under the terms of a Member's health plan.

- 1.30. “**Covered Services**” means those health care services and supplies for which a Plan Member is entitled to receive coverage under the terms and conditions of his or her Plan.
- 1.31. “**CPT®**” and “**CPT® Codes**” mean medical nomenclature published by the American Medical Association containing a systematic listing and coding of procedures and services provided to patients by physicians and non-physician health professionals. When used herein, “**CPT®**” and “**CPT® Codes**” refer to such medical nomenclature as it exists as of the date of this Agreement and as it may be amended, modified or superseded thereafter during the term of this Agreement.
- 1.32. “**Credentialing Committee**” means any committee maintained by Company which has decision-making authority regarding credentialing and re-credentialing of individual Physicians as Participating Physicians with Company.
- 1.33. “**day**” means a calendar day, unless otherwise noted herein.
- 1.34. “**Deductible**” means the amount a Plan Member must pay for Covered Services during a specified coverage period in accordance with the Plan Member’s plan before benefits are payable by such Plan.
- 1.35. “**Delegated Entity**” means an entity that is not an Affiliate of Company to the extent that such entity (i) maintains its own contracts with Physicians separate from any contracts between Company and Physicians, and, by agreement with Company, (ii) (A) agrees to provide Plan Members with access to such Physicians pursuant to the terms of such agreements; and (B) performs some or all of the functions with respect to Plans which otherwise would be performed by Company, including without limitation claims adjudication, utilization review, utilization management and Physician credentialing.
- 1.36. “**Downcoding**” shall have the meaning assigned to that term in § 7.19 of this Agreement.
- 1.37. “**Effective Date**” shall have the meaning assigned to that term in § 15 of this Agreement.
- 1.38. “**Effective Period**” shall have the meaning assigned to that term in § 7 of this Agreement.

- 1.39. “**EOB**” means Explanation of Benefit or any comparable form or statement communicating to Plan Members the results of Company’s adjudication of claim(s) submitted by, with respect to or on behalf of such Plan Members.
- 1.40. “**ERA/EFT Software**” shall have the meaning assigned to that term in § 7.12 of this Agreement.
- 1.41. “**ERISA**” means the Employment Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated thereunder.
- 1.42. “**Execution Date**” means the later of (i) the date on which the signature of Company has been delivered to Class Counsel; and (ii) the date on which the signatures of all Representative Plaintiffs, Signatory Medical Societies, and Class Counsel have been delivered to Company.
- 1.43. “**Final Order and Judgment**” means the order and form of judgment approving this Agreement and dismissing Company with prejudice, in each case in the form attached hereto as Exhibit D.
- 1.44. “**First Alternate**” shall have the meaning assigned to that term in § 12.1(b) of this Agreement.
- 1.45. “**Foundation**” shall have the meaning assigned to that term in § 8.1 of this Agreement.
- 1.46. “**Fully Insured Plan**” means a Plan as to which Company assumes all or a majority of healthcare cost and/or utilization risk, depending on the product.
- 1.47. “**Gross Disbursement**” shall have the meaning assigned to that term in § 17(b) of this Agreement.
- 1.48. “**Implementation Date**” means the date of entry of the Final Order and Judgment approving this Agreement
- 1.49. “**Individually Negotiated Contract**” means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to substantial modifications to the terms of Company’s standard form agreement to individually suit the needs of a particular Participating Physician or Physician Organization.
- 1.50. “**Mailed Notice**” means the form of notice attached hereto as Exhibit E.

- 1.51. “**Material Adverse Change**” means any change in Policies that could reasonably be expected to have a material adverse impact on (i) the aggregate level of payment by Company to Participating Physicians for Covered Services or (ii) Participating Physicians’ administration of their practices.
- 1.52. “**Medical Necessity**” or “**Medically Necessary**” shall have the meaning assigned to that term in § 7.16(a)(i) of this Agreement.
- 1.53. “**Medical Necessity External Review Process**” shall have the meaning assigned to that term in § 7.11(a) of this Agreement.
- 1.54. “**Medical Necessity Independent Review Organization**” means an organization that provides independent medical reviews of Company's denials of coverage which are based on the lack of medical necessity or the experimental/investigational nature of the proposed or rendered service or supply.
- 1.55. “**Multiple Procedure Logic**” means the adjustment(s) to payment(s) for one or more procedures or other services, in each case constituting Covered Services (excluding evaluation and management CPT® Codes), when multiple such procedures or services are performed at the same session.
- 1.56. “**Non-Participating Physician**” means any Physician other than a Participating Physician.
- 1.57. “**Notice Date**” shall have the meaning assigned to that term in §6.1 of this Agreement.
- 1.58. “**Objection Date**” shall have the meaning assigned to that term in §6.1 of this Agreement.
- 1.59. “**Opt-Out**” shall have the meaning assigned to that term in § 6.1 of this Agreement.
- 1.60. “**Opt-Out Deadline**” shall have the meaning assigned to that term in §6.1 of this Agreement.
- 1.61. “**Overpayment**” means, with respect to a claim submitted by or on behalf of a Physician (or Physician Group or Physician Organization), any erroneous or excess payment that Company makes because of payment of an incorrect rate, duplicate payment for the same Physician Service, payment

with respect to an individual who was not a Plan Member as of the date the Physician provides the Physician Service(s) that are the subject of such payment, or payment for any non-Covered Service; provided that “**Overpayment**” shall not mean any erroneous or excess payment arising out of inappropriate coding or other error in the claim submission to which such payment relates and shall not mean any adjustment to a prior payment when Company makes such adjustment in whole or part on the basis of information contained in a separate claim submitted by a Physician for Physician Services rendered on the same date of the same Physician Services to which the original payment relates (other than duplicate bills).

- 1.62. “**Participating Physician**” means any Physician who has entered into and on and after the Implementation Date continues to have a valid written contract with Company (directly or indirectly through a Physician Organization, Physician Group or other entity authorized by physician) to provide Covered Services to Plan Members and, where applicable, has been credentialed by Company or by a Delegated Entity pursuant to Company’s credentialing policies in effect at the time of such credentialing.
- 1.63. “**Parties**” shall have the meaning assigned to that term in the preamble of this Agreement.
- 1.64. “**Person**” and “**Persons**” means all persons and entities (including without limitation natural persons, firms, corporations, limited liability companies, joint ventures, joint stock companies, unincorporated organizations, agencies, bodies, governments, political subdivisions, governmental agencies and authorities, associations, partnerships, limited liability partnerships, trusts, and their predecessors, successors, administrators, executors, heirs and assigns).
- 1.65. “**Petitioner**” shall have the meaning assigned to that term in § 12.2 of this Agreement.
- 1.66. “**Physician**” means an individual duly licensed by a state licensing board as a Medical Doctor or as a Doctor of Osteopathy and shall include both Participating Physicians and Non-Participating Physicians.
- 1.67. “**Physician Amount**” shall have the meaning assigned to that term in §8.4(a) of this Agreement.

- 1.68. “**Physician Group**” means two or more Physicians who practice medicine under a single taxpayer identification number.
- 1.69. “**Physician Advisory Committee**” shall have the meaning assigned to that term in § 7.9(a) of this Agreement.
- 1.70. “**Physician Organization**” means any association, partnership, corporation or other form of organization (including without limitation independent practice associations and physician hospital organizations) that arranges for care to be provided by Physicians organized under multiple taxpayer ID numbers, to Plan Members.
- 1.71. “**Physician Services**” means Covered Services that a Physician provides to a Plan Member, as specified in applicable agreements with Company, or otherwise.
- 1.72. “**Physician Specialty Society**” means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.
- 1.73. “**Plan**” means a Plan Member’s health care benefits as set forth in the Plan Member’s Summary Plan Description, Certificate of Coverage or other applicable coverage document.
- 1.74. “**Plan Member**” means an individual enrolled in or covered by a Plan offered or administered by Company.
- 1.75. “**Preliminary Approval Date**” means the date the Preliminary Approval Order is entered by the Court.
- 1.76. “**Preliminary Approval Hearing**” shall have the meaning assigned to that term in § 4 of this Agreement
- 1.77. “**Preliminary Approval Order**” means the preliminary approval order, in the form attached hereto as Exhibit F.
- 1.78. “**Provider Track**” shall have the meaning assigned to that term in the recitals of this Agreement.
- 1.79. “**Provider Website**” means the secure (password protected) online resource for Participating Physicians to obtain information about Company, its products and policies and other information described in more detail in this Agreement, and which is currently located at www.aetna.com/providerhealthoffice/.

- 1.80. “**Public Website**” means the online resource for the public to obtain information about Company, its products and policies and other information and which is currently located at www.aetna.com.
- 1.81. “**Published Notice**” means the form of notice attached hereto as Exhibit G.
- 1.82. “**Qualifying Physician Offices**” shall have the meaning assigned to that term in § 7.12 of this Agreement.
- 1.83. “**Related Claim**” shall have the meaning assigned to that term in § 13 of this Agreement.
- 1.84. “**Released Parties**” shall have the meaning assigned to that term in § 13(c) of this Agreement.
- 1.85. “**Released Rights**” or “**Released Claims**” means any and all manner of claims, demands, actions, suits, and causes of action released under § 13(c) of this Agreement.
- 1.86. “**Releasing Parties**” shall have the meaning assigned to that term in § 13(a) of this Agreement.
- 1.87. “**Representative Plaintiffs**” means collectively Susan McIntosh, M.D., Kevin Lynch, M.D., Stephen Levinson, M.D., Karen Laugel, M.D., Edgar Borrero, M.D., Albert Ellman, M.D., Robert Scher, M.D., Raymond Wesley, M.D., Kevin Molk, M.D., Manual Porth, M.D., Michael C. Burgess, M.D., Eugene Mangieri, M.D., Glenn Kelly, M.D., Leonard Klay, M.D., Charles B. Shane, M.D., Jeffrey Book, M.D., Andres Taleisnik, M.D., Julio Taleisnik, M.D., David Boxstein, M.D., Roger Wilson, M.D., Susan R. Hansen, M.D., Edward Davis, M.D., Thomas Backer, M.D., Martin Moran, M.D., H. Robert Harrison, Ph.D., M.D., and Lance R. Goodman, M.D.
- 1.88. “**Retained Claims**” shall have the meaning assigned to that term in § 13(d) of this Agreement.
- 1.89. “**Retired Physician**” means a Class Member who, subsequent to August 4, 1990, has become an inactive Physician, has retired from the practice of, or has otherwise ceased to practice, medicine or has died.
- 1.90. “**Retired Physician Amount**” shall have the meaning assigned to that term in § 8.4(a) of this Agreement.

- 1.91. “**Reversion Amount**” shall have the meaning assigned to that term in §8.6 of this Agreement.
- 1.92. “**Second Alternate**” shall have the meaning assigned to that term in § 12.1(b) of this Agreement.
- 1.93. “**Self-Insured Plan**” and “**Self-Funded Plan**” means any Plan other than a Fully Insured Plan.
- 1.94. “**Senior Management**” shall have the meaning assigned to that term in § 12.7 of this Agreement.
- 1.95. “**Settlement Administrator**” shall have the meaning assigned to that term in § 8.3 of this Agreement.
- 1.96. “**Settlement Amount**” shall have the meaning assigned to that term in §8.2 of this Agreement.
- 1.97. “**Settlement Fund**” shall have the meaning assigned to that term in § 8.2 of this Agreement.
- 1.98. “**Settlement Hearing**” means the hearing at which the Court shall consider and determine whether to enter the Final Order and Judgment and make such other orders as are contemplated by this Agreement.
- 1.99. “**Settlement Hearing Date**” shall have the meaning assigned to that term in § 6.2 of this Agreement.
- 1.100. “**Signatory Medical Societies**” shall have the meaning assigned to that term in the preamble of this Agreement.
- 1.101. “**State Medical Society**” means a state medical society or association that is chartered by the American Medical Association.
- 1.102. “**Subscriber Track**” shall have the meaning assigned to that term in the recitals of this Agreement.
- 1.103. “**Subsidiary**” means any entity of which securities or other ownership interests having ordinary voting power to elect a majority of the board of directors or other persons performing similar functions are, as of the Implementation Date, directly or indirectly owned by Aetna Inc., but only so long as such securities or other ownership interests having ordinary voting power to elect a majority of the board of directors or other persons performing similar functions are, directly or indirectly, held by Aetna Inc.].

1.104. “**Tag-Along Actions**” shall have the meaning assigned to such term in § 16.1 of this Agreement.

1.105. “**Termination Date**” shall have the meaning assigned to that term in § 15(g) of this Agreement.

2. The Action and Class Covered by This Agreement.

This Agreement sets forth the terms of an agreement with respect to the Action between Company and all Class Members who have not validly and timely requested to Opt-Out of this Agreement. This Agreement relates only to the Action and other Provider Track actions assigned MDL Docket No. 1334, unless otherwise specified herein.

3. Commitment to Support and Communications with Class Members.

Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and Company agree to cooperate with each other and to take all actions reasonably necessary to obtain Court approval of this Agreement and entry of the orders of the Court that are required to implement its provisions. Such Parties also agree to support this Agreement in accordance with and subject to the provisions of this Agreement.

Company hereby agrees to withdraw its pending appeal of the Court’s September 26, 2002 Order Granting Provider Track Class Certification before the United States Court of Appeals for the Eleventh Circuit. Notwithstanding the foregoing, if this Agreement is terminated or does not become effective for any reason, the Signatory Medical Societies and Class Counsel agree that, in addition to otherwise restoring the Parties to their status prior to entering into this Agreement, any further ruling on the propriety of the Court’s September 26, 2002 Order Granting Provider Track Class Certification certifying a class in the Action shall apply to the Released Parties as if the Released Parties had participated in further proceedings with respect to that Order.

Class Counsel and the Signatory Medical Societies shall make every reasonable effort to encourage Class Members to participate and not to Opt-Out. In addition, Class Counsel shall make all reasonable efforts to enforce the Compliance Dispute Resolution provisions of this Agreement (§ 12).

Representative Plaintiffs, Class Counsel and Company agree that Company may communicate with Class Members regarding the provisions of this Agreement, so long such communications are not inconsistent with the Mailed Notice or other agreed upon communications concerning the Agreement.

4. Preliminary Approval of Settlement.

As soon as possible after the execution of this Agreement, and in all events no later than May 22, 2003, Representative Plaintiffs, Class Counsel and Company shall jointly submit the documents attached hereto as Exhibits E, F and G to the Court.

The hearing in which the Court considers and determines whether to enter the Preliminary Approval Order and approve the Mailed Notice, the Published Notice and the Claim Form shall be referred to as the “**Preliminary Approval Hearing.**” Representative Plaintiffs, Class Counsel and Company agree to urge the Court to set the date for the Preliminary Approval Hearing no later than the week of June 2, 2003.

5. Notice to Class Members; Notice to Parties Pursuant to This Agreement.

After the Court has entered the Preliminary Approval Order and approved the Mailed Notice, the Published Notice and the Claim Form, notice to Class Members shall be disseminated in such form as the Court shall direct; provided that the forms of notice are substantially similar to the Mailed Notice and the Published Notice. A copy of the Claim Form shall be included with the copy of the Mailed Notice that is disseminated to Retired Physicians and Active Physicians. The Mailed Notice shall request and require that any Class Member who has assigned a claim covered by this Agreement to another Person, in whole or in part, to deliver the Mailed Notice to such Person.

Class Counsel and Company shall be jointly responsible for identifying names and addresses of Class Members and determining whether such Class Members are Retired Physicians or Active Physicians and shall cooperate with each other and the Settlement Administrator to make such identifications and determinations.

Company shall pay the reasonable cost of notice to Class Members, including without limitation first class mail costs for the mailing of the Mailed Notice, substantially in the same form as Exhibit E. Payment by Company of the cost of the Mailed Notice shall be non-refundable and shall be in addition to the other agreements made herein. Company shall pay for the cost to publish the Published Notice no more than three times in the legal notices section in the national editions of THE WALL STREET JOURNAL and USA TODAY. If publication in one or more of said publications on the foregoing schedule is determined not to be practicable, then either Class Counsel or Company may apply to the Court for alternative notice by publication. Company shall also publish the Published Notice on the Public Website, and, to the extent feasible, shall also publish notice in a nationwide periodical addressing issues of concern to physicians such as The Journal of the American Medical

Association or The American Medical News. Company shall maintain the Public Website notices at Company's cost through at least the Objection Date.

All notices to any Party (including without limitation any designations made by Class Counsel pursuant to this Agreement) required under this Agreement shall be sent by first class U.S. Mail, by hand delivery, or by facsimile, to the recipients designated in this Agreement. Timeliness of all submissions and notices shall be measured by the date of receipt, unless the addressee refuses or delays receipt. The Persons designated to receive notices under this Agreement are as follows, unless notification of any change to such designation is given to each other Party hereto pursuant to this § 5:

Representative Plaintiffs and Signatory Medical Societies:

Notice to be given to Class Counsel on behalf of Representative Plaintiffs and Signatory Medical Societies.

Class Counsel:

Archie Lamb, Esq.
Law Offices of Archie Lamb, LLC
2017 2nd Avenue South
Birmingham, AL 35203
Telephone: 205-324-4644
Fax: 205-324-4649

Harley Tropin, Esq.
Kozyak Tropin & Throckmorton
2800 First Union Financial Center
200 South Biscayne Boulevard
Miami, FL 33131-2335
Telephone: 305-372-1800
Fax: 305-372-3508

Edith Kallas, Esq.
Milberg Weiss Bershad Hynes & Lerach LLP
One Pennsylvania Plaza
New York, NY 10119-0165
Telephone: 212-594-5300
Fax: 212-868-1229

Company:

Office of the General Counsel
Aetna Inc.
151 Farmington Avenue

Hartford, Connecticut 06156
Telephone: 860-273-0123
Facsimile: 860-273-8340

With a copy to:

Lewis B. Kaden, Esq.
Davis Polk & Wardwell
450 Lexington Avenue
New York, New York 10011
Telephone: 212-450-4000
Facsimile: 212-450-4800

and to:

Hilarie Bass, Esq.
Greenburg Traurig P.A.
1221 Brickell Avenue
Miami, Florida 33131
Telephone: 305-579-0500
Facsimile: 305-579-0717

In the event that any Party receives a notice from any another Party (in accordance with the provisions of § 5 of this Agreement and as required by any other provision of this Agreement) and such receiving Party does not respond to such notice within 15 days of receipt thereof, such receiving Party shall be deemed to have accepted any proposal made by the notifying Party in such notice and shall be deemed to have waived any rights under this Agreement with respect to the matter that is the subject of such notice.

6. Procedure for Final Approval; Limited Waiver.

Following the dissemination of notice as described in § 5, Representative Plaintiffs, Class Counsel and Company shall seek the Court's final approval of this Agreement. Class Members shall have until the Objection Date to file, in the manner specified in the Mailed Notice, any objection or other response to this Agreement. The Parties agree to urge the Court to set the Objection Date for the date that is 60 days after the Notice Date (the "**Objection Date**").

6.1. Opt-Out Timing and Rights.

The Parties will jointly request of the Court that the Mailed Notice and the Published Notice be disseminated no later than 30 days after the Preliminary Approval Date (the "**Notice Date**").

The Mailed Notice and the Published Notice shall provide that Class Members may request exclusion from the Class by providing notice, in the manner specified in the such Notice, on or before a date set by the Court as the Opt-Out Deadline. Representative Plaintiffs, Class Counsel and Company agree to urge the Court to set the Opt-Out Deadline for the date that is 60 days after the Notice Date (the “**Opt-Out Deadline**”).

Class Members have the right to exclude themselves (“**Opt-Out**”) from this Agreement and from the Class by timely submitting to the Clerk of the Court a request to Opt-Out and otherwise complying with the agreed upon Opt-Out procedure approved by the Court. Class Members who so timely request to Opt-Out shall be excluded from this Agreement and from the Class. Any Class Member who does not submit a request to Opt-Out by the Opt-Out Deadline or who does not otherwise comply with the agreed upon Opt-Out procedure approved by the Court shall be bound by the terms of this Agreement and the Final Order and Judgment. Any Class Member who does not Opt-Out of this Agreement shall be deemed to have taken all actions necessary to withdraw and revoke the assignment to any Person of any claim against Company.

Any Class Member who timely submits a request to Opt-Out shall have until the Settlement Hearing to deliver to Class Counsel and the Settlement Administrator a written revocation of such Class Member’s request to Opt-Out. Class Counsel shall timely apprise the Court of such revocations.

Within ten (10) days after the Opt-Out Deadline, the Settlement Administrator shall furnish Company with a complete list in machine-readable form of all Opt-Out requests filed by the Opt-Out Deadline and not timely revoked. Company shall pay costs of obtaining a copy of the Opt-Out requests. Notwithstanding any other provisions in this Agreement, after reviewing said list and/or copies of Opt-Out requests and revocations, Company reserves the right, in its sole and absolute discretion, to terminate this Agreement by delivering a notice of termination to Class Counsel, with a copy to the Court, prior to the commencement of the Settlement Hearing if Company determines that Opt-Out requests have been filed (i) relating to more than 25,000 individual Physicians who are Class Members or (ii) representing Class Members who, in the aggregate, received at least five percent (5%) of the total dollar payments that Company made to Class Members in calendar year 2002.

6.2. Setting the Settlement Hearing Date and Settlement Hearing Proceedings.

Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and Company agree to urge the Court to hold the Settlement Hearing on the date that is 105 days after the Notice Date (the “**Settlement Hearing Date**”) and to work together to identify and submit any evidence that may be required by the Court to satisfy the burden of proof for obtaining approval of this Agreement and the orders of the Court that are necessary to effectuate the provisions of this Agreement, including without limitation the Final Order and Judgment and the orders contained therein (including without limitation the Bar Order). At the Settlement Hearing, the Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and Company shall present evidence necessary and appropriate to obtain the Court’s approval of this Agreement, the Final Order and Judgment and the orders contained therein (including without limitation the Bar Order) and shall meet and confer prior to the Settlement Hearing to coordinate their presentation to the Court in support of Court approval thereof.

6.3. Limited Waiver.

Solely for purposes of securing settlement of the Action, upon the Effective Date, Representative Plaintiffs, the Class Members and Company shall be deemed to have waived any and all rights (known or unknown) to arbitrate any Released Claim.

7. Settlement Consideration: Business Practice Initiatives.

The settlement consideration to the Class Members who have not validly and timely requested to Opt-Out of this Agreement includes, among other things, initiatives and other commitments with respect to Company’s business practices. The Parties agree that the business practice initiatives and other commitments set forth below, which absent this Agreement Company would be under no obligation to undertake, constitute substantial value, and will enhance and facilitate the delivery of Physician Services by Class Members who have not validly and timely requested to Opt-Out of the Agreement. Company investigated and began to implement certain of the business practice initiatives described in this § 7 while the Parties were engaged in discussions to resolve the Action. Such initial and partial implementation, which shows the Parties’ good faith desire to resolve the Action, were undertaken to form part of the consideration of the settlement. Company shall have the unilateral and unrestricted right to block access to and/or not apply any or all of the business practice initiatives set forth below to such Class Members, if any, who Opt Out. Without in any way qualifying or limiting the foregoing,

Company (a) is informed that it is not uncommon for some members of a class action to opt out for a variety of reasons independent of, among other things, the substantive allegations in the complaint or the terms of a proposed settlement, and (b) states its present intention to exercise the right referred to in the immediately preceding sentence to Class Members who Opt-Out.

Company covenants and agrees that, during the period from and after the Execution Date and until the Preliminary Approval Date, it shall not effect any material changes in the business practices that are the subject of the Complaint, except changes to such business practices that are contemplated by this Agreement.

Company shall be obligated to commence implementing each commitment set forth in this § 7 from and after the date set forth on Exhibit H attached hereto across from the relevant section number on such Exhibit and shall continue implementing each such commitment until the Termination Date, except as otherwise expressly provided in §§ 7.1, 7.2, 7.4 or 7.12 or as modified by § 12.8, (such earlier date, the “**Conclusion Date**”). With respect to each commitment set forth in this § 7, the “**Effective Period**” for such commitment shall be the period of time beginning on the start date set forth for such commitment on Exhibit H attached hereto and continuing through the Conclusion Date for such commitment. Notwithstanding anything to the contrary contained herein, with respect to each commitment set forth in this § 7, from and after the Conclusion Date for such commitment, Company shall be under no obligation whatsoever to continue to implement such commitment.

7.1. Automated Adjudication of Claims.

Company shall make investments designed to facilitate the automated adjudication of claims submitted by Physicians, which is intended to reduce the average time taken by Company to pay Clean Claims for Covered Services. Company shall develop and implement plans and time lines reasonably calculated to increase the rate of auto-adjudication of claims submitted by Physicians by not less than 5 percentage points from the period beginning January 1, 2001 to December 31, 2004. Company believes that the expenditures contemplated by the following sentence shall achieve the foregoing goal. Company shall invest not less than \$5,000,000 but shall not be required to invest more than \$10,000,000 during the period from January 1, 2003 through December 31, 2004 toward achieving the goal enumerated in this subsection. The Certification filed by Company annually and at the end of the Effective Period shall indicate the sum invested toward this end as of the most recent practicable date prior to such Certification.

7.2. Increased Internet and Clearinghouse Functionality.

Company shall make investments to enhance the ability of Physicians to register referrals, pre-certify procedures, submit claims for Covered Services, check Plan Member eligibility for Covered Services (based upon current information supplied by or relating to Plan sponsors), and check the status of claims for Covered Services, in each case via the Internet and clearinghouses. Company shall also add the ability for Participating Physicians to obtain comparable functionality directly from the Provider Website.

7.3. Availability of Fee Schedules and Scheduled Payment Dates.

Company shall develop and implement a plan reasonably designed to permit a Participating Physician or Physician Group that, in each case, has entered into a written contract directly with Company to view, by December 31, 2004, on the Provider Website, on a confidential basis, the complete fee schedule applicable to such Participating Physician pursuant to that Participating Physician's direct written agreement with Company. Each such fee schedule shall state the dollar amount allowable for each CPT® code for Covered Services rendered by such Participating Physician's office. Commencing with the Implementation Date and continuing until implementation of the initiative described above, Company, upon written request from a Participating Physician or Physician Group that, in each case, has entered into a written contract directly with Company, will provide the fee schedule for up to fifty (50) CPT® codes, as specified by such Participating Physician. Company shall be obligated to honor only one such request made annually by such Participating Physician. Company will attempt to include provisions in its agreements with Delegated Entities that require comparable disclosure.

7.4. Investment as to §§ 7.2 and 7.3.

Company shall invest not less than \$8,000,000 but shall not be required to invest more than \$15,000,000 during the period from January 1, 2003 through December 31, 2004 toward implementing and maintaining the improvements and functionalities set forth in §§ 7.2 and 7.3 above. The Certification filed by Company annually and at the end of the Effective Period shall indicate the sum invested toward the goals set forth in such sections.

7.5. Reduced Pre-Certification Requirements.

Company has reduced the number of procedures requiring pre-certification by Physicians, reduced the number of services requiring submission of clinical information for pre-certification medical review, standardized pre-certification lists across Company products for Participating Physicians, and introduced a process allowing Physicians to request pre-certification via electronic data interchange and Internet access. Attached hereto as Exhibit I is the current pre-certification list applicable to Participating Physicians. Not later than six (6) months after the Implementation Date, Company shall disclose on the Provider Website any customized pre-certification list for one or more Self-Funded Plans applicable to Participating Physicians and shall update such disclosures as needed. The Certification to be filed annually and at the end of the Effective Period shall attach a copy of Company's standard pre-certification list as of such date.

7.6. Greater Notice of Policy and Procedure Changes.

Company shall provide Participating Physicians with 90 days' advance notice of all planned Material Adverse Changes to Company's policies and procedures affecting performance under contracts with Participating Physicians, except to the extent that a shorter notice period is required to comply with changes in applicable law. The Certification to be filed annually and at the end of the Effective Period shall include a listing of the dates on which Company provided Participating Physicians with advance notice of such planned Material Adverse Changes.

7.7. Initiatives to Reduce Claims Resubmissions.

Company has begun implementation of a series of initiatives, which have increased the percentage of claim issues resolved on initial review and thereby reduced the percentage of resubmitted claims. These initiatives include, among other things, a practice of making up to three (3) inquiries for additional information upon receipt of incomplete claims from physicians before denying such claims. Company agrees to continue these or comparable business practices during the Effective Period. Company agrees to provide evidence of activities that are reasonably designed to enhance the implementation of such practice or practices in the Certification to be filed annually and at the end of the Effective Period.

7.8. Disclosure of and Commitments Concerning Claim Payment Practices.

- (a) Company agrees that by December 31, 2004 it shall cause its automated “bundling” and other claims payment rules to be consistent in all material respects across ongoing claims systems and products. The Certification to be filed annually and at the end of the Effective Period shall describe the efforts made by Company toward this end.
- (b) Company shall take actions reasonably necessary on its part to obtain assistance from McKesson Corporation, or comparable software vendors, in order to make available on the Provider Website by December 31, 2003 or as soon thereafter as practicable a web-based pre-adjudication tool incorporating the McKesson Corporation software product known as “ClaimCheck®” (or other equivalent software then used by Company), as customized by Company. Such software shall produce results consistent with the standards set forth in § 7.20(b). Company agrees to design such tool so that it may provide information to Participating Physicians regarding the manner in which Company’s claim system adjudicates invoices for specific CPT® codes or combinations of such codes. The Certification to be filed annually and at the end of the Effective Period shall describe the efforts made by Company toward this end.
- (c) Company agrees to disclose on the Provider Website by December 31, 2003, or as soon thereafter as practicable, its payment rule or approach in each area in which CMS has promulgated a definitive rule or approach that is relevant to payment of Physicians for Covered Services. The Certification to be filed annually and at the end of the Effective Period must include pertinent portions of the Provider Website, or other medium through which it makes such disclosure, as the same exists as of the date of such Certification.
 - (i) Not later than six (6) months after the Implementation Date, Company shall publish on the Provider Website a list of each Company-specific customization to the standard claims editing software product then used by Company; provided that no such customization shall be inconsistent with the undertakings set forth in this Agreement.
 - (ii) Effective as of the Execution Date, Company shall not routinely require submission of clinical records before or after payment of claims, except as to claims for unlisted codes, claims to which a

modifier 22 is appended, and other limited categories of claims as to which Company subsequently determines that routine review of medical records is appropriate; provided that if Company subsequently determines to routinely require submission of clinical records before or after payment of a specified category of claims, Company shall promptly disclose on the Public Website and the Provider Website any such claim category or categories. Notwithstanding the foregoing, Company may require submission of clinical records before or after payment of claims for the purpose of investigating fraudulent, abusive or other inappropriate billing practices but only so long as, and only during such times as, Company has reasonable basis for believing that such investigation is warranted and Physicians may contest such requirement pursuant to § 7.10(c). Nothing contained in this § 7.8(c)(ii) is intended, or shall be construed, to limit Company's right to require submission of medical records for pre-certification purposes consistent with § 7.5 herein.

(iii) Not later than six (6) months after the Implementation Date, Company shall publish on the Provider Website any circumstances as to which it has determined that particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers; provided that no such determination shall be inconsistent with the undertakings set forth in this Agreement.

(d) If changes are made, Company shall update the disclosures set forth in §§ 7.8(a) and (c) and shall update the customization lists specified in §§ 7.8(c)(i) and (ii). All such updates shall be included in the Certification to be filed annually and at the end of the Effective Period.

7.9. Physician Advisory Committee.

(a) Prior to the later to occur of (i) January 31, 2004 and (ii) selection of the members of the Physician Advisory Committee in accordance with § 7.9(c) of this Agreement, Company shall take all actions necessary on its part to establish a Physician Advisory Committee ("**Physician Advisory Committee**") to discuss agenda items of

nationwide scope. The Physician Advisory Committee shall meet at least once every six months during the Effective Period. Company shall establish an electronic mail box on the Provider Website or comparable mechanism to enable Participating Physicians to communicate with the Physician Advisory Committee. Non-Participating Physicians may submit written proposals to the Physician Advisory Committee concerning Company's business practices.

- (b) The dates of the Physician Advisory Committee's meetings shall be included in the Certification to be filed annually and at the end of the Effective Period.
- (c) The Physician Advisory Committee shall include nine (9) members, one of whom shall be Company's Chief Medical Officer or his designee, who shall serve as chairperson of the Physician Advisory Committee. Except as provided in this § 7.9(c), the remaining members shall be Participating Physicians in active clinical practice. Company shall select two (2) members in addition to its Chief Medical Officer not later than 30 days after the Preliminary Approval Date; Representative Plaintiffs shall select three (3) members not later than 30 days after the Preliminary Approval Date, and those six shall select the remaining three (3) members not later than 90 days after the Preliminary Approval Date. The Parties shall use reasonable efforts to cause one of such remaining three (3) members to be a Non-Participating Physician. The members selected by the Representative Plaintiffs shall include at least one board-certified primary care Participating Physician and at least one board-certified specialist Participating Physician. The names of the members of the Physician Advisory Committee shall be included in the Certification to be filed annually and at the end of the Effective Period.
- (d) Any motion for the Physician Advisory Committee to consider an issue must be proposed by the chairperson or have the support of at least three (3) Physician Advisory Committee members. The issue shall be heard only if, at a meeting at which a quorum is present, a majority of the membership votes in favor of hearing the issue. A quorum shall consist of at least two (2) of the appointees of the Representative Plaintiffs, two (2) of the representatives of Company and two (2) of the representatives selected by the representatives appointed by Company and the Representative Plaintiffs. The Physician Advisory

Committee shall have authority to recommend changes to Company's business practices. Company shall consider whether the implementation of any recommendation of the Physician Advisory Committee is commercially feasible and consistent with the best interests of Company's Participating Physicians, Plan Members, customers, shareholders and other constituents. If Company decides not to accept a recommendation of the Physician Advisory Committee, Company shall communicate that decision in writing to the Committee with an explanation of Company's reasons and disclose the recommendation and response on the Provider Website. Company agrees to include in the Certification filed annually and at the end of the Effective Period a listing of all Physician Advisory Committee recommendations made to Company and Company's responses to such recommendations.

- (e) Payment provisions for expenses of members of the Physician Advisory Committee shall be typical for organizations of this type, including without limitation a reasonable per diem to be set by Company.

7.10. New Dispute Resolution Process for Physician Billing Disputes.

- (a) Not later than the Implementation Date, Company shall take all actions necessary on its part to arrange for the establishment of an independent Billing Dispute External Review Board or Boards (the "**Billing Dispute External Review Board**") for resolving disputes with Physicians concerning (i) application of Company's coding and payment rules and methodologies to patient-specific factual situations, including without limitation the appropriate payment when two or more CPT® codes are billed together, or whether a payment-enhancing modifier is appropriate, (ii) or concerning whether Company has complied with the provisions of this Agreement, including without limitation § 7.8(c)(ii), in requiring that a Physician submit records, either prior to or after payment, in connection with Company's adjudication of such Physician's claims for payments or (iii) any Retained Claims, so long as such Retained Claims are submitted by the Physician to the Billing Dispute External Review Board prior to the later to occur of (x) 90 days after the Implementation Date or (y) 30 days after exhaustion of Company's internal appeals process. Each such matter shall be a "**Billing Dispute.**" The Billing Dispute External

Review Boards shall not have jurisdiction over any other disputes, including without limitation those disputes that fall within the scope of the Medical Necessity External Review Process set forth in § 7.11 of this Agreement, Compliance Disputes and disputes concerning the scope of Covered Services. Nothing contained in this § 7.10 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supercede in any respect the claims procedures of § 503 of ERISA.

- (b) Any Physician or Physician Group may submit Billing Disputes to the Billing Dispute External Review Board upon payment of a filing fee calculated as set forth in § 7.10(e) and in accordance with the provision of this § 7.10(b)(iv), after the Physician or Physician Group exhausts Company's internal appeals process, when the amount in dispute (either a single claim for Covered Services or multiple claims involving similar issues) exceeds \$500. Company shall post a description of its provider internal appeals process on the Provider Website.
 - (i) Notwithstanding the foregoing, a Physician or Physician Group may submit a Billing Dispute if less than \$500 is at issue and if such Physician or Physician Group intends to submit additional Billing Disputes during the one (1) year period following the submission of the original Billing Dispute which involve issues that are similar to those of the original Billing Dispute, in which event the Billing Dispute External Review Board will, at the request of such Physician or Physician Group, defer consideration of such Billing Dispute while the Physician or Physician Group accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the Termination Date, the Physician or Physician Group has not accumulated the requisite amount of Billing Disputes and Company has chosen not to continue the Billing Dispute process following the Termination Date, then any rights the Physician or Physician Group had as to such Billing Disputes, including rights to arbitration, shall be tolled from the date the Billing Dispute was submitted to the

Billing Dispute External Review Board through and including the Termination Date.

- (ii) In any event, a Physician or Physician Group will have one (1) year from the date he or she submits the original Billing Dispute and notifies the Billing Dispute External Review Board that consideration of such Billing Dispute should be deferred to submit additional Billing Disputes involving issues that are similar to those of the original Billing Dispute and amounts in dispute that in aggregate exceed \$500. In the event such additional Billing Disputes are not so submitted pursuant to the preceding sentence, the Billing Dispute External Review Board shall dismiss the original Billing Dispute and any such additional Billing Disputes and, in that event, the filing fee will be refunded by Company to the Physician or Physician Group.
- (iii) The filing fee shall be payable upon the submission of the original Billing Dispute and shall apply to all subsequent Billing Disputes submitted pursuant to the first sentence of 7.10(b)(ii) until the aggregate amount at issue exceeds \$1,000 at which time additional filing fees will be payable in accordance with § 7.10(e). The Physician or Physician Group may withdraw the Billing Disputes at any time before the aggregate amount in dispute reaches \$500 and, in that event, the filing fee will be refunded by Company to the Physician or Physician Group.
- (iv) The Physician or Physician Group must exhaust Company's internal appeals process before submitting a Billing Dispute to the Billing Dispute External Review Board; provided that a Physician or Physician Group shall be deemed to have satisfied this requirement if Company does not communicate notice of a decision resulting from such internal appeals process within 45 days of receipt of all documentation reasonably needed to decide the internal appeal. In the event Company and a Physician or Physician Group disagree as to whether the requirements of the preceding sentence have been satisfied, such disagreement shall be resolved by the Billing Dispute External Review Board. Except as otherwise provided in § 7.10(a),

all Billing Disputes must be submitted to the Billing Dispute External Review Board no more than 90 days after a Physician or Physician Group exhausts Company's internal appeals process and the Billing Dispute External Review Board shall not hear or decide any Billing Dispute submitted more than 90 days after Company's internal appeals process has been exhausted. Company shall supply appropriate documentation to the Billing Dispute External Review Board not later than 30 days after request by the Billing Dispute External Review Board, which request shall not be made, if Billing Disputes are submitted pursuant to § 7.10(b)(ii), until Billing Disputes have been submitted involving amounts in dispute that in aggregate exceed \$500.

- (v) Except to the extent otherwise specified in this § 7.10(b), procedures for review by the Billing Dispute External Review Board, including without limitation the documentation to be supplied to the reviewers or review organizations and a prohibition on *ex parte* communications between any party and the Billing Dispute External Review Board, shall be set by agreement between Company and Class Counsel, or their designee, and shall be set forth in the Certification filed annually and at the end of the Effective Period. Such procedures shall provide that (x) a Physician submitting a Billing Dispute to the Billing Dispute External Review shall state in the documents submitted to the Billing Dispute External Review Board the amount in dispute, and (y) that the Billing Dispute External Review Board shall not be permitted to issue an award based on an amount that exceeds the amount stated by such Physician or Physician Group in the documents submitted to the Billing Dispute External Review Board to be in dispute.
- (c) Any Physician who contests the appropriateness of Company's requirement that such Physician submit records, either prior to or after payment, in connection with Company's adjudication of such Physician's claims for payments may elect not to utilize the internal review process and request that the Billing Dispute External Review Board grant expedited review of the Company's requirement, if the Physician demonstrates to the Billing

Dispute External Review Board that Company's requirement has a significant adverse economic effect on the Physician which justifies expedited review. In the event that the Billing Dispute External Review Board determines that such Physician has not so demonstrated the Billing Dispute External Review Board shall dismiss such claim without prejudice, pending the exhaustion by such Physician of Company's internal appeals process.

- (d) Company and Class Counsel, or their designee, shall select the organization(s) that shall constitute the Billing Dispute External Review Board or Boards. If Company and Class Counsel, or their designee, cannot agree on members of the Billing Dispute External Review Board or Boards within 30 days of the Preliminary Approval Date, the matter shall be deemed a Compliance Dispute and referred to the Compliance Dispute Review Officer. Billing Disputes shall be stayed and any time limitations shall be tolled pending resolution of such Compliance Dispute. With respect to Billing Disputes brought by Participating Physicians, the members of the Billing Dispute External Review Board or Boards shall be bound by the terms of the applicable agreement between the Participating Physician and Company and the provisions of this Agreement. Otherwise, the Billing Dispute External Review Board shall resolve Billing Disputes based on generally accepted medical billing standards.
- (e) For any Billing Dispute that a Physician submits to the Billing Dispute External Review Board, the Physician submitting such Billing Dispute shall pay to Company a filing fee calculated as follows: (i) if the amount in dispute is \$1,000 or less, the filing fee shall be \$50 or (ii) if the amount in dispute exceeds \$1,000, the filing fee shall be equal to \$50, *plus* 5% of the amount by which the amount in dispute exceeds \$1,000, but in no event shall the fee be greater than 50% of the cost of the review.
- (f) Company's contract(s) with the Billing Dispute External Review Board or with members of the Billing Dispute External Review Board shall require decisions to be rendered not later than 30 days after receipt of the documents necessary for the review and to provide notice of such decision to the parties promptly thereafter.
- (g) In the event that the Billing Dispute External Review Board issues a decision requiring payment by Company,

Company shall make such payment within fifteen days after Company receives notice of such decision.

- (h) Company agrees to record in writing a summary of the results of the review proceedings conducted by the Billing Dispute External Review Board(s), including without limitation the issues presented. Company agrees to include a summary of the dispositions of such proceedings in the Certification to be filed annually and at the end of the Effective Period. If the same issue is the subject of not fewer than twenty (20) Billing Dispute External Review Board proceedings during the Effective Period, and Company's position is overturned in at least fifty percent (50%) of such matters, the Physician Advisory Committee shall discuss such payment issue at the next scheduled meeting, and at that time shall consider recommending an appropriate policy or practice change.
- (i) Except for Retained Claims, the Billing Dispute External Review Board process shall be available at the option of the Physician. If such Physician elects to utilize this process, then any decision by the Billing Dispute External Review Board shall be binding on Company and the Physician. For Retained Claims, all Billing Disputes shall be directed not to the Court nor to any other state court, federal court, arbitration panel (except as hereinafter provided) or any other binding or non-binding dispute resolution mechanism but instead shall be submitted to final and binding resolution before the Billing Dispute External Review Board so long as such Billing Dispute arises after the establishment of the Billing Dispute External Review Board pursuant to § 7.10(a).

7.11. Medical Necessity External Review Process.

- (a) Except as otherwise required by state law, Company currently maintains a nationwide process permitting Members of Fully Insured Plans, and Plan Members of Self-Insured Plans for which the sponsor of such Self-Insured Plan elects to participate, to seek independent external review of Company's determination that certain services or supplies are not Covered Services because they are not medically necessary or are experimental and investigational in nature. Additionally, certain states afford certain Plan Members external review opportunities on the terms and conditions specified by each such state.
“**Medical Necessity External Review Process**” means any

such process maintained by Company or afforded by states, in each case as described in the preceding two sentences. Company shall recommend the Medical Necessity External Review Process maintained by Company to Plan Sponsors for Self-Funded Plans, but except to the extent Plan Sponsors accept such recommendation, nothing contained in this § 7.11 is intended, or shall be construed, to apply to any Self-Funded Plan, except to the extent such Self-Funded Plan has chosen to provide its Plan Members with access to the Medical Necessity External Review Process. Company shall continue to maintain the Medical Necessity External Review Process or comparable process during the Effective Period. Within nine (9) months after the Implementation Date, or as soon thereafter as is practicable, Company shall make arrangements to enable Physicians to access each Medical Necessity External Review Process in circumstances in which a Plan Member could access that process under Company's policy or applicable law. The terms on which Physicians may access such process shall be identical to those applicable to Plan Members, except to the extent provided below in this § 7.11. To the extent that applicable law or regulation prevents Company from making arrangements in particular states for Physicians to access the Medical Necessity External Review Process established pursuant to such law or regulation, Company shall establish a comparable process in each such state, with terms and conditions consistent with this § 7.11.

- (b) Notwithstanding the provisions of §7.11(a), Physicians may not seek review of any claim for which the Plan Member (or his or her representative) seeks review through the Medical Necessity External Review Process. In the event that both Plan Member (or his or her representative) and Physician seek review, the Plan Member's claim shall go forward and the Physician's claim shall be dismissed and may not be brought by or on behalf of the Physician in any forum.
- (c) Notwithstanding the provisions of § 7.11(a), Physicians may not seek review of any claim for which the Plan Member (or his or her representative) has filed suit under § 502(a) of ERISA. In that event, or if such a suit is subsequently initiated, the Plan Member's lawsuit shall go forward and the Physician's claims shall be dismissed and may not be brought by or on behalf of the Physician in any forum; provided that such dismissal shall be without

prejudice to any Physician seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Physician and not to such Plan Member.

- (d) Nothing contained in this § 7.11 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures under § 503 of ERISA.
- (e) Company shall maintain an internal appeals process for medical necessity denials and shall disclose such process on the Public Website. Company shall adjudicate all such appeals of medical necessity denials on the timeframes that are applicable to Plans subject to ERISA, regardless of whether such Plans are actually subject to ERISA. Upon the express request of a Physician pursuing through such internal appeals process Company's denial of coverage for that Physician's service on the ground that such service is or was not medically necessary, before deciding such appeal, Company shall consult with a specialist in the same specialty (or, in Company's sole and absolute discretion, the same sub-specialty) as the Physician appealing such decision. Physician may access the Medical Necessity External Review Process only after exhausting any applicable Company or Plan Sponsor internal appeals process.
- (f) Physician shall initiate the Medical Necessity External Review Process by submitting to Company a request for external review. That request shall be deemed timely if submitted by Physician within the time frame specified in the communication from Company to Plan Member advising of the adverse coverage determination. Company shall forward timely requests to the applicable Medical Necessity Independent Review Organization. Company shall make external review request forms available on the Public Website.
- (g) To access the Medical Necessity External Review Process, Physician shall pay a filing fee of \$50; provided that if the matter involves services or supplies for which Company requires pre-certification (other than pre-certification required for registration purposes only), then the filing fee shall be the lesser of \$250 or 50% of the Billing Dispute External Review Board's fees.

- (h) In the event the Medical Necessity External Review Process is initiated by a Physician, the Medical Necessity Independent Review Organization shall request documentation from Company promptly but in any event no later than five (5) Business Days after the Physician pays the filing fee and Company shall provide such requested documentation within ten Business Days. The Medical Necessity Independent Review Organization shall provide a decision within 30 days of Company's submission of all necessary information.
- (i) Company shall cause its contracts with each Medical Necessity Independent Review Organization to be consistent with the terms of this § 7.11.
- (j) This Medical Necessity External Review Process shall be available at the option of the Physician. If such Physician elects to utilize this process, then any decision by the Medical Necessity Independent Review Organization shall be binding on Company and the Physician.

7.12. Electronic Remittance Advice and Electronic Fund Transfers.

- (a) As an inducement for increased electronic submission of claims, beginning within six (6) months after the Implementation Date, or as soon thereafter as practicable, Company shall establish a mechanism to reimburse Qualifying Physician Offices for their actual cost toward each Qualifying Physician Office's acquisition of software to facilitate electronic remittance advice and electronic funds transfer transactions ("**ERA/EFT Software**"), such reimbursement not to exceed \$500 per Qualifying Physician Offices; provided that Company's reimbursement obligation shall terminate on the earlier of two years from its date of inception or at such time as Company has paid \$5,000,000.00 pursuant to this § 7.12.

"Qualifying Physician Offices" shall mean offices through which Participating Physicians have submitted in excess of three hundred (300) claims to Company electronically in the calendar quarter immediately preceding the date upon which such Qualifying Physician Office applies for the reimbursement described in this § 7.12.

If as of the second anniversary of the Implementation Date Company has not paid up to \$5,000,000 in subsidy payments pursuant to this § 7.12, Company shall then offer

reimbursement in an amount not to exceed \$200.00 per Participating Physician office, to offices through which Participating Physicians have submitted in excess of one hundred (100) but less than three hundred (300) claims to Company electronically in the calendar quarter immediately preceding the date upon which such Participating Physician office applies for the reimbursement described in this §7.12. Notwithstanding the foregoing, Company's reimbursement obligation pursuant to this § 7.12 shall terminate at such time as Company has paid a total of \$5,000,000 in subsidy and reimbursement payments pursuant to this § 7.12.

- (b) Where multiple offices acquire a single software package, they will be treated as a single Qualifying Physician Office for purposes of determining if they are entitled to payment pursuant to this § 7.12.
- (c) Company and Class Counsel, or their designee, shall mutually agree upon the documentation to be submitted by a Qualifying Physician Office to receive such reimbursement; provided that such documentation shall include, at a minimum, evidence establishing that such Qualifying Physician Office has acquired and implemented ERA/EFT Software subsequent to the Implementation Date and prior to the date on which such Qualifying Physician Office seeks reimbursement pursuant to this § 7.12. Company shall make reimbursement pursuant to this § 7.12 not later than 30 days after receipt by Company of satisfactory documentation, as specified pursuant to the preceding sentence.
- (d) Company will publicize on the Provider Website the availability of electronic remittance advice and electronic funds transfer capabilities. Company will also make reasonable investments, not required to exceed \$500,000, over the course of two years commencing upon initiation of this inducement program to conduct educational seminars and other programs, as Company deems appropriate, to educate Participating Physicians about ERA/EFT Software capabilities and to promote the reimbursement program.
- (e) The aggregate amounts of reimbursements and monies spent toward educational activities provided through the most recently practicable date shall be included in the

Certification to be filed annually and at the end of the Effective Period.

7.13. Participating in Company's Network.

(a) Credentialing of Physicians.

Commencing six (6) months after the Implementation Date, or as soon thereafter as is practicable, upon request of a Physician Group (which is comprised of Participating Physicians) that has agreed to employ a Physician new to that Physician Group, Company shall make commercially reasonable efforts to complete primary source verification within 90 days of receiving such Physician's completed application to be a Participating Physician and commit that the Credentialing Committee in each market shall meet at least once every 45 days to consider credentialing applications for which primary source verification has been completed. Company shall permit Physicians and Participating Physician groups to submit applications prior to the time when the Physician becomes actively employed with a Participating Physician group. Company agrees to include in the Certification the dates of such Credentialing Committee meetings during the Effective Period. The commitment set forth in this § 7.13(a) shall not extend to Physician Groups practicing in Arkansas or other states in which a state authority has responsibility for verifying credentialing information.

(b) All Products Clauses.

Company agrees that it shall not require a Participating Physician to participate in capitated fee arrangements in order to participate in products in which such Participating Physician is compensated on a fee for service basis. In the event that a Participating Physician (or Physician Group comprised of Participating Physicians or Physician Organization) chooses not to participate in all Company products, or terminates participation in some Company products, the fee-for-service rate schedule offered to or applied by Company to such Participating Physician (or Physician Group comprised of Participating Physicians or Physician Organization) shall not be lower than Company's standard fee-for-service rate schedule for the geographic market in which such Participating Physician (or Physician Group comprised of Participating Physicians or Physician Organization) practices. Nothing

in this § 7.13(b) is intended or shall be construed to prohibit Company from offering a higher fee-for-service rate schedule, or other incentive, to any Participating Physician (or Physician Group comprised of Participating Physicians or Physician Organization) who elects to participate (or continue participation in) all of Company's products. Nothing contained herein shall restrict in any way Company's contracting practices with respect to hospitals.

(c) Termination Without Cause.

Company agrees to include in its contracts with individual Participating Physicians and Physician Groups consisting of fewer than five Participating Physicians a provision permitting either party to terminate such contract without cause on not less than ninety (90) calendar days prior written notice; provided that if a Participating Physician provides notice of termination of such contract not more than fifteen (15) calendar days after receipt of a notice of Material Adverse Change, then such contract shall terminate coincident with the effective date of such Material Adverse Change. Company shall continue to have the right to negotiate and enter into contracts with Physician Organizations and Physician Groups consisting of five or more Participating Physicians allowing termination only for cause during the contract's initial term.

7.14. How Much Company Shall Pay.

(a) Standardization of Rates.

Company agrees to establish and operate a fee schedule or schedules for fee-for-service payments to Participating Physicians for each geographic market in which it maintains a network. Company agrees to update those fee schedules annually, and shall not reduce any scheduled fees for Physician Services, except as set forth below in this § 7.14(a), between such annual updates. The dates of such annual revisions, if any, shall be included in the Certification to be filed annually and at the end of the Effective Period. Notwithstanding the foregoing, in between such annual updates Company may increase or decrease the fee schedule payment rates for vaccines, pharmaceuticals, durable medical supplies or other goods or non-Physician Services to reflect changes in market prices, and Company may update fee schedules for Physician Services to add payment rates for newly-adopted

CPT® codes and for new technologies, and new uses of established technologies, that Company concludes are eligible for payment, and to update such fee schedules to reflect any applicable interim revisions made by CMS. Nothing contained herein shall prevent Company from maintaining, altering or expanding the use of capitation or other compensation methodologies.

(b) Payment Rules For Injectibles, DME, Administration Of Vaccines, and Review of New Technologies.

Company agrees to pay a fee (per the applicable fee schedule for Participating Physicians and a reasonable fee for Non-Participating Physicians) for the administration of vaccines and injectibles in addition to paying for such vaccines and injectibles. Company agrees to pay Participating Physicians for the cost of injectibles and vaccines at the rate set forth in the applicable fee schedule in each market, as in effect from time to time. With respect to capitated Participating Primary Care Physicians, Company agrees to continue paying fees in addition to the capitation payments for primary care services administered pursuant to the schedules recommended by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices, as applicable; provided that if the primary care Participating Physician so requests, Company may include such fees within the scope of capitated services. As of the effective date of such recommendation, Company shall pay for vaccines newly recommended by the institutions identified above. Other than as specified in the preceding sentence with respect to vaccines, if a Physician Specialty Society recommends a new technology or treatment or a new use for an established technology or treatment as an appropriate standard of care, Company shall evaluate such recommendation and issue a Coverage Policy Bulletin or the equivalent not later than 120 days after Company learns of such Physician Specialty Society recommendation. Company agrees to list in the Certification to be filed annually and at the end of the Effective Period the dates on which such updates are completed and to include in such Certification any written policies and procedures it has developed regarding payments for the administration of vaccines and injectibles.

7.15. Recognition of Assignments of Benefits by Plan Members.

Company shall recognize all valid assignments by Plan Members of Plan benefits to Physicians; provided that

Company shall not be obligated to recognize such assignments in any market in which a competitor with substantial market share declines to recognize similar benefits assignments. Nothing in this § 7.15 is intended or shall be construed to limit Class Members' right to challenge any such competitor's non-acceptance of benefit assignments.

7.16. Application of Clinical Judgment to Patient-Specific and Policy Issues.

(a) Patient-specific Issues Involving Clinical Judgment.

(i) Medical Necessity Definition

Company shall include in its agreements with Participating Physicians the following definition of “Medically Necessary” or comparable term in each such agreement: “**Medically Necessary**” or “**Medical Necessity**” shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with

the standards set forth in the second sentence of § 7.16(b).

(ii) Medical Necessity Denial Rate

For the calendar year beginning after the Implementation Date, and thereafter during the Effective Period, Company shall make an annual, aggregate disclosure of the percentage of Covered Services recommended or provided by treating Physicians that Company, in accordance with § 7.16(a)(i) denies payment or authorization of on grounds of medical necessity. Company shall make this disclosure by means of the Provider Website or other comparable electronic medium. In calculating this percentage, neither denial or reduction in payment for other reasons (e.g., benefit exclusion or limitation, bundling, calculation of prevailing or usual and customary rate) nor reduction in hospital or other facility charges shall be treated as a medical necessity denial for purposes of the preceding sentence, and denials by Delegated Entities shall not be included in this disclosure. Company shall include in the denominator for such calculations all pre-authorization requests and all claims, measured by individually listed services or procedures codes, submitted directly to Company (i.e. not through a Delegated Entity) by Physicians. Copies of the annual disclosures specified in this paragraph shall be included in the Certification to be filed annually and at the end of the Effective Period.

(b) Policy Issues Involving Clinical Judgment.

In adopting clinical policies (e.g., Coverage Policy Bulletins and clinical practices guidelines) with respect to Covered Services, Company shall rely on credible scientific evidence published in peer-reviewed medical literature generally recognized by the medical community, and shall continue to make such policies readily available to Members

and Participating Physicians via the Public Website or by other electronic means. In formulating such policies, Company shall take into account Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors. Promptly after adoption, Company shall file a copy of each new policy or guideline with the Physicians' Advisory Committee.

(c) Future Consideration by Company of an Administrative Exemption Program.

Company shall consider the feasibility and desirability of exempting certain Participating Physicians from certain administrative requirements based on criteria such as the Participating Physician's delivery of quality and cost effective medical care and accuracy and appropriateness of claims submissions. Company shall not be obliged to implement any such exemption process during the term hereof, and this § 7.16(c) is not intended and shall not be construed to limit Company's ability to implement any such program on a pilot or experimental basis, base exemptions on any Company determined basis, or otherwise to implement one or more programs in only some markets.

7.17. Billing and Payment.

(a) Time Period for Submission of Bills for Services Rendered.

Except to the extent otherwise expressly specified by a Self-Funded Plan, Company shall not contest the timeliness of bills for Covered Services if such bills are received within 120 days after the later of: (i) the date of service and (ii) the date of the Physician's receipt of an EOB from the primary payor, when Company is the secondary payor. Company shall recommend to Self-Funded Plan sponsors that they adopt the 120 day time period referenced in the preceding sentence. Company shall waive the above requirement for a reasonable period in the event that Physician provides notice to Company, along with appropriate evidence, of extraordinary circumstances that resulted in the delayed submission. Company shall determine "extraordinary circumstances" and the reasonableness of the submission date. Except to the extent expressly provided in the first sentence of this § 7.17(a), nothing herein shall limit Company's ability to provide incentives for prompt submission of bills. The Certification to be filed annually and at the end of the Effective Period shall

include copies of the training and policy manuals enacted by Company to effectuate this commitment.

(b) Claims Submission.

Company agrees to accept both properly completed paper claims submitted on Form CMS-1500, UB-92 or the equivalent, and also electronic claims populated with similar information in HIPAA-compliant format or fields. Company shall not require Non-Participating Physicians to utilize electronic transactions. Company may continue to require submission of additional information in connection with review of specific claims and as contemplated elsewhere in this Agreement, including without limitation §§ 7.8, 7.19 and 7.20; provided that nothing in this sentence is intended or shall be construed to alter or limit any restrictions set forth elsewhere in this Agreement concerning Company's ability to make requests for medical records in connection with adjudication of claims. Company shall disclose on the Provider Website and the Public Website its policies and procedures regarding the appropriate format for claims submissions and requests for additional information. The Certification to be filed at the end of the Effective Period shall include a description of Company's policies and procedures regarding the appropriate format for claims submissions and requests for additional claim information.

7.18. Timelines for Processing of Clean Claims.

Company shall direct the issuance of a check or electronic funds transfer in payment for Clean Claims for Covered Services within the following time periods, in each case measured from the later of Company's receipt of such claim or the date on which Company is in receipt of all information needed and in a format required for such claim to constitute a Clean Claim, including without limitation all documentation reasonably needed by Company to determine that such claim does not contain any material defect or error; provided that nothing contained herein is intended or shall be construed to alter Company's ability to request documentation consistent with the provisions of § 7.8(c)(ii): 15 days for claims that Physicians submit electronically and 30 days for claims that Physicians submit on paper forms. Within six (6) months following the Implementation Date, Company shall cause to be incorporated into its interactive voice response telephone system sufficient functionality to permit a Physician to determine the date on which a submitted claim was determined by Company to constitute a Clean Claim. Company shall date stamp paper

claims for Covered Services upon receipt in the mailroom and generate an electronic acknowledgment of receipt of electronic claims for Covered Services when received by applicable Company computer system. Commencing one year after the Implementation Date, for each Clean Claim with respect to which Company has directed the issuance of a check or electronic funds transfer later than the applicable period specified in the preceding sentence Company shall pay interest at the lesser of the prime rate and eight percent (8%) per annum on the balance due on each such claim from the end of the applicable specified period up to but excluding the date on which Company issues the check (or issues instructions for electronic funds transfer) for payment of such Clean Claim; provided that to the extent that payment is made later than the period specified by applicable law, Company shall pay interest at any rate specified by such law or regulation in lieu of the interest payment otherwise contemplated by this sentence. Notwithstanding the foregoing, Company shall have no obligation to make any interest payment (i) with respect to any Clean Claim if, within 30 days of the submission of an original claim, a duplicate claim is submitted while adjudication of the original claim is still in process; (ii) to any Participating Physician who balance bills a Plan Member in violation of such Participating Physician's agreement(s) with Company; or (iii) with respect to any time period during which a Force Majeure, as defined in § 7.32 of this Agreement, prevents adjudication of claims. Company shall attempt to include in its contracts with each clearinghouse a requirement that each such clearinghouse transmit claims to Company within twenty four (24) hours after such clearinghouse's receipt thereof. The Certification to be filed annually and at the end of the Effective Period shall include the policy manual and training materials promulgated by Company to effectuate the commitment made in this § 7.18.

7.19. No Automatic Downcoding of Evaluation and Management Claims.

As of the Implementation Date, Company shall not automatically reduce the code level of evaluation and management codes billed for Covered Services ("**Downcoding**"). Notwithstanding the foregoing sentence, Company shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by selected Physicians or Physician Groups or Physician Organizations) based on a review of the information in the written medical record at the time the service

was rendered for particular claims, a review of information derived from Company's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate coding of evaluation and management services; provided that the decision to reduce is based at least in part on a review of the clinical record.

7.20. Bundling and Other Computerized Claim Editing.

- (a) Company agrees to cooperate with and promote the establishment of one or more claim-editing software packages acceptable to Physicians and health plans and a mutually acceptable process for modifying such software package(s) to accommodate future evolution of CPT® and/or other billing rules or conventions. Company shall cause one or more suitable Company employees to provide reasonable assistance to such development efforts. Company agrees to adopt, without customization, any software developed pursuant to such development efforts if and when (1) designees of Class Counsel, which shall include the American Medical Association and State Medical Societies for States in which collectively 75% of the Physicians practice, certify their support of such software; and (2) other health insurers providing coverage to not less than seventy-five (75%) of natural persons insured through commercial insurance plans agree to adopt such software on the same basis. To the extent that any such agreed upon software is inconsistent with the terms of this Agreement, this Agreement shall be deemed to be modified to conform to the agreed-upon software, effective upon such adoption. The Parties agree to consult to determine actions necessary to effectuate this commitment that will be consistent with applicable law.
- (b) Pending adoption of such revised software product, Company agrees to take actions necessary on Company's part to cause the claim-editing software program it uses in the interim to continue to produce editing results consistent with the standards set forth in this § 7.20(b) and, if Company has actual knowledge of non-conformity with such standards, to take reasonable actions necessary on its part to promptly modify such software to any extent necessary to conform to such standards; provided that nothing in this paragraph is intended or shall be construed to require Company to pay for anything other than Covered Services for Plan Members, to make payment at any

particular rates, to limit Company's right to deny or adjust claims based on reasonable belief of fraudulent, abusive or other inappropriate billing practices (so long as the Physician has been given the opportunity to provide clinical records and Company has reviewed any clinical records so provided), or to supersede Individually Negotiated Contracts that specifically provide for alternative payment logic when the doctor has requested in writing that alternative payment logic, which is contained in Individually Negotiated Contracts, remain in effect. For purposes of this § 7.20(b) only, if any change to CPT® affects Company's obligations hereunder, Company will promptly develop plans to cause its payments to Physicians to be consistent with the commitments set forth in this § 7.20(b). Except as set forth below, the obligations set forth below in this § 7.20(b) shall take effect as of the Implementation Date.

- (i) No modifier 51-exempt codes shall be subject to Multiple Procedure Logic.
- (ii) "Add-on" codes, as designated by CPT®, shall be recognized and eligible for payment as separate codes and shall not be subject to Multiple Procedure Logic.
- (iii) If a bill contains a CPT® code for performance of an evaluation and management CPT® code appended with a modifier 25 and a CPT code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and eligible for payment, unless the clinical information indicates that use of the modifier 25 was inappropriate or Company has disclosed pursuant to § 7.8(c)(iii) that such services are not appropriately reported together.
- (iv) A CPT® code that includes supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that for each such procedure (e.g., review of x-ray or biopsy analysis), Company shall not be required to pay for supervision or interpretation by more than one Physician.

- (v) Other than codes specifically identified as modifier 51-exempt or “add-on”, a CPT® code that is considered an “indented code” within the CPT® code book shall not be reassigned into another CPT® code unless more than one indented code under the same indentation is also submitted with respect to the same service, in which case only one such code shall be eligible for payment; provided that for indented code series contemplating that multiple codes in such series properly may be reported and billed concurrently (e.g., cardiac catheterization series), all such codes properly billed shall be recognized and eligible for payment.
- (vi) A CPT® code appended with a modifier 59 shall be recognized and separately eligible for payment to the extent they designate a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that (1) such procedures or services are not normally reported together but are appropriately reported together under the particular circumstances and (2) it would not be more appropriate to append any other CPT®-modifier to such code or codes.
- (vii) During the Effective Period, no global periods for surgical procedures shall be longer than any period then designated on a national basis by CMS for such surgical procedures.
- (viii) Company shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® code is one among a series that differentiates among simple, intermediate and complex.
- (ix) Commencing six (6) months after the Implementation Date, or as soon thereafter as is reasonably practicable, Company shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as modifier 51 exempt since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and

(B) above, Company shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require Company to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.

- (x) Nothing contained in this § 7.20 shall be construed to limit Company's recognition of modifiers to those modifiers specifically addressed in this § 7.20.
- (a) Notwithstanding anything to the contrary in this § 7.20, Company shall continue to have the right to deny or pend claims based on a review of relevant medical records or based on a review of information derived from Company's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate billing.

7.21. EOB and Remittance Advice Content.

- (a) Company shall expend resources reasonably sufficient, with cost to Company not to exceed \$4,000,000, to revise by December 31, 2003 or as soon thereafter as practicable, the EOB forms for its traditional products to contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, any adjustment to the invoice submitted and generic explanation therefor in compliance with HIPAA requirements and such EOB shall specify an address and phone number for questions regarding the claim described on such EOB. Consistent with the desire that Plan Members receive accurate communications that do not disparage Non-Participating Physicians, each such EOB shall indicate the amount for which the Physician may bill the Member and state "Physician may bill you" such amount, or contain language to substantially similar effect, and shall not characterize disallowed amounts as unreasonable. The explanation of payment or similar forms that Company sends to Physicians communicating the results of claims adjudications shall contain at least: the name of and a number identifying the Plan Member, the

date of service, the amount of payment per line item, the procedure code(s), the amount of payment, any adjustment to the invoice submitted and generic explanation therefor in compliance with HIPAA requirements, as well as any adjustment or change in any code on a line by line basis, and shall specify an address and phone number for questions by the Physician regarding the claim described on such explanation of payment or comparable form. The forgoing sentence is not intended and shall not be construed to limit Company's right to replace the communications referred to in the preceding sentence with electronic remittance advices or the equivalent, to the extent such electronic remittances or the equivalent provide similar information and are consistent with legal requirements. Company shall include in the Certification to be filed annually and at the end of the Effective Period the final revised EOB form for its traditional products and the form or forms of communications sent to Physicians.

- (b) Representative Plaintiffs, Class Counsel and Company agree that this Agreement is not intended to alter or change the rights of a Non-Participating Physician to balance bill or to bill the Plan Member at rates and on terms that are agreed to between the Non-Participating Physician and the Plan Member.

7.22. Overpayment Recovery Procedures.

As of the Implementation Date, Company shall initiate or continue to take actions reasonably designed to reduce Overpayments. Such actions may include, without limitation, system enhancements to identify duplicate invoices prior to payment and construction and maintenance of a common Physician database for use in connection with payment of Physician invoices. Company shall publish on the Public Website and the Provider Website an address and procedures for Physicians to return Overpayments. In addition, other than for recovery of duplicate payments, Company shall provide Physicians with 30 days written notice before initiating Overpayment recovery efforts. The notice shall state the patient name, service date, payment amount, proposed adjustment, and explanation or other information (including without limitation procedure code, where appropriate) giving Physicians reasonably specific notice of the proposed adjustment. Company shall not initiate Overpayment recovery efforts more than 24 months after the original payment; provided that no time limit shall apply to initiation of

Overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Self-Funded Plan, and in the event that a Physician asserts a claim of underpayment Company may defend or set off such claim based on Overpayments going back in time as far as the claimed underpayment. The training and policy manual materials promulgated to effectuate this commitment, as well as the forms or methods promulgated to provide notice of overpayment and in effect at the end of the Effective Period, must be included in the Certification to be filed by Company annually and at the end of the Effective Period.

7.23. Efforts to Improve Accuracy of Information About Eligibility of Plan Members.

Commencing with the Implementation Date, Company shall initiate or continue to take actions reasonably designed to reduce Overpayments and claim denials resulting from inaccuracy of information about eligibility of Plan Members. Such actions may include, without limitation, the following:

- (a) Working collaboratively with large third party administrators who handle customer eligibility to develop systems for collecting and transmitting Plan Member eligibility information to Company on a timely and accurate basis.
- (b) Developing scorecards for large third party eligibility administrators to track the timeliness of the information they deliver to Company and the turnaround time for validating the termination of a Plan Member where the termination was implied by the removal of the Plan Member's name from the most recent eligibility file.
- (c) Working collaboratively with large third party eligibility administrators to develop systems that extract Plan Member termination information directly from a customer's payroll system to reduce the turnaround time for transmitting such information and the likelihood of errors.
- (d) Working collaboratively with plan sponsors to (i) increase the percentage of customers transmitting eligibility information to Company in an electronic format and (ii) increase the frequency of the transmissions of eligibility files from the customer to Company.

- (e) Developing employee metrics for Company's internal eligibility personnel to measure performance and reward behaviors that reduce the impact of retroactive termination of Plan Members on claims payments. The performance measures may include, without limitation, such behaviors as: (i) the timely delivery of reports to third party eligibility administrators/plan sponsors relating to terminated Plan Members; (ii) timely follow-up with such third party eligibility administrators/plan sponsors on such reports to verify the Plan Member's termination; and (iii) timely error correction.
- (f) Contacting customers by telephone prior to their contract renewal date to determine in as high a percentage as practicable whether the customer intends to terminate or renew coverage for its employees with Company.
- (g) The Certification filed annually and at the end of the Effective Period shall include the policy and training manuals promulgated to effectuate the commitments set forth in §§ 7.23(a)-(f) and any other relevant materials.

7.24. Provider Service Centers.

By December 31, 2004, or as soon thereafter as practicable, Company shall establish a reasonable number of dedicated provider service centers, or shall take other actions reasonably designed to improve the speed, accuracy and efficiency of responses to Physician inquiries and concerns. Company shall make expenditures reasonably needed to implement such commitments of not less than \$10,000,000, but shall not be required to expend more than \$15,000,000 within such time period. The amount of such expenditure shall be recorded in the Certification to be filed annually and at the end of the Effective Period and the Certification shall report, on an aggregate annual basis, the percentage of calls to the provider service centers (or equivalent organization) that are answered within 30 seconds.

7.25. Effect of Company Confirmation of Patient/Procedure Medical Necessity.

Company agrees that if Company certifies, in accordance with § 7.16(a) of this Agreement, that a proposed treatment is medically necessary for a particular Plan Member, Company shall not subsequently revoke that medical necessity determination absent evidence of fraud, evidence that the information submitted was materially erroneous or incomplete, or evidence of material

change in the Plan Member's health condition between the date that the certification was provided and the date of the treatment that makes the proposed treatment inappropriate for such Plan Member. In the event that Company certifies the medical necessity of a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the certified course of treatment shall be deemed to be a new request and Company's denial of such request shall not be deemed to be inconsistent with the preceding sentence. Any policies and procedures promulgated to effectuate this commitment and in effect at the end of the Effective Period shall be included in the Certification to be filed annually and at the end of the Effective Period.

7.26. Electronic Connectivity.

The Provider Website shall operate at times and with a degree of reliability comparable to that for Company's other websites. If for any 30-day period during the Effective Period, the Provider Website is inoperable or lacks reliability comparable to that for Company's other websites, Company shall take commercially reasonable measures to enhance the operability and reliability of the Provider Website. The Certification to be filed annually and at the end of the Effective Period must include the dates during the Effective Period on which the Provider Website has been substantially inoperable.

7.27. Information About Physicians on the Public Website.

Information currently posted on the Public Website about individual Physicians is derived from data supplied by those Physicians and from applicable agreements between Company and that Physician. Company shall take steps reasonably necessary to ensure that the Provider Website has the capacity to enable Participating Physicians to update their name, address, and telephone number; When Company is notified in writing by a Physician that such Physician is incorrectly listed the Public Website as a Participating Physician, Company shall delete any such erroneous reference within ten (10) Business Days after receipt of such notice and shall make corresponding changes in systems affecting the level of payments and generation of EOBs. The policy and training manuals promulgated and training efforts implemented to effectuate this goal shall be included in the Certification to be filed annually and at the end of the Effective Period.

7.28. Capitation and Physician Organization-Specific Issues.

(a) Capitation Reporting.

Company agrees to provide monthly reports to Participating Physicians, Physician Groups and Physician Organizations that receive capitation. These monthly reports will include membership information to allow reconciliation by Participating Physicians, Physician Groups and Physician Organizations, as applicable, of capitation payments, including without limitation Plan Member identification number or the equivalent, name, age, gender, medical group/Physician Organization number, co-payment, monthly capitation amount, primary care Physician, provider effective date, and, in the monthly report following an applicable change (e.g., selection of new PCP) a report of such change, as well as an explanation of any deductions. Copies of the forms of relevant reports in use by Company during the Effective Period shall be attached to the Certification to be filed annually and at the end of the Effective Period.

(b) Payments for Plan Members Under Capitation Who Do Not Select PCP at Time of Enrollment.

For a Plan Member who is enrolled in a Plan requiring selection of a primary care physician in a local market in which Company compensates all primary care Physicians on a capitated basis, if the Plan Member does not choose a primary care Physician upon enrollment, Company shall assign the Plan Member to a primary care Physician that is a Participating Physician randomly related to the Plan Member's home address zip code or on the basis of another reasonable method developed by Company. The Plan Member shall have the right to select a new primary care Physician at any time in accordance with such Plan Member's Plan. Company shall pay the assigned primary care Physician capitation or other contract rates, and the assigned primary care Physician shall become responsible for the care of the Plan Member in accordance with the applicable terms of such Participating Physician's agreement with Company, from the date of notice of the assignment; provided that if Company sends the notice of assignment after the Plan Member's coverage becomes effective, then Company shall pay such Participating Physician, Physician Group or Physician Organization, as applicable, the applicable rate retroactive to the Plan Member's effective date. The Certification to be filed annually and at the end of the Effective Period must include the training and policy manual materials promulgated to effectuate this commitment, and in effect during the Effective Period, as well as any forms or other

informational materials distributed to randomly designated Plan Members notifying them of their right to select a new primary care Physician.

7.29. Miscellaneous.

(a) “Gag” Clauses.

Company shall omit from its contracts with Participating Physicians any provision limiting the free, open and unrestricted exchange of information between Participating Physicians and Plan Members regarding the nature of the Plan Member’s medical conditions or treatment and provider options and the relative risks and benefit of such options, whether or not such treatment is covered under the Plan Member’s Plan, and any right to appeal any adverse decision by Company regarding coverage of treatment that has been recommended or rendered. Company agrees not to penalize or sanction Participating Physicians in any way for engaging in any free, open and unrestricted communication with a Plan Member or for advocating for any service on behalf of a Plan Member.

(b) Ownership of Medical Records.

Company’s standard agreements shall confirm that, as between Company and Participating Physicians, Physicians own their medical records and that Company has a right to receive or review such records only as reasonably needed in the ordinary course for customary uses such as for disease management, patient management, quality review, quality management, claims payment and audit purposes, including without limitation any audit activities undertaken by Company to comply with NCQA accreditation rules; provided that nothing herein is intended or construed to convey to Physicians any property interest in Company’s data or intellectual property that incorporates any medical records or related data obtained by Company from such Physician.

(c) Arbitration.

In any arbitration proceeding between Company and a Participating Physician who practices individually or in a Physician Group of less than five Physicians, the maximum fee payable by such Participating Physician shall be the lesser of (i) fifty percent (50%) of the total fee or (ii) \$1,000.

(d) Impact of this Agreement on Standard Agreements and Individually Negotiated Contracts.

Company's standard agreements and/or ancillary documents (e.g., criteria schedule) shall incorporate or be consistent with the commitments and undertakings Company makes in this Agreement. To the extent that Company's existing agreements with Participating Physicians, contain provisions inconsistent with the terms hereof, Company shall administer such agreements consistent with the terms set forth in this Agreement; provided that where Company and a Participating Physician, Physician Group or Physician Organization have an Individually Negotiated Contract, this Agreement shall not modify or nullify the individually negotiated terms of such Individually Negotiated Contracts unless the Participating Physician, Physician Group or Physician Organization notifies Company in writing, specifically setting forth the negotiated terms it seeks to have modified or nullified by this Agreement. Furthermore, Company upon request may separately agree with individual Participating Physicians, Physician Groups or Physician Organizations on customized rates and/or payment methodologies that deviate from the terms of its standard agreements.

(e) Impact of this Agreement on Covered Services

Notwithstanding anything to the contrary contained in this Agreement, nothing contained in this § 7 shall supercede or otherwise alter the scope of Covered Services of any Plan.

(f) Privacy of Records.

Company shall safeguard the confidentiality of Plan Member medical records in accordance with HIPAA, state and other federal law and any other applicable legal requirements. The training and policy manual materials promulgated to effectuate this commitment and in effect during the Effective Period shall be included in the Certification to be filed annually and at the end of the Effective Period.

(g) Pharmacy Risk Pools.

Company's contracting policies shall not require the use of pharmacy risk pools. The training and policy manual materials promulgated to effectuate this commitment and in effect during the Effective Period shall be included in the

Certification to be filed annually and at the end of the Effective Period.

(h) Ability of Physicians to Obtain “Stop Loss” Coverage From Insurers Other Than Company.

Company shall not restrict physicians from purchasing stop loss coverage from insurers other than Company. The training and policy manual materials promulgated to effectuate this commitment and in effect during the Effective Period shall be included in the Certification to be filed annually and at the end of the Effective Period.

(i) Pharmacy Provisions.

Company shall disclose to Plan Members whether that Plan Member’s health plan uses a formulary and, if so, explain what a formulary is, how Company determines which prescription medications are included in the formulary, and how often Company reviews the formulary list. When Company provides pharmacy coverage, Company shall make formulary information available to Plan Members. Company shall maintain the process, as reasonably amended, for covering formulary-excluded medications when medically necessary that is in place on the Execution Date. Company shall cover drugs prescribed for non-approved, medically necessary use except to the extent that the applicable Plan Member’s Plan expressly excludes such prescriptions; provided that Company shall retain the right to pre-certify coverage of specific medications for non-approved use. Company’s disclosure concerning pre-certification and potential restrictions on non-approved use of prescription medications shall be similar in substance to disclosure concerning formularies, as described above. The training and policy manual materials promulgated and training efforts implemented to effectuate the commitment set forth in this § 7.30(j), as well as any disclosure forms or methods, shall be included in the Certification to be filed annually and at the end of the Effective Period.

(j) Mail Order Discount Card.

Not later than six (6) months after the Implementation Date, Company shall begin distributing to Physicians forms permitting their patients to enroll in a program, sponsored by Company or an Affiliate, enabling individuals to purchase prescription medications at discounted prices through a Company-affiliated mail order pharmacy. Company shall

distribute such forms to each Physician (or Physician Office or Physician Group) upon request, and may in its discretion provide forms to other Physicians (or Physician Offices or Physician Groups) absent such request. Each such Physician (or Physician Office or Physician Group) shall have sole discretion to provide or decline to provide such forms to his or her patients, including without limitation uninsured individuals or individuals whose health insurance does not include pharmacy coverage, and Company shall not charge any fee to any Physician (or Physician Office or Physician Group) in connection with such distribution. The availability and amount of discounts shall be dependent on Company's ability to negotiate discounts for such medications; provided that Company will in good faith attempt to obtain prices representing on average a discount of at least twenty percent (20%) from prices that card holders ordinarily would pay for purchasing comparable medications through retail pharmacies.

(k) Physician Specialty Society Guidelines.

Notwithstanding anything to the contrary in this § 7, no claims adjudication policy or practice adhered to by Company shall be deemed to violate the terms of this Agreement to the extent such policy or practice is consistent with the then current billing or claims adjudication guidelines issued by a Physician Specialty Society.

(l) Scope of Company's Responsibilities.

The obligations undertaken by Company under § 7 of this Agreement shall be applicable only to those functions or activities performed directly by Company and its employees, or third parties (other than Delegated Entities) performing functions on Company's behalf. To the extent it deems practicable, Company shall endeavor to include in contracts entered into with Delegated Entities subsequent to the Implementation Date terms that are substantially equivalent to the terms of this Agreement; provided that Company shall not be liable hereunder in the event any Delegated Entity acts in a manner inconsistent with the terms of this Agreement.

(m) Copies of Contract.

Company shall provide a copy of its contract with a particular Physician (including without limitation contracts with a Physician Organization or a Physician Group in which such Physician participates) to such Physician, upon receipt by

Company of a written request by such Physician to provide such copy, except in circumstances where Company is restricted from providing a copy of the Physician Organization or Physician Group agreement specifically because of terms contained in that Physician Organization or Physician Group agreement. Company will not require that a restriction as described in the previous sentence be included in its agreements with Physician Organizations or Physician Groups.

(n) State and Federal Laws and Regulations.

Nothing contained in § 7 of this Agreement is intended to, or shall, in any way reduce, eliminate or supercede any Party's existing obligation to comply with applicable provisions of relevant state and federal law and regulations, and Company shall comply with state and federal law and regulations.

(o) Ability of Company to Modify Means of Disclosure.

Company may alter the method or means by which it makes any disclosure or otherwise transmits information as described in, and required by, this Agreement, so long as Company reasonably believes, expects and intends that the newly-adopted means or method of disclosure or transmission is as effective or more effective than the means or method set forth in this Agreement.

(p) Limitations on Obligations of Non-Participating Physicians.

No affirmative obligation that § 7 imposes on Physicians shall apply to any Non-Participating Physician unless and until, and then only to the extent that, with regard to each individual claim, such Non-Participating Physician submits or transmits to Company a claim for payment which designates therein that Physician has accepted assignment of payment of said claim.

7.30. Compliance With Applicable Law and Requirements of Government Contracts.

The obligations undertaken in § 7 herein shall be fulfilled by Company to the extent permissible under applicable laws and current or future government contracts. If, and during such time as, Company is unable to fulfill its obligations under this Agreement to the extent contemplated by this Agreement because to do so would require state or federal regulatory approval or action, Company shall perform the

obligation to the extent permissible by applicable law or by the terms of a government contract and shall continue to fulfill its other obligations under this Agreement, to the extent permitted by applicable law or by government contract. To the extent that any state or federal regulatory approval is required for any Party to implement any part of this Agreement, such Party shall make all reasonable efforts to obtain any necessary approvals of state or federal regulators as needed for the implementation of this Agreement. For any act required by this Agreement that cannot be undertaken without regulatory approval, the Implementation Date or Effective Date as to that act shall be delayed until such approval is granted.

7.31. Estimated Value of Section 7 Initiatives.

The Parties estimate that the approximate aggregate value of the initiatives and other commitments with respect to Company's business practices set forth in § 7 of this Agreement is \$300 million.

7.32. Force Majeure.

Company shall not be liable for any delay or non-performance of its obligations under this § 7 arising from any act of God, governmental act, act of terrorism, war, fire, flood, explosion or civil commotion. The performance of Company's obligations under this § 7, to the extent affected by the delay, shall be suspended for the period during which the cause persists.

8. Other Settlement Consideration.

In addition to the business initiatives set forth in § 7 of this Agreement, the settlement consideration shall include the establishment by Company of a charitable foundation, as described in more detail in § 8.1, and a settlement fund for payment of claims to Class Members, which will be established and operated in accordance with the provisions of §§ 8.2 through 8.6.

8.1. Foundation.

Company shall cause to be incorporated a not-for-profit corporation having the form of incorporation, officers, governance structure and purposes set forth in the term sheet that is attached hereto as Exhibit J (the "**Foundation**"). Prior to the date the Foundation is established, Class Counsel shall decide upon a name for the Foundation, which name shall be reasonably acceptable to Company. The Foundation shall be governed as set forth on Exhibit J by those Signatory Medical Societies specifically identified therein. Company shall take all actions necessary to obtain tax-exempt status for the Foundation under I.R.C. § 501(c)(3) as soon as reasonably practicable. All costs and expenses of

establishing the Foundation shall be paid by the Foundation and shall reduce the amount otherwise contributed by Company to the Foundation pursuant to this § 8.1. Upon the Effective Date, Company shall contribute \$20 million to the Foundation. Additional funding shall be provided to the Foundation by the Settlement Fund in accordance with §§ 8.5 and 8.6 of this Agreement.

8.2. Settlement Fund.

By no later than the Implementation Date, Company shall cause to be established an account for the administration of settlement payments to Class Members (the “**Settlement Fund**”), which account shall be governed by the terms of an escrow agreement to be entered into between Company and the escrow agent that is retained by Company to manage such account. Upon the Effective Date, Company shall cause to be contributed to the Settlement Fund the amount of \$100 million (the “**Settlement Amount**”), by wire transfer in immediately available funds. Such payment shall be treated as a payment to a Qualified or Designated Settlement Fund under I.R.C. § 468B and the regulations or proposed regulations promulgated thereunder (including without limitation Treasury Reg. § 1.468B-1-5 or any successor regulation).

8.3. Responsibilities of the Settlement Administrator.

The settlement administrator that is selected and retained by Company (the “**Settlement Administrator**”), under the joint supervision of Company and Class Counsel or their designees, and subject to the supervision, direction and approval of the Court, shall be responsible for the administration of the Settlement Fund. The responsibilities of the Settlement Administrator shall expressly include without limitation: (a) the determination of the eligibility of any Class Member to receive payment from the Settlement Fund and the amount of payment to be made to each Class Member, in accordance with the provisions of § 8.4 of this Agreement; (b) the determination as to whether the election of any Class Member to transfer a settlement payment to the Foundation has been authorized by such Class Member, in accordance with the provisions of § 8.4 of this Agreement; (c) the administration of an appropriate procedure for the adjudication of disputes that may arise with respect to the eligibility of a Class Member to receive a payment from the Settlement Fund or the amount of the payment authorized to be made by the Settlement Fund to any Class Member under the provisions of this Agreement; (d) the filing of any tax returns necessary to report any income earned by the Settlement Fund and the payment from the Settlement Fund, as and when legally required, of any tax payments (including interest and penalties) due on income earned by the Settlement Fund and to request refunds, when and if appropriate, with any such tax refunds that are issued to become part of the Settlement Fund; and (e) the compliance by the

Settlement Fund with any other applicable law. The fees and expenses of the Settlement Administrator shall be paid by Company; provided that neither Company nor Class Counsel shall be responsible for any other costs, expenses or liabilities of the Settlement Fund.

8.4. Method of Distribution of the Settlement Fund; Contributions to the Foundation.

- (a) The portion of the Settlement Fund that will be available in the aggregate to satisfy claims by Retired Physicians (the “**Retired Physician Amount**”) shall be equal to the Settlement Amount multiplied by two times the quotient derived by dividing the number of Retired Physicians by the total number of Class Members. Each Retired Physician shall be entitled to elect either (i) to receive a payment from the Settlement Fund equal to the Retired Physician Amount divided by the number of Retired Physicians or (ii) to direct the Settlement Fund to contribute an equivalent amount to the Foundation on his or her behalf.
- (b) The portion of the Settlement Fund that will be available in the aggregate to satisfy claims by Class Members other than Retired Physicians (the “**Active Physician Amount**”) shall be determined by subtracting the Retired Physician Amount from the Settlement Amount.
- (c) Each Active Physician shall be entitled to elect either to receive payment from the Settlement Fund or to direct the Settlement Fund to contribute an equivalent amount to the Foundation on his or her behalf, in each case in an amount to be determined according to the following formula:
 - (i) For each Active Physician, the Settlement Administrator shall determine, based on the books and records of Company for the years 2000, 2001 and 2002 and based on a list of all Active Physicians to be provided by the Settlement Administrator, if the aggregate payments during that period from Company to such Active Physician were (x) less than \$5,000, (y) at least \$5,000 but less than \$50,000, or (z) \$50,000 or greater.
 - (ii) As the result of the categorization in §8.4(c)(i), the Settlement Administrator shall determine the total number of Active Physicians who fall within each of the three categories set forth in that paragraph.

The Active Physician Amount shall be allocated based on the results of this categorization such that each Active Physician who falls within §8.4(c)(i)(x) shall be entitled to receive the Base Amount, each Active Physician who falls within §8.4(c)(i)(y) shall be entitled to receive twice the Base Amount and each Active Physician who falls within §8.4(c)(i)(i)(z) shall be entitled to receive three times the Base Amount.

- (d) The Settlement Administrator shall establish procedures to permit an Active Physician to establish, through the submission of billing records or similar information, that he or she should fall into a category entitled to a higher payment from the Settlement Fund, either because (i) the Active Physician received payments from Company through a Delegated Entity for providing Covered Services to Plan Members or (ii) the Active Physician would have qualified for such higher category based on aggregate payments received from Company over an earlier consecutive three-year period during the Class Period.
- (e) Company and Class Counsel shall cooperate and shall work together between the date hereof and the Preliminary Approval Date to agree upon an estimate of the number of Class Members, the number of Retired Physicians and the number of Active Physicians. These estimated numbers shall form the basis of the estimates of amounts that Retired Physicians and Active Physicians who submit Claim Forms will be entitled to receive in the settlement, which estimated amounts will be included in the Claim Forms distributed to such Retired Physicians and Retired Physicians. Company shall be entitled to make adjustments to the foregoing determinations in the event it subsequently determines that such estimate was materially inaccurate.
- (f) Company, Class Counsel and the Signatory Medical Societies shall make every reasonable effort to encourage Class Members to elect in their Claim Form to contribute their portion of the Settlement Fund to the Foundation.

8.5. Payment of Authorized Claims by the Settlement Fund

- (a) Each Class Member must submit a Claim Form to the Settlement Administrator in accordance with the instructions included in the Mailed Notice and the Published Notice no later than the date that is three (3)

months after the Notice Date (the “**Claim Deadline**”) in order for such Class Member to have a valid right to receive payment from the Settlement Fund.

- (b) Promptly after the Claim Deadline, the Settlement Administrator shall calculate the amount that is payable to, or on behalf of, each Class Member (or the Foundation) pursuant to the provisions of § 8.5(a) of this Agreement. Such calculations shall be based on (i) the formulas contained in § 8.4(a) – 8.4(d) of this Agreement; (ii) the estimated numbers of Retired Physicians and Active Physicians provided to the Settlement Administrator by Company and Class Counsel pursuant to § 8.4(e) of this Agreement and other information provided to the Settlement Administrator by Company and Class Counsel, (iii) Company’s books and records for the period beginning from 2000 through the end of 2002 and (iv) the number of Claim Forms submitted to the Settlement Administrator pursuant to the provisions of § 8.5(a) of this Agreement and the information contained therein or submitted therewith.
- (c) Promptly upon the later to occur of (i) completion by the Settlement Administrator of the calculations of the amounts that are payable in respect of Class Members who submitted claims in accordance with § 8.5(a) of this Agreement or (ii) the Effective Date (such later date, the “**Claims Payment Date**”), the Settlement Administrator shall cause the Settlement Fund to issue payment in accordance with the terms of the agreement between Company and the Settlement Administrator to Class Members who submitted claims in accordance with § 8.5(a) of this Agreement or to the Foundation, as directed by such Class Members.

8.6. Reversion to Foundation of Unclaimed Amounts

Promptly after the Claims Payment Date and after all amounts have been paid to Class Members or to the Foundation, at the direction of Class Members, in each case pursuant to § 8.5(c) of this Agreement, the Settlement Administrator shall determine the amount of funds remaining in the Settlement Fund, including interest earned on such funds but excluding taxes owed (the “**Reversion Amount**”). The Settlement Administrator shall provide written notice of the Reversion Amount to Company and Class Counsel and, no later than 20 Business Days after providing such written notice, the Settlement Administrator shall cause the

Settlement Fund to remit the Reversion Amount to the Foundation by wire transfer.

9. Attorneys' Fees, and Representative Plaintiffs' Fees

9.1. Company Shall Pay Attorneys' Fees.

Class Counsel intend to apply to the Court for an award of Attorneys' Fees in an amount not to exceed \$50 million, which application Company agrees not to oppose. Company shall pay such Attorneys' Fees in the amount awarded by the Court up to but not exceeding such unopposed amount in accordance with § 9.3 of this Agreement. If the Court awards Attorneys' Fees in excess of \$50 million, Class Counsel, on behalf of themselves and the Class, hereby covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The Attorneys' Fees agreed to be paid pursuant to this provision are in addition to and separate from all other consideration and remedies paid to and available to the Class Members who have not validly and timely requested to Opt-Out of this Agreement. Company shall not be obligated to pay any attorneys' fees or expenses incurred by or on behalf of any Releasing Party in connection with the Action, other than the payment of Attorneys' Fees in accordance with this § 9.1.

9.2. Company Shall Pay Representative Plaintiffs' Fees.

In addition to Attorney's Fees, Class Counsel intends to apply to the Court for an award of fees for each Representative Plaintiff in the amount of \$7,500, which application Company agrees not to oppose. Company shall pay such fees to Representative Plaintiffs in the amount awarded by the Court up to but not exceeding such unopposed amount in accordance with § 9.3. If the Court awards fees to Representative Plaintiffs in excess of \$7,500 each, Company shall have the right in its sole and absolute discretion to terminate this Agreement. The fees to Representative Plaintiffs agreed to be paid pursuant to this § 9.2 are in addition to the other consideration afforded the Class Members who have not validly and timely requested to Opt-Out of this Agreement. Company shall support the award of fees to Representative Plaintiffs up to \$7,500 as reasonable and appropriate and shall not to object to such request nor appeal an award up to the amounts specified above. Such amounts are the only consideration and fees that Released Parties shall be obligated to give Class Counsel or Representative Plaintiffs as a result of prosecuting and settling this Action, other than the additional express agreements made herein.

9.3. Timing of Fee Payments.

Attorneys' Fees and Representative Plaintiff fees shall be due and payable no later than five Business Days after the Effective Date. Attorneys' Fees and Representative Plaintiff fees shall not bear interest if paid as specified in the immediately preceding sentence. Payment of the Attorneys' Fees and Representative Plaintiffs' fees shall be in cash in immediately available funds, wired to one or more United States financial institutions as the Class Counsel may direct in writing ten (10) Business Days prior to the date that the payment is due. Past due amounts shall bear interest at the lesser of 8% or the Prime Rate. When and if Company transfers funds to the financial institution designated by Class Counsel in satisfaction of Attorneys' Fees as set forth in this § 9.3 and said amount is actually received and collected in immediately available funds by such designated financial institution, then Company is relieved of its obligation regarding payment of that amount as among the Class Counsel.

10. Application to Fully Funded and Self Funded Plans

This Agreement applies to Company's conduct with respect to both Fully –Insured Plans and Self-Funded Plans, except where otherwise specified or as provided by applicable law.

11. Limited Liability.

The Billing Dispute External Review Board or Boards (and its members and agents, if any), the Compliance Dispute Facilitator (and his agents, if any), the Internal Compliance Officer (and his agents, if any) and the Compliance Dispute Review Officer (and his agents, if any) do not owe a fiduciary duty to the Class Members, the Representative Plaintiffs, or Company. The Parties shall ask the Court to grant the Billing Dispute External Review Board, the Compliance Dispute Facilitator (and his agents, if any), the Internal Compliance Officer (and his agents, if any) and the Compliance Dispute Review Officer (and his agents, if any) limited immunity from liability to the effect that the above-mentioned (and their members and agents, if any) shall be liable only for willful misconduct and gross negligence.

12. Compliance Disputes Arising Under This Agreement.

12.1. Jurisdiction.

- (a) Compliance Dispute Facilitator.

All Compliance Disputes shall be directed not to the Court nor to any other state court, federal court, arbitration panel or any other binding or non-binding dispute resolution mechanism but to the Compliance Dispute Facilitator to be designated by Class Counsel. Company shall publish on the Public Website the name and address of the Compliance Dispute Facilitator. The proposed Order and Final Judgment shall provide that no state or federal court or dispute resolution body of any kind shall have jurisdiction over any enforcement of § 7 of this Agreement at any time, including without limitation through any form of review or appeal, except to the extent otherwise provided in this Agreement.

(b) Compliance Dispute Review Officer.

Pursuant to §§ 12.3 - 12.6, and subject to § 12.5, the Compliance Dispute Facilitator shall refer Compliance Disputes that satisfy the requirements of § 12.3(b) to the Compliance Dispute Review Officer for resolution. The Compliance Dispute Review Officer shall be agreed upon by Company and Class Counsel within 30 days of the Preliminary Approval Date. If the Compliance Dispute Review Officer is no longer able to serve in such role for any reason, then a replacement shall be chosen by mutual agreement of Class Counsel, or their designee, and Company. If Class Counsel, or their designee, and Company cannot mutually agree on such replacement Compliance Dispute Review Officer, such replacement Compliance Dispute Review Officer shall be a Person to be agreed upon by Company and Class Counsel prior to the Effective Date (the “**First Alternate**”). If the First Alternate is unable or unwilling to serve in such role for any reason, then such replacement Compliance Dispute Review Officer shall be a Person to be agreed upon by Company and Class Counsel prior to the Effective Date (the “**Second Alternate**”). If the Second Alternate is unable or unwilling to serve in such role for any reason, then such Compliance Dispute Review Officer shall be a Person to be agreed upon by Company and Class Counsel prior to the Effective Date.

(c) Company shall pay the fees and costs of the Compliance Dispute Facilitator and the Compliance Dispute Review Officer, which it shall fund yearly in amounts to be agreed upon prior to the Effective Date by Company and the Compliance Dispute Review Officer and the Compliance Dispute Facilitator, subject to review by Class Counsel. If these agreed-upon amounts shall be exceeded in any year, Company and Class Counsel (or their designee) shall meet

and confer in good faith to determine whether mutually acceptable additional funding amounts can be agreed. If the parties are unable to reach agreement following such good faith conferral, each party reserves the right to apply to the Court for relief relating exclusively to this § 12.1(c).

12.2. Who May Petition the Compliance Dispute Facilitator.

The following may petition the Compliance Dispute Facilitator (each a “**Petitioner**”):

- (a) any Class Member who has not validly and timely requested to Opt-Out of this Agreement and that, based on particularized facts, contends that Company has materially failed to perform specific obligations under § 7 of this Agreement, and that such Class Member is adversely affected by Company’s failure to comply with such specific obligations under § 7 such Compliance Dispute; and
- (b) any Signatory Medical Society, so long as such Signatory Medical Society (i) identifies in its petition to the Compliance Dispute Facilitator a Class Member who has not validly and timely requested to Opt-Out of this Agreement and that satisfies the requirements of § 12.2(a) and (ii) brings the Compliance Dispute solely on behalf of such Class Member.
- (c) Nothing in subsections (a) and (b) of this §12.2 is intended or shall be construed to limit the remedies that the Compliance Dispute Review Officer may order pursuant to §12.6(f) herein.

12.3. Procedure for Submission, and Requirements, of Compliance Disputes.

(a) Compliance Dispute Claim Form

Before the Compliance Dispute Facilitator may consider a Compliance Dispute, a Petitioner must submit a properly completed Compliance Dispute Claim Form, attached hereto as Exhibit C and approved by the Court, to the Compliance Dispute Facilitator. The Compliance Dispute Claim Form may include supporting documentation or affidavit testimony. The Compliance Dispute Claim Form shall be made available by the Compliance Dispute Facilitator to Class Members upon request.

(b) Qualifying Submissions

When the Compliance Dispute Facilitator is petitioned pursuant to § 12.2(a) of this Agreement, in order for the Compliance Dispute Facilitator to refer the Compliance Dispute to the Compliance Dispute Review Officer, the Compliance Dispute Facilitator must determine that:

- (i) the Petitioner has satisfied the requirements of § 12.2;
- (ii) the Petitioner has submitted a properly completed Submission not later than 30 days after such Compliance Dispute arose; and
- (iii) in the Compliance Dispute Facilitator's judgment, the Petitioner's Compliance Dispute
 - (a) is not frivolous,
 - (b) sufficiently alleges adverse impact to the Petitioner or, in the case of a Petitioner that is a Signatory Medical Society, the Class Member identified in the Submission and on whose behalf the Compliance Dispute is brought, in each case resulting from the alleged material failure by Company to comply with an obligation under § 7 of this Agreement to the Petitioner,
 - (c) cannot be easily resolved by the Compliance Dispute Facilitator without the intervention of the Compliance Dispute Review Officer, and
 - (d) is not properly the subject of a proceeding pursuant to §§ 7.10 or 7.11 of this Agreement.

If the Compliance Dispute Facilitator determines that the Petitioner's Compliance Dispute is properly the subject of an External Review proceeding pursuant to §§ 7.10 or 7.11 of this Agreement, the Compliance Dispute Facilitator shall expressly inform the Petitioner of the External Review procedures available to such Petitioner.

12.4. Rejection of Frivolous Claims.

The Compliance Dispute Facilitator may reject as frivolous, and the Compliance Dispute Review Officer shall not hear, any Compliance Dispute that the Compliance Dispute Facilitator determines in his or her sole and absolute discretion to be frivolous, filed for nuisance purposes, or otherwise without merit on its face. The Compliance Dispute Facilitator may issue a written explanation or a written order of the grounds for denial of Petitioner's Compliance Dispute. Petitioner shall have no right to appeal the Compliance Dispute Facilitator's decision.

12.5. Dispute Resolution Without Referral to Compliance Dispute Review Officer.

If in the Compliance Dispute Facilitator's judgment Petitioner's Compliance Dispute can be resolved using available resources without the invocation of the Compliance Dispute Review Officer's authority, the Compliance Dispute Facilitator shall refer the Petitioner to the appropriate resources or otherwise assist in the resolution of Petitioner's Dispute. All Parties agree that dispute resolution without invocation of the Compliance Dispute Review Officer's authority is preferable, and all Parties further agree to assist the Compliance Dispute Facilitator in these efforts.

12.6. Procedure for Compliance Dispute Review Officer Determination of Compliance Disputes.

(a) Initial Negotiation.

In the event the Compliance Dispute Facilitator has determined pursuant to §§ 12.2 - 12.5 that the Compliance Dispute Review Officer should resolve a particular Compliance Dispute, the Compliance Dispute Facilitator shall notify the Compliance Dispute Review Officer, Petitioner and Company of such determination and the basis therefor. Unless the Petitioner specifies otherwise, the Compliance Dispute Facilitator shall serve as the Petitioner's representative in the Compliance Dispute process thereafter with respect to such Compliance Dispute. The Compliance Dispute Review Officer shall then direct the Petitioner and Company to convene negotiations at a time and place agreeable to both so that they may reach agreement on whether a breach of Company's obligations under § 7 of this Agreement has occurred and, if so, what remedy, if any, should be implemented. At these negotiations, the Compliance Dispute Review Officer shall, if requested by both Petitioner and Company, serve as a non-binding mediator. If the Petitioner and Company cannot resolve

the Compliance Dispute within 90 days of the date of the determination and notification by the Compliance Dispute Facilitator that the Compliance Dispute Review Officer should resolve the Compliance Dispute, then they shall so inform the Compliance Dispute Review Officer.

(b) Memoranda to Compliance Dispute Review Officer.

If the Compliance Dispute Review Officer has been notified pursuant to § 12.6(a) that no agreement has been reached through negotiation, the Compliance Dispute Review Officer shall request written memoranda from the Petitioner and Company as to the merits of the Compliance Dispute and appropriate remedies for such Compliance Dispute. The Petitioner shall have 15 days from the date of the Compliance Dispute Review Officer's request to submit its memorandum and appropriate supporting exhibits, and Company shall respond within 15 days after Company's receipt of Petitioner's memorandum and accompanying exhibits. Requests for extensions of time for the submission of such materials must be submitted to the Compliance Dispute Review Officer no less than five (5) days before the date the memoranda and supporting exhibits in question are due.

(c) Oral Argument Concerning Compliance Dispute.

Petitioner or Company may, at the time of submission of the memoranda described in § 12.6(b), request oral argument before the Compliance Dispute Review Officer on the subject of the Compliance Dispute and appropriate remedies, if any. If either Person so requests, the Compliance Dispute Review Officer shall hear such argument at a time and place convenient to the Compliance Dispute Review Officer, the Petitioner, and Company.

(d) Decisions by the Compliance Dispute Review Officer.

In resolving a Compliance Dispute, the Compliance Dispute Review Officer shall decide, based on the written submissions, oral argument and any other information that the Compliance Dispute Review Officer in his or her sole discretion deems necessary, whether Company has failed to comply with its obligations under § 7 of this Agreement, and if so, direct what actions are to be taken by Company. In no event shall the Compliance Dispute Review Officer direct that Company spend amounts or take actions above or below Company's obligations under § 7 of this Agreement. The Compliance Dispute Review

Officer must, at the time he or she announces his or her decision, issue a written opinion setting forth the basis of the decision.

(e) Rehearing by the Compliance Dispute Review Officer.

After the Compliance Dispute Review Officer has issued a written opinion in accordance with § 12.6(d), the Petitioner or Company, or both, may petition the Compliance Dispute Review Officer within ten (10) days from receipt of the decision, in writing, for rehearing on the question of whether a § 7 violation has occurred and whether the remedies (if any) required by the Compliance Dispute Review Officer are appropriate. The Compliance Dispute Review Officer may deny the petition for rehearing or issue a new written opinion after considering such a petition.

(f) Systemic Violations.

If the Compliance Dispute Review Officer determines that Company is engaged in a systemic violation of its obligations under § 7 of this Agreement, then the Compliance Dispute Review Officer may order appropriate remedies to address such systemic violation.

(g) Finality of the Compliance Dispute Review Officer's Decision.

Upon the issuance of the Compliance Dispute Review Officer's decision after a rehearing, if any, the decision of the Compliance Dispute Review Officer shall be final unless appealed to the Court, and such decision shall not be appealed by Petitioner or Company to any other federal court, any state court, any State Medical Society, any arbitration panel or any other binding or non-binding dispute resolution mechanism. In the event that Petitioner or Company seeks review in the Court of a final decision of the Compliance Dispute Review Officer, the Court shall consider only whether the Compliance Dispute Review Officer's final decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," as defined by 5 U.S.C. § 706(2)(A), and whether the decision was contrary to or inconsistent with the second sentence of § 12.6(d) of this Agreement. If and only if the Court finds the final decision was "arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with law", or that the decision was contrary to or inconsistent with the second sentence of § 12.6(d) of this Agreement, the Court may remand

the Dispute to the Compliance Dispute Review Officer for further proceedings.

(h) Enforcement by the Court.

If the Compliance Dispute Review Officer certifies that either Company or Petitioner is not in compliance with any decision issued or remedy ordered by the Compliance Dispute Review Officer, such Person shall have 30 days from the date of such certification to cure the non-compliance. If after such 30 day period, the Person is not in compliance and the Compliance Dispute Review Officer certifies that the Person has failed to cure the non-compliance during such 30 day period, the other Person (Company or Petitioner, as the case may be) may petition the Court for enforcement.

12.7. Internal Compliance Officer.

In addition to and separate from the Compliance Dispute Review Officer and the Compliance Dispute Facilitator, Company shall designate an Internal Compliance Officer to generally monitor and facilitate Company's compliance with the obligations set forth in this Agreement. The Internal Compliance Officer shall report to Company's president, chief executive officer or general counsel ("**Senior Management**") and shall take whatever steps and conduct whatever compliance checks and investigations as he and Senior Management deem reasonably necessary and appropriate to monitor Company's compliance with this Agreement. Within 30 days after the end of each calendar year during the Effective Period, the Internal Compliance Officer shall file a written report with the Compliance Dispute Review Officer, the Compliance Facilitator and, upon written request, Class Counsel summarizing the Internal Compliance Officer's activities during the prior year and evaluating any problems or difficulties that Company encountered in complying with the terms of this Agreement, and shall simultaneously provide a copy of such report to the Physician Advisory Committee. Each annual report shall contain all the certifications required in the Certification to be filed at the end of the Effective Period; provided that following the initial annual report, subsequent reports may incorporate by reference any materials in prior year's reports that remain operative and have not been amended during the interim.

12.8. Settlement Commitments Modifiable to Prevent Substantial Impairment of Company's Competitive Position.

Company may alter or modify the agreements and undertakings set forth in § 7 only to the extent provided in this § 12.8. Company may spend less than the minimum amounts prescribed in § 7 if Company devises programs or plans that are reasonably designed to achieve comparable results or systems functionality at a lower cost. In that event, subject to appropriate confidentiality provisions, Company shall (i) file any such revised business program or plan with the Physician Advisory Committee not less than 30 days before implementation of such revised program or plan, together with the prior business program or plan and a certification of the Internal Compliance Officer that the revision is consistent with the preceding sentence and (ii) concurrently therewith give notice to Class Counsel (or their designee) of such filing and meet and confer with Class Counsel (or their designee) with respect thereto, if requested. Company may not revise any undertaking described in § 7 within the first 12 months after the Preliminary Approval Date. Thereafter, Company may modify any undertaking described in § 7 nationally or in particular geographic markets as reasonably needed to compete in the applicable marketplace. In that event, Company shall (i) file notice of any proposed modification with the Compliance Dispute Review Officer, the Physician Advisory Committee and Class Counsel, or their designee, not less than 60 days prior to implementing any such change and (ii) concurrently therewith, give notice to Class Counsel (or their designee) of such filing and meet and confer with Class Counsel (or their designee) with respect thereto, if requested. If Class Counsel, with the concurrence of the Compliance Dispute Facilitator, reasonably determines that such modification is not needed by Company for competitive reasons, then that determination shall be deemed to create a Compliance Dispute, and shall be referred to the Compliance Dispute Review Officer for resolution pursuant to § 12 hereof. Other than for proposed modifications to §§ 7.3, 7.6, 7.8, 7.9, 7.10, 7.11, 7.16, 7.18, 7.19 and 7.20, Company shall have the right to implement the proposed modification until any Compliance Dispute pursuant to § 12 is resolved. In the event that Company substantially modifies any provision of § 7 pursuant to this § 12.8, then the covenant not to sue that is set forth in § 13 shall be of no further force and effect with respect to the business practice that is the subject of such modification, to the extent of such modification.

13. Release; Covenant Not to Sue.

(a) Upon the Implementation Date, the “**Released Parties,**” which shall include Company and each of its present and former

parents, present and former wholly-owned subsidiaries, present and former divisions and Affiliates (including without limitation Lion Connecticut Holdings, Inc. (formerly known as “Aetna Inc.”, a Connecticut corporation) and each of its subsidiaries as of December 14, 2000) and each of their respective current or former officers, directors, employees, and attorneys (and the predecessors, heirs, executors, administrators, legal representatives, successors and assigns of each of the foregoing), but excluding all Delegated Entities and The Prudential Insurance Company of America, shall be released and forever discharged by the Signatory Medical Societies and all Class Members who have not validly and timely requested to Opt-Out of this Agreement, and by their respective heirs, executors, agents, legal representatives, professional corporations, partnerships, assigns, and successors, but only to the extent such Claims are derived by contract or operation of law from the Claims of Class Members, (collectively, the “**Releasing Parties**”) from any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys’ fees, losses, claims, liabilities and demands of whatever kind or character (each a “**Claim**”), arising on or before the Preliminary Approval Date, that are, were or could have been asserted against any of the Released Parties based on or arising from the factual allegations of the Complaint, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons.

(b) The Releasing Parties further agree to forever abandon and discharge any and all claims that exist now or that might arise in the future against any other persons or entities, which claims arise from, or are based on, conduct by any of the Released Parties that occurred on or before the Preliminary Approval Date and are, or could have been, alleged in the Complaint, whether any such claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons. Nothing in this Agreement is intended to relieve any Person or entity that is not a Released Party from responsibility for its own conduct or conduct of other Persons who are not Released Parties, or to preclude any Representative Plaintiff from introducing any competent and admissible evidence to the extent consistent with § 15.

(c) The claims and rights released and discharged pursuant to § 13(a) and (b), subject to the exception contained in § 13(d), shall be referred to collectively as “**Released Rights**” or “**Released Claims**.”

(d) Notwithstanding the foregoing, the Releasing Parties are not releasing claims for payment (each a “**Retained Claim**” and,

collectively, the “**Retained Claims**”) for Covered Services as to which, as of the Implementation Date, (i) no claim with respect to such Covered Services has been filed with Company; provided that the contractual period for filing such claim has not elapsed; or (ii) a claim with respect to such Covered Services has been filed with Company but such claim has not been finally adjudicated by Company. For purposes of clause (ii), above, final adjudication shall include completion of Company’s internal appeals process. In the event that a claim referred to in clause (ii) is finally adjudicated less than thirty (30) days prior to the Implementation Date, such claim shall constitute a Retained Claim if Physician seeks relief under § 7.10 not later than thirty (30) days after notice of such final adjudication, but otherwise such claim shall constitute a Released Claim. Retained Claims shall be resolved pursuant to the provisions of § 7.10 of this Agreement.

(e) Except to the extent provided in § 13(e)(3) and § 13(f), upon the Implementation Date, each Releasing Party shall be deemed to have covenanted and agreed not to sue with respect to, or assert, against any Released Party, in any forum:

(1) any Released Claim;

(2) any cause of action, judgment, lien, indebtedness, costs, damages, obligation, attorneys’ fees, losses, claims, liabilities and demands of whatever kind or character arising after the Preliminary Approval Date, that in any way relates to, arises from, is similar to, or is based on, the causes of action and/or factual allegations in the Complaint, but only to the extent such cause of action, judgment, lien, indebtedness, cost, damage, obligation, attorneys’ fee, loss, claim, liability or demand is based on any actions or omissions by the Company that are consistent with Company’s practices and procedures as of the Execution Date, as modified by the requirements and provisions of this Agreement; and

(3) any Retained Claim or any Compliance Dispute, which respectively shall be asserted and pursued only pursuant to the provisions of § 7.10 and § 12.1 through § 12.7 of this Agreement (it being understood that this subsection 13(e)(3) shall not apply to any claims that arise within 20 days before the Termination Date that could not reasonably be presented or resolved pursuant to the procedures set forth in § 12; provided that any such claim shall be prosecuted on an individual basis only and not otherwise).

(f) Notwithstanding the foregoing, Releasing Parties shall retain the rights: (i) to enforce Company's obligations under § 7.29(n) pursuant to the procedures set forth in § 12.1 through 12.7 of this Agreement; (ii) to bring an action asserting claims against Company by or on behalf of Physicians to recover amounts alleged to be owed to such Physicians by any Physician Organization that has become insolvent, provided that no such action may be commenced or maintained against Company unless substantially all health plans or insurers who contracted with such Physician Organization and have not paid all amounts allegedly owed to Physicians with respect to such insolvent Physician Organization are named as defendants in addition to Company and further provided that in any such action Company may assert all available legal claims and defenses, including without limitation defenses based on the fraudulent conduct of such Physician Organization; and (iii) to institute judicial proceedings seeking solely non-monetary, non-injunctive declaratory relief with respect solely to the meaning or interpretation of state and federal law or regulations. In the event that Releasing Parties believe that one or more actions of Company are inconsistent with any declaration issued in connection with a proceeding described in (iii), above, Releasing Parties may pursue a Compliance Dispute pursuant to § 12.1 through 12.6 of the Agreement, but shall not otherwise seek to enforce such declaration as to Company.

(g) The Parties agree that Company shall suffer irreparable harm if a Releasing Party takes action inconsistent with either § 13(e) or § 13(f), and that in that event Company may seek an injunction from the Court as to such action without further showing of irreparable harm.

(h) Nothing contained in this Agreement is intended, or shall be construed, to preclude any Party from seeking legislative or regulatory changes as to matters addressed herein or from seeking to enforce any such changes using any available legal remedy.

14. California Civil Code § 1542

Each Class Member who has not validly and timely requested to Opt-Out of this Agreement and each Signatory Medical Society hereby expressly waives and releases, upon the entry of Final Order and Judgment, any and all provisions, rights and benefits conferred by California Civil Code § 1542, which reads:

“General Release; extent. A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the

release, which if known by him must have materially affected his settlement with the debtor”;

and all provisions, rights and benefits conferred by any law of any state or territory of the United States, or principle of common law, which are similar, comparable or equivalent to California Civil Code § 1542. Each Class Member who has not validly and timely requested to Opt-Out of this Agreement and each Signatory Medical Society may hereafter discover facts other than or different from those which he, she or it knows or believes to be true with respect to the claims which are the subject matter of the provisions of § 13, but each such Class Member and each Signatory Medical Society hereby expressly waives and fully, finally and forever settles and releases, upon the entry of Final Order and Judgment, any known or unknown, suspected or unsuspected, contingent or non-contingent claim with respect to the subject matter of the provisions of § 13, whether or not concealed or hidden, without regard to the discovery or existence of such different or additional facts.

15. Stay of Discovery, Termination, and Effective Date of Agreement.

(a) Until the Preliminary Approval Order has been entered, including the stay of discovery as to the Released Parties in the form contained therein, the Releasing Parties and Class Counsel covenant and agree that Class Counsel shall not pursue discovery against the Released Parties and shall not in any way subsequently argue that the Released Parties have failed to comply with their discovery obligations in any respect by reason of the Released Parties’ suspension of discovery efforts following the Execution Date.

(b) If, at the Preliminary Approval Hearing or within 15 days thereafter, the Court does not enter the Preliminary Approval Order and approve the Mailed Notice, the Published Notice and the Claim Form submitted to the Court pursuant to § 4 of this Agreement, in each case in substantially the same form as Exhibits A, E, F and G, each of Class Counsel and Company shall have the right, in the sole and absolute discretion of such Party, to terminate this Agreement by delivering a notice of termination to the other, it being understood that, notwithstanding the foregoing, if the Court does not grant the stay of discovery as to Company and the interim injunction with respect to the Tag Along Actions, each in the form contained in the Preliminary Approval Order, Company may in its sole and absolute discretion terminate this Agreement by delivering a notice of termination to Class Counsel. In the event of any termination pursuant to the terms hereof, the Parties shall be restored to their original positions, except as expressly provided herein.

(c) If the Court has not entered the Final Order and Judgment (including without limitation the Bar Order) substantially in the form attached hereto as Exhibit D by the date that is 180 calendar days after the Preliminary Approval Date, each of Class Counsel and Company may, in the sole and absolute discretion of such Party, terminate this Agreement by delivering a notice of termination to the other.

(d) If the Final Order and Judgment (including without limitation the Bar Order) is entered by the Court and the time for appeal from all of such orders and judgment has elapsed (including without limitation any extension of time for the filing of any appeal that may result by operation of law or order of the Court) with no notice of appeal having been filed, the “**Effective Date**” shall be the 11th day after the last date on which notice of appeal could have been timely filed. If the Final Order and Judgment (including without limitation the Bar Order) is entered and an appeal is filed as to any of them, the “**Effective Date**” shall be the eleventh (11th) calendar day after the Final Order and Judgment (including without limitation the Bar Order), is affirmed, all appeals are dismissed, and no further appeal to, or discretionary review in, any Court remains.

(e) From and after the Effective Date, the Releasing Parties and Class Counsel covenant agree that the Releasing Parties and Class Counsel shall not pursue discovery against the Released Parties. Nothing contained herein shall preclude the Releasing Parties or Class Counsel from introducing and relying on otherwise admissible evidence as to other defendants.

(f) Notwithstanding § 15(d), if one or more notices of appeal are filed from the Final Order and Judgment (including without limitation the Bar Order), Company shall have the right, in its sole and absolute discretion, to provide notice of the occurrence of the Effective Date and the Parties shall thereafter be bound by this Agreement and shall perform their respective obligations as if the Final Order and Judgment had been affirmed. If the Final Order and Judgment (including without limitation the Bar Order) is not affirmed in their entirety on any such appeal or discretionary review, Company may, in its sole and absolute discretion, terminate this Agreement by delivering a notice of termination to Class Counsel. If Company does not elect to so terminate this Agreement, Company shall be entitled, in its sole and absolute discretion, to provide notice of the occurrence of the Effective Date (if the Company has not already done so pursuant to the first sentence of this paragraph) and the Parties shall continue to be bound by this Agreement and shall perform their respective

obligations hereunder as if the Final Order and Judgment had been affirmed in its entirety on such appeal or discretionary review.

(g) This Agreement shall terminate (the “**Termination Date**”) upon the earlier to occur of (i) termination of this Agreement by any Party pursuant to the terms hereof and (ii) the four-year anniversary of the Preliminary Approval Date. Effective on the Termination Date, the provisions of this Agreement shall immediately become void and of no further force and effect and there shall be no liability on the part of any of the Parties, except for willful or knowing breaches of this Agreement prior to the time of such termination; provided that in the event of a termination of this Agreement as contemplated by clause (ii) of this § 15(g), (B) the provisions of §§ 13(a), (b), (c), (d), (e)(1), (f), (g), (h) and §§ 18, 20 and 21 shall survive such termination indefinitely, (B) the provisions of § 7.10 and § 7.11 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Billing Disputes that are in the process of being resolved by the Billing Dispute External Review Board as of the date of such termination and any disputes described in § 7.11(a) that are being resolved pursuant to the Medical Necessity External Review Process as of the date of such termination and (C) the provisions of §§ 12.1 through 12.6 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Compliance Disputes that are in the process of being resolved by the Compliance Dispute Review Officer as of the date of such termination. In the event of termination of this Agreement as contemplated by clause (ii) of this § 15(g), Company agrees to file on the Termination Date a document (the “**Certification**”) with the Compliance Dispute Review Officer enumerating the items described elsewhere in this Agreement as required elements of such Certification. Company shall provide a copy of such Certification to the Physicians Advisory Committee. Upon the filing of the duly completed Certification by Company on the Termination Date, all of Company’s obligations under this Agreement shall be satisfied. No decision or ruling of the Compliance Dispute Review Officer shall have any force on the Parties after the Termination Date and Company shall be under no obligation to continue performance of any kind under this Agreement. Company may, in its sole and absolute discretion, elect to continue after the Termination Date, the implementation of various business practices described in this Agreement.

16. Related Provider Track Actions.

16.1. Ordered Stays and Dismissals in Tag-Along Actions

As to any action brought by or on behalf of Class Members that asserts any claim that as of the Implementation Date would constitute a Released Claim against Company, other than the Action, that has been, or will in the future, be consolidated with the Provider Track Actions under MDL Docket No. 1334 (the “**Tag-Along Actions**”), Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and the Company shall cooperate to obtain an order of the Court, to be included in the Preliminary Approval Order, providing for the interim stay of all proceedings as to Company in each such action pending entry of the Final Order and Judgment. In addition, no later than ten (10) business days after the Effective Date, Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and Company shall jointly apply for orders from the Court dismissing each of the Tag-Along Actions with prejudice as to Company; provided that no such dismissal order shall be sought with respect to any Tag-Along Action with respect to any named plaintiff that has timely submitted an Opt-Out request.

16.2. Certain Related State Court Actions

As to any action in which at least one Class Counsel is counsel of record that is now pending, hereafter may be filed in or remanded to any state court that asserts any of the Released Claims against Company on behalf of any Class Member, Representative Plaintiffs, the Signatory Medical Societies and Class Counsel agree that they will cooperate with Company, and file all documents necessary, (a) to obtain an interim stay of all proceedings against Company in any such state court action and (b) on or promptly after the Effective Date, to obtain the dismissal with prejudice of any such action, other than with respect to any named plaintiff that has timely submitted an Opt-Out request.

16.3. Other Related Actions

As to any action not referred to in §§ 16.1 or 16.2 that is now pending or hereafter may be filed in any court that asserts any of the Released Claims against Company on behalf of any Class Member who has not timely submitted an Opt-Out request, Representative Plaintiffs, the Signatory Medical Societies and Class Counsel agree that they will cooperate with Company, to the extent reasonably practicable, in Company’s effort to seek relief from the Court or the forum court to obtain the interim stay and dismissal with prejudice of such action as to Company to the extent necessary to effectuate the other provisions of this Agreement.

17. Provisions Applicable to Other Proposed Settlements.

- (a) In the event that Class Counsel are engaged, or engage in the future, in settlement negotiations with any of the other

defendants in the Class Action, Class Counsel agree to use their best efforts to ensure that the terms of any settlement agreement entered into with any such defendant on behalf of Class Members within one year of the Preliminary Approval Date satisfy the following test:

- (i) all cash disbursements to be paid by such defendant under the proposed settlement, exclusive of attorneys' fees and representative plaintiffs' fees and exclusive of sums contemplated to be invested to effectuate business initiatives described in the such proposed settlement, (the "**Cash Amount**") shall total at least the Cash Amount to be paid by Company under this Agreement, multiplied by a fraction, the numerator of which is such defendant's subscriber base as of December 31, 2002, and the denominator of which is the number of Plan Members as of that same date; and
- (ii) the value of the non-monetary relief provided in such settlement is at least as valuable to Physicians as the value of the non-monetary relief contained in § 7 of the Agreement.

(b) In the event that Class Counsel and Company do not agree, for the purposes of this provision, on the value of the Cash Amount contemplated by any proposed settlement as described in § 17(a), the Cash Amount shall be deemed to be the lesser of:

- (i) the value that Class Counsel attribute to the cash disbursements as described in § 17(a)(i) herein to be paid by such defendant under the proposed settlement when Class Counsel present such settlement agreement to the court for approval, and
- (ii) the pre-tax amount of the disbursements as described in subsection § 17(a)(i) herein of the settlement agreement plus any amount such defendant has recovered or anticipates recovering based on or under any insurance policy (the "**Gross Disbursement**") as such Gross Disbursement is reflected on the financial statements of such settling defendant.

(c) Where a settlement described in § 17(a) is proposed to be made with an economically distressed defendant, § 17(a) herein shall not apply to such settlement; provided that Class Counsel

may only propose a settlement with such an economically distressed defendant to a court upon prior written consent of Company, which consent shall not be unreasonably withheld. If Class Counsel believe that Company has unreasonably withheld such consent, Class Counsel may petition the Court to grant preliminary and final approval of such a settlement for good cause shown.

(d) If Class Counsel concludes it is in the best interest of Class Members (or a similar class of Physicians) to propose a settlement inconsistent with § 17(a), Class Counsel will first meet and confer with Company for the purpose of seeking an agreement that they have complied with § 17(a). If Company does not agree, Class Counsel may petition the Court to grant preliminary and final approval of such a settlement for good cause shown.

18. Not Evidence; No Admission of Liability.

The Parties agree that in no event shall this Agreement, in whole or in part, whether effective, terminated, or otherwise, or any of its provisions or any negotiations, statements, or proceedings relating to it in any way be construed as, offered as, received as, used as or deemed to be evidence of any kind in the Action, in any other action, or in any judicial, administrative, regulatory or other proceeding, except in a proceeding to enforce this Agreement. Without limiting the foregoing, neither this Agreement nor any related negotiations, statements or proceedings shall be construed as, offered as, received as, used as or deemed to be evidence, or an admission or concession of liability or wrongdoing whatsoever or breach of any duty on the part of Company, the Defendants, the Representative Plaintiffs or the Signatory Medical Societies, or as a waiver by Company, the Defendants, the Representative Plaintiffs or the Signatory Medical Societies of any applicable defense, including without limitation any applicable statute of limitations. None of the Parties waives or intends to waive any applicable attorney-client privilege or work product protection for any negotiations, statements or proceedings relating to this Agreement. The Parties agree that this provision shall survive the termination of this Agreement pursuant to the terms hereof.

19. Entire Agreement.

This Agreement, including its Exhibits, contains an entire, complete, and integrated statement of each and every term and provision agreed to by and among the Parties; it is not subject to any condition not provided for herein. This Agreement supersedes any prior agreements or understandings, whether written or oral, between and among Representative Plaintiffs, Class Members, Class Counsel, Company and the Signatory Medical Societies regarding the subject matter of the Action

or this Agreement. This Agreement shall not be modified in any respect except by a writing executed by all the Parties.

20. No Presumption Against Drafter.

None of the Parties shall be considered to be the drafter of this Agreement or any provision hereof for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter hereof. This Agreement was drafted with substantial input by all Parties and their counsel, and no reliance was placed on any representations other than those contained herein.

21. Continuing Jurisdiction and Exclusive Venue.

21.1. Continuing Jurisdiction.

Except as otherwise provided in this Agreement, it is expressly agreed and stipulated that the United States District Court for the Southern District of Florida shall have exclusive jurisdiction and authority to consider, rule upon, and issue a final order with respect to suits, whether judicial, administrative or otherwise, which may be instituted by any Person, individually or derivatively, with respect to this Agreement. This reservation of jurisdiction does not limit any other reservation of jurisdiction in this Agreement nor do any other such reservations limit the reservation in this subsection.

Except as provided in §§ 12.1(a) and 12.6(g) or otherwise provided in this Agreement, Company, each Signatory Medical Society and each Class Member who has not validly and timely requested to Opt-Out of this Agreement hereby irrevocably submits to the exclusive jurisdiction and venue of the United States District Court for the Southern District of Florida for any suit, action, proceeding, case, controversy, or dispute relating to this Agreement and/or Exhibits hereto and negotiation, performance or breach of same.

21.2. Parties Shall Not Contest Jurisdiction.

In the event of a case, controversy, or dispute arising out of the negotiation of, approval of, performance of, or breach of this Agreement, the Parties hereby agree to pay, and the Court is authorized to award, attorneys' fees and costs to the prevailing party. Solely for purposes for such suit, action or proceeding, to the fullest extent that they may effectively do so under applicable law, the Parties irrevocably waive and agree not to assert, by way

of motion, as a defense or otherwise, any claim or objection that they are not subject to the jurisdiction of such Court, or that such Court is in any way an improper venue or an inconvenient forum. Furthermore, the Parties shall jointly urge the Court to include the provisions of this § 21 in its order finally approving this Agreement.

22. Cooperation.

Representative Plaintiffs, Class Counsel and Company agree to move that the Court enter an order to the effect that should any Person desire any discovery incident to (or which the Person contends is necessary to) the approval of this Agreement, the Person must first obtain an order from the Court that permits such discovery.

23. Counterparts.

This Agreement may be executed in counterparts, each of which shall constitute an original. Facsimile signatures shall be considered valid signatures as of the date hereof, although the original signature pages shall thereafter be appended to this Agreement.

24. Additional Signatory Medical Societies.

The Parties agree that, from and after the date of this Agreement, additional medical societies may elect to execute a signature page to this Agreement and thereby agree to be bound by the provisions of this Agreement that are applicable to Signatory Medical Societies. Upon such execution of a signature page, each such additional medical society shall be deemed to be a Signatory Medical Society for all purposes of this Agreement and shall be bound by all of the provisions of this Agreement that are applicable to Signatory Medical Societies.

25. Successors and Assigns.

The provisions of this Agreement shall be binding upon and inure to the benefit of Aetna Inc. and its respective successors and assigns; provided that Aetna Inc. may not assign, delegate or otherwise transfer any of its rights or obligations under this Agreement without the consent of Class Counsel.

26. Governing Law.

Company and the Signatory Medical Societies agree that, with respect to disputes arising between and among such Persons, this Agreement shall be governed by and construed in accordance with the

laws of the State of Florida, without regard to the conflicts of law rules of such state.

EXECUTED and DELIVERED on May 21, 2003.

COMPANY:

AETNA INC.

Name:

Title:

REPRESENTATIVE PLAINTIFFS:

Susan McIntosh, M.D.

Kevin Lynch, M.D.

Stephen Levinson, M.D.

Karen Laugel, M.D.

Edgar Borrero, M.D.

Albert Ellman, M.D.

Robert Scher, M.D.

Raymond Wesley, M.D.

Kevin Molk, M.D.

Manual Porth, M.D.

Michael C. Burgess, M.D.

Eugene Mangieri, M.D.

Glenn Kelly, M.D.

Leonard Klay, M.D.

Charles B. Shane, M.D.

Jeffrey Book, M.D.

Andres Taleisnik, M.D.

Julio Taleisnik, M.D.

David Boxstein, M.D.

Roger Wilson, M.D.

Susan R. Hansen, M.D.

Edward Davis, M.D.

Thomas Backer, M.D.

Martin Moran, M.D.

H. Robert Harrison, Ph.D., M.D.

Lance R. Goodman, M.D.

SIGNATORY MEDICAL SOCIETIES:

ALASKA STATE MEDICAL
ASSOCIATION

Name:
Title:

CONNECTICUT STATE MEDICAL
SOCIETY

Name:
Title:

EL PASO COUNTY MEDICAL
SOCIETY

Name:
Title:

HAWAII MEDICAL ASSOCIATION

Name:
Title:

NEBRASKA MEDICAL ASSOCIATION

Name:
Title:

NEW HAMPSHIRE MEDICAL
SOCIETY

Name:
Title:

MEDICAL SOCIETY OF NEW JERSEY

Name:
Title:

MEDICAL SOCIETY OF THE STATE
OF NEW YORK

Name:
Title:

NORTH CAROLINA MEDICAL
SOCIETY

Name:
Title:

SOUTH CAROLINA MEDICAL
ASSOCIATION

Name:
Title:

TENNESSEE MEDICAL ASSOCIATION

Name:
Title:

RUSSEL C. LIBBY, M.D.
President, Medical Society of Northern
Virginia (formerly Fairfax County and
Alexandria Medical Societies)

NIRMALA LIMAYE, M.D.
President, Arlington County
Medical Society

KENNETH JOSOVITZ, M.D.
President, Prince William County
Medical Society

RANDALL PEYTON, M.D.
President, Loudoun County
Medical Society

**Collectively known as, and on behalf
of, North Virginia Medical Societies**

WASHINGTON STATE MEDICAL
ASSOCIATION

Name:

Title:

CALIFORNIA MEDICAL ASSOCIATION

Name:
Title:

MEDICAL ASSOCIATION OF GEORGIA

Name:
Title:

FLORIDA MEDICAL ASSOCIATION

Name:
Title:

LOUISIANA STATE MEDICAL SOCIETY

Name:
Title:

DENTON COUNTY MEDICAL
ASSOCIATION

Name:
Title:

CLASS COUNSEL:

LAW OFFICES OF ARCHIE LAMB, LLC

Name:

Title:

KOZYAK TROPIN & THROCKMORTON

Name:

Title:

DOFFERMYRE, SHIELDS, CANFIELD,
KNOWLES & DEVINE

Name:

Title:

DRUBNER, HARTLEY & O'CONNOR,
LLC

Name:

Title:

EYSTER, KEY, TUBB, WEAVER &
ROTH, LLP

Name:

Title:

FOOTE, MEYERS, MIELKE &
FLOWERS

Name:
Title:

GORDON, SILBERMAN, WIGGINS &
CHILDS, P.C.

Name:
Title:

GRAY & WEISS

Name:
Title:

LOWE, MOBLEY & LOWE

Name:
Title:

MILBERG WEISS BERSHAD HYNES &
LERACH LLP

Name:
Title:

SAVERI & SAVERI, INC.

Name:
Title:

STEWART, TILGHMAN, FOX &
BIANCHI

Name:
Title:

WHATLEY DRAKE, LLC

Name:
Title:

WHITE, DUNN & BOOKER

Name:
Title: