UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
Miami Division

MDL NO. 1334
Master File No. 00-1334-MD-MORENO

_____/

IN RE: MANAGED CARE LITIGATION
_____/

THIS DOCUMENT RELATES TO
ONLY PROVIDER TRACK CASES
_____/

CASE NO. 03-22804-CIV-MORENO

DR. JEFFREY SOLOMON; DR. ORLAND ARMSTRONG; DR. ROBERT VRANES; DR. ALLEN KNECHT; DR. LAVERNE A. SABOE, JR.; DR. DAVID MILROY; DR. AMY HOFFMAN; DR. ROBIN O'NEAL; HUBBARD HEALTH CLINIC, INC.; AMERICAN PODIATRIC MEDICAL ASSOCIATION; FLORIDA CHIROPRACTIC ASSOCIATION; CALIFORNIA PODIATRIC MEDICAL ASSOCIATION; FLORIDA PODIATRIC MEDICAL ASSOCIATION; TEXAS PODIATRIC MEDICAL ASSOCIATION; FLORIDA PSYCHOLOGICAL ASSOCIATION; and ARIZONA CHIROPRACTIC SOCIETY for the individuals on behalf of themselves and on behalf of all others similarly situated, and for the associations in a representational capacity,

Plaintiffs,

v.

ANTHEM, INC.; HEALTH NET, INC.; HUMANA INC.; HUMANA HEALTH PLAN, INC.; PACIFICARE HEALTH SYSTEMS, INC.; PRUDENTIAL INSURANCE COMPANY OF AMERICA; UNITED HEALTH GROUP; UNITED HEALTH CARE; COVENTRY HEALTH CARE, INC.; WELLPOINT HEALTH NETWORKS, INC.; AETNA, INC.; and AETNA-USHC, INC.,

Defendants.

_____/

CASE NO. 04-20143-CIV-MORENO

SCOTT J. ASHTON, D.P.M.; KATHY TISKO, P.T.;
MICK M. MAHAN, D.C. and
CHARLES P. BARNWELL, D.C.

Plaintiffs,

v.

ANTHEM, INC.; HEALTH NET, INC.; HUMANA INC.; HUMANA HEALTH PLAN, INC.; PACIFICARE HEALTH SYSTEMS, INC.; PRUDENTIAL INSURANCE COMPANY OF AMERICA; UNITED HEALTH GROUP; UNITED HEALTH CARE; COVENTRY HEALTH CARE, INC.; WELLPOINT HEALTH NETWORKS, INC.; AETNA, INC.; and AETNA-USHC, INC.,

Defendants.

_____/

SETTLEMENT AGREEMENT

dated as of

_____

by and among

HUMANA INC. AND HUMANA HEALTH PLAN, INC.,

THE REPRESENTATIVE PLAINTIFFS,

THE ASSOCIATION PLAINTIFFS

AND CLASS COUNSEL

SETTLEMENT AGREEMENT

This Agreement is made and entered into as of the date set forth on the signature pages hereto by and among the Representative Plaintiffs in the Actions (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 Class Counsel, Humana Inc. and Humana Health Plan, Inc. ("Company"), and those Association Plaintiffs and healthcare provider specialty societies identified on the signature pages hereto (collectively referred to as the "**Signatory Healthcare Provider Specialty Societies**"**)** (the Representative Plaintiffs, the Class Members who have not validly and timely requested to Opt Out of this Agreement, Company and the Signatory Healthcare Provider 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 by representatives of said providers;

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 October 17, 2003, plaintiffs in *Solomon, et al. v. Anthem, Inc., et al.*, filed a class action complaint in the United States District Court for the Southern District of Florida, Case No. 03-22804-CIV-JORDAN ("***Solomon***"), alleging claims by all Healthcare Providers (as defined herein) against, among other defendants, Humana Inc. and Humana Health Plan, Inc. *Solomon* set forth claims related to those alleged in the pending *In re Managed Care Litigation*, MDL No. 1334 and was transferred to Judge Federico A. Moreno on December 17, 2003 to be consolidated with *In re Managed Care Litigation* as a tag-along action in the Provider Track. On December 15, 2005, Plaintiffs' First Amended Class Action Complaint was filed in *Solomon*;

WHEREAS, on January 20, 2004, plaintiffs in *Ashton, et al. v. Anthem, Inc., et al.* filed a class action complaint in the United States District Court for the Southern District of Florida, Case No. 04-20143-CIV-MORENO ("***Ashton***"), alleging claims by all Healthcare Providers (as defined herein) against, among other defendants, Humana Inc. and Humana Health Plan, Inc. *Ashton* set forth claims related to those alleged in the pending *In re Managed Care Litigation*, MDL No. 1334 and was consolidated with *In re Managed Care Litigation* as a tag-along action in the Provider

Track. On December 15, 2005, a First Amended Class Action Complaint was filed in *Ashton*;

WHEREAS, Company denies the material factual allegations and legal claims asserted in the Complaints referenced above, 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 Complaints including, without limitation, the allegations that the Representative Plaintiffs and/or other Class Members have suffered damages; that Company improperly manipulated claim procedures or Capitation payments or any other payments; that Company paid at incorrect rates or improperly applied reimbursement policies; that Company fraudulently misrepresented the criteria for insurance coverage determinations, treatment decisions, claims payments and adequacy of Capitation 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 Complaints;

WHEREAS, Company believes it has a number of defenses to the claims set forth in the Complaints that Company believes are meritorious; nonetheless, Company has a desire to make more transparent, simplify and otherwise improve the systems through which it conducts business with Representative Plaintiffs and has concluded that further conduct of the Actions would be protracted and expensive and that it is desirable that the Actions 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 Actions have merit; nonetheless, Representative Plaintiffs and Class Counsel recognize and acknowledge the expense and length of continued proceedings that would be necessary to prosecute the Actions against Company through trial and appeals;

WHEREAS, Representative Plaintiffs and Class Counsel also have taken into account the uncertain outcome and the risk of any class action, especially in complex actions such as the Actions, as well as the difficulties and delays inherent in such Actions, 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 Class Counsel have determined that this Agreement is in the best interests of themselves and the other Class Members;

WHEREAS, the Signatory Healthcare Provider Societies have determined that it is in their best interests to obtain the benefits afforded to such Signatory Healthcare Provider Societies by the applicable provisions of this Agreement, and, in exchange therefore, to make the commitments and agreements contained herein, including, without

limitation, those contained in § 13;

NOW, THEREFORE, IT IS HEREBY STIPULATED AND AGREED by and among the Parties that, subject to the approval of the Court, the Actions 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 and all exhibits to this Agreement, the following terms have the meaning specified.

1.1 "Actions" means the First Amended Complaint – Class Action in *Solomon* and the First Amended Complaint – Class Action in *Ashton*.

1.2 "Acquirer" mean an entity that has entered or enters into a written agreement with Company for change of control or transfer of assets or stock as described above and (i) the transaction has closed or (ii) the transaction has not closed but the agreement has been approved by the boards of directors of Company and Acquirer and has been publicly announced.

1.3 "Adverse Determination" shall have the meaning assigned to that term in § 7.11(b)(i) of this Agreement.

1.4 "Affiliate" or "Affiliates" 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" and "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" means this Settlement Agreement, inclusive of all exhibits hereto.

1.6 "AMA" means the American Medical Association.

1.7 "*Ashton*" means *Ashton, et al. v. Anthem, Inc., et al.,* Case No. 04-20143-CIV-MORENO.

1.8 "Assignment of Benefits" means an assignment by a Plan Member to a Healthcare Provider of rights to reimbursement available to Plan Member pursuant to the applicable Plan Documents.

1.9 "Association Plaintiffs" means collectively the following: American Podiatric Medical Association, Florida Chiropractic Association, Florida

Psychological Association, Florida Podiatric Medical Association, Texas Podiatric Medical Association, California Podiatric Medical Association, and Arizona Chiropractic Society

1.10 "Attorneys' Fees" means the funds for attorneys' fees and expenses that may be awarded by the Court to Class Counsel.

1.11 "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 other Persons in the form included as part of the Final Order and Judgment.

1.12 "Base Amount" shall have the meaning assigned to that term in §§ 8.1(b) and 8.1(i) of this Agreement.

1.13 "Billing Dispute" shall have the meaning assigned to that term in § 7.10(a) of this Agreement.

1.14 "Billing Dispute External Review Board" shall have the meaning assigned to that term in § 7.10(a) of this Agreement.

1.15 "Capitation" means the payment by Company to Healthcare Providers, Healthcare Provider Groups or Healthcare Provider Organizations of a per member per month amount (including but not limited to percentage of premium) by which Company transfers to the provider the financial risk for those Covered Services as set forth in the contract between Company and the provider.

1.16 "CCI" or the "Correct Coding Initiative" means CMS's published list of edits and adjustments that are made to health care providers' claims submitted for services or supplies provided to patients insured under the federal Medicare program and/or under other federal insurance programs.

1.17 "Certification" shall mean the document Company files identified in § 7.34 of this Agreement.

1.18 "Claim Form" means a document in substantially the form attached hereto as Exhibit ___.

1.19 "Class" means any and all Healthcare Providers, Healthcare Provider Groups and Healthcare Provider Organizations (and all Persons claiming by or through them) who or which provided Covered Services to any Plan Member or any individual enrolled in or covered by a plan offered or administered by any Persons named as defendants in the *Solomon* and *Ashton* actions or by any of their respective current or former Subsidiaries from January 1, 1990 through the date of the entry of the Preliminary Approval Order; provided, however, that the Class shall not include (a) hospitals or facilities; (b) laboratories; (c) Physicians; (d) suppliers of

medical equipment who or which do not provide health care services along with their provision of medical equipment or do not bill separately for health care services with their provision of medical supplies; and (e) any Healthcare Provider who is or was an employee of a Company staff-model HMO at the time of providing such Covered Services.

1.20 "Class Counsel" means those persons identified in § 5 of this Agreement as Class Counsel.

1.21 "Class Member" means any Person who is a member of the Class.

1.22 "Clinical Information" means clinical, operative or other medical records and reports kept in the ordinary course of a Healthcare Provider's, Healthcare Provider Group's or Healthcare Provider Organization's business, and, where applicable, requested statements of Medical Necessity.

1.23 "CMS" means the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration).

1.24 "CMS-1500" means the health care provider claim form number 1500 created by CMS (formerly HCFA-1500), as such form exists on the date of this Agreement and as it may be amended, modified or superseded thereafter during the term of this Agreement.

1.25 "Combining Person" shall have the meaning assigned to that term in § 24 of this Agreement.

1.26 "Company" means Humana Inc. and each of its Subsidiaries and Affiliates, including Humana Health Plan, Inc.

1.27 "Complaints" means the initial complaint and any and all subsequent complaints filed in the Actions.

1.28 "Complete Claim" means, except as otherwise provided in § 7.18(a) of this Agreement, 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) meets all of the requirements of § 7.17(b); (d) (i) when submitted via paper has all the elements of the 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 of the elements of the standard electronic formats, as required by applicable Federal authority and state regulatory authority; (e) is a claim for which Company is the primary payor or Company's responsibility as a secondary payor has been established, and for which verification of student eligibility has been submitted if requested; (f) contains no defect or error that would affect the adjudication of the claim; (g) includes supporting documentation

consistent with this Agreement sufficient for Company to make a payment determination; and (h) is under a Plan for which all applicable premiums have been paid.

1.29 "Compliance Dispute" means any claim that Company has failed to carry out any of its obligations under § 7 of this Agreement (with the exception of § 7.29(f)); provided, however, that none of the following shall be deemed a Compliance Dispute: (a) a Released Claim; (b) a Retained Claim; (c) a Billing Dispute; and (d) a claim for which the Adverse Determination Review Process is available.

1.30 "Compliance Dispute Claim Form" means a document in substantially the same form as Exhibit ___, attached hereto.

1.31 "Compliance Dispute Facilitator" means the person who, pursuant to § 12.1(a) of this Agreement, shall screen Compliance Disputes.

1.32 "Compliance Dispute Review Officer" means the person chosen pursuant to § 12.1(b) of this Agreement and charged with the administration of Certifications and Compliance Disputes under this Agreement.

1.33 "Conclusion Date" shall have the meaning assigned to that term in § 7 of this Agreement.

1.34 "Copayment" means a fixed fee that Plan Members must pay directly to Physicians or Healthcare Providers in connection with their use of specified health care benefits covered by their Plan (*e.g.*, an office visit or physical therapy session).

1.35 "Court" shall have the meaning assigned to that term in the recitals of this Agreement.

1.36 "Covered Services" means a health care benefit that is within the coverage described in the Plan Documents applicable to an eligible Company Plan Member.

1.37 "CPT®," "CPT® Codes," and "CPT® Coding" mean medical nomenclature published by the AMA containing a systematic listing and coding of procedures and services provided to patients by healthcare 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.

1.38 "Credentialing Committee" means any committee maintained by Company which has decision-making authority regarding credentialing and re-credentialing of individual Healthcare Providers as Participating Healthcare Providers with Company.

1.39 "Delegated Entity" means (a) a full-service, licensed health plan with which it is reasonably necessary for Company to contract because Company does not have reasonable capacity to provide specialty services or administer coverage in the geographic areas served by such health plan; and (b) an entity that is not an Affiliate of Company to the extent that such entity (i) maintains its own contracts with Healthcare Providers separate from any contracts between Company and Healthcare Providers, and, (ii) by agreement with Company, (A) agrees to provide Plan Members with access to such Healthcare Providers pursuant to 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, utilizations management and Healthcare Provider credentialing.

1.40 "Downcoding" shall have the meaning assigned to that term in § 7.19 of this Agreement.

1.41 "Edit" means a practice or procedure pursuant to which one or more adjustments are made to CPT® Codes or HCPCS Level II Codes included in a claim that result in (a) payment being made based on some, but not all, of the CPT® Codes or HCPCS Level II Codes included in the claim, (b) payment being made based on different CPT® Codes or HCPCS Level II Codes than those included in the claim, (c) payment for one or more of the CPT® Codes or HCPCS Level II Codes included in the claim being reduced by application of Multiple Procedure Logic, (d) payment for one or more of the CPT® Codes or HCPCS Level II Codes being denied, or (e) any combination of the above.

1.42 "Effective Date" shall have the meaning assigned to that term in § 14.4 of this Agreement.

1.43 "Effective Period" shall have the meaning assigned to that term in § 7 of this Agreement.

1.44 "Enrollment" or "Enrollment Date" shall mean the date upon which a Plan Member becomes eligible to receive Covered Services.

1.45 "EOB" means an Explanation of Benefits or any comparable form or statement communicating to a Plan Member the results of Company's adjudication of claim(s) with respect to or on behalf of such Plan Member.

1.46 "ERA/EFT" means the capability to facilitate electronic remittance advice and electronic funds transfer.

1.47 "ERISA" means the Employment Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, et seq., and the applicable rules and regulations promulgated thereunder.

1.48 "Execution Date" means the later of (i) the date on which the signature of Company has been delivered to Class Counsel; or (ii) the date on which the signatures of all Representative Plaintiffs, Association Plaintiffs and Class Counsel have been delivered to Company.

1.49 "External Review" shall have the meaning assigned to that term in § 7.11(e)(i) of this Agreement.

1.50 "Fee-for-Service Claim" means a claim for payment submitted to Company or another health insurer by a Participating Healthcare Provider, or by a Nonparticipating Healthcare Provider who has obtained an assignment of benefits from the Plan Member, for providing Covered Services to the Plan Member.

1.51 "FDA" means the Food and Drug Administration.

1.52 "Final Order and Judgment" means the order and form of judgment approving this Agreement and dismissing Company with prejudice in the Actions, in the form attached hereto as Exhibits ____.

1.53 "Final Order Date" means the date on which the Court enters the Final Order and Judgment.

1.54 "First Alternate" shall have the meaning assigned to that term in § 12.1(b) of this Agreement.

1.55 [This section intentionally left blank]

1.56 "Force Majeure" shall have the meaning assigned to that term in § 7.32 of this Agreement.

1.57 "Fully-Insured Plan" means a Plan as to which Company assumes all or a majority of the healthcare cost and/or utilization risk.

1.58 "HCPCS Level II Codes" means alphanumeric codes used to identify those codes not included in CPT® and that are commonly referred to as Healthcare Common Procedure Coding System Level II Codes.

1.59 "Healthcare Provider" means any Person who has 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 Complaints or by any of their respective current or former subsidiaries from January 1, 1990 through the date of the entry of the Preliminary Approval Order, including but not limited to chiropractors, psychologists, counselors, podiatrists, acupuncturists, optometrists, physical and occupational therapists, nurse midwives, nurse practitioners, nurse anesthetists, nutritionists, orthotists, prosthetists, audiologists and speech and hearing therapists; provided, however, Healthcare Provider does not

include those Persons or entities excluded from the Class as set forth in § 1.19 of this Agreement.

1.60 "Healthcare Provider Advisory Committee" shall have the meaning assigned to that term in § 7.9(a) of this Agreement.

1.61 "Healthcare Provider Group" means any distinct legal entity (*e.g.*, association, partnership or corporation) under which two or more Healthcare Providers practice and bill for their services under a single taxpayer identification number held by that entity.

1.62 "Healthcare Provider Organization" means any distinct legal entity (*e.g.*, association, partnership or corporation) under whose auspices two or more Healthcare Providers practice and bill for their services under multiple taxpayer identification numbers held by that entity.

1.63 "Healthcare Provider Services" means Covered Services that a Healthcare Provider provides to a Plan Member, as specified in applicable agreements with Company or otherwise.

1.64 "Healthcare Provider Specialty Society" means the following health care specialty societies: American Chiropractic Association, American Podiatric Medical Association, American Physical Therapist Association, American Psychological Association, American Optometric Association, American Academy of Nurse Practitioners, American College of Nurse-Midwives, National Association of Social Workers, American Association of Oriental Medicine, American Speech-Language-Hearing Association, and American Occupational Therapy Association.

1.65 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

1.66 "Implementation Date" shall have the meaning assigned to that term in § 7 of this Agreement.

1.67 "Independent Review Organization" shall have the meaning assigned to that term in § 7.11(e)(i) of this Agreement.

1.68 "Interest Rate" means a 4.75% rate of return without compounding.

1.69 "Internal Compliance Officer" shall have the meaning assigned to that term in § 12.7 of this Agreement.

1.70 "Individually Negotiated Contract" means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to one or more substantial modifications to the terms of Company's applicable standard form agreement to individually suit, in whole or in part, the needs of a Participating Healthcare Provider, Healthcare Provider Group or

Healthcare Provider Organization.

1.71 "Mailed Notice" means the form of notice attached hereto as Exhibit ____.

1.72 "Medical Necessity" and "Medically Necessary" shall have the meaning assigned to those terms in § 7.16(a) of this Agreement.

1.73 "Multiple Procedure Logic" means the practices or procedures used by Company to reduce the allowable amount for one or more of the CPT® Codes or HCPCS Level II Codes included in a claim as a result of multiple surgical procedures or services having been performed on the same patient, on the same date of service.

1.74 "Non-Participating Healthcare Provider" means any Healthcare Provider other than a Participating Healthcare Provider and includes, where appropriate, Healthcare Provider Groups and Healthcare Provider Organizations.

1.75 "Mental and Behavioral Health Organization" or "MBHO" shall mean an entity with whom Company contracts to provide mental and behavioral health services to its members and which contracts with a network of Healthcare Providers and other providers for the purpose of fulfilling the MBHO's contractual obligations to Company.

1.76 "Non-Released Litigation" shall have the meaning assigned to that term in § 13.3(b) of this Agreement.

1.77 "Notice Date" shall have the meaning assigned to that term in § 6.1 of this Agreement.

1.78 "Objection Date" shall have the meaning assigned to that term in § 6 of this Agreement.

1.79 "Opt Out" shall have the meaning assigned to that term in § 6.1 of this Agreement.

1.80 "Opt-Out Deadline" shall have the meaning assigned to that term in § 6.1 of this Agreement.

1.81 "Overpayment" means, with respect to a claim submitted by or on behalf of a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization, any erroneous or excess payment that Company makes for any reason, including, but not limited to, (a) payment at an incorrect rate, (b) duplicate payments for the same Healthcare Provider Service, (c) payment with respect to an individual who was not a Plan Member on the date the Healthcare Provider provided the Healthcare Provider Service(s) that are the subject of such payment, and (d) payment for any non-Covered Service.

1.82 "Participating Healthcare Provider" means a Healthcare Provider who has entered into a valid written contract with Company (directly or indirectly through a Healthcare Provider Organization, Healthcare Provider Group or other entity authorized by the Healthcare Provider at the time the claim arose) to provide Covered Services to Plan Members and, where applicable, who meets Company's credentialing requirements, during the effective period of such a contract.

1.83 "Party" or "Parties" means the Company, Representative Plaintiffs and/or Association Plaintiffs.

1.84 "Person" or "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).

1.85 "Petitioner" shall have the meaning assigned to that term in § 12.2 of this Agreement.

1.86 "Physician" means an individual duly licensed by a state licensing board as a Medical Doctor or as a Doctor of Osteopathy.

1.87 "Plan" means a benefit plan through which a Plan Member obtains health care benefits set forth in pertinent Plan Documents.

1.88 "Plan Documents" means the documents defining the health care benefits available to a Plan Member, including the Plan Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document, and the terms and conditions under which such benefits are available under the Plan.

1.89 "Plan Member" means an individual enrolled in or covered by a Plan offered and administered by Company.

1.90 "Post-Service Appeal" shall have the meaning assigned to that term in § 7.11(c)(ii)(A) of this Agreement.

1.91 "Precertification" means approval by the Company that the service or supply is Medically Necessary and/or not experimental or investigational.

1.92 "Preliminary Approval Date" means the date that the Preliminary Approval Order is entered by the Court.

1.93 "Preliminary Approval Hearing" shall have the meaning assigned to that term in § 4 of this Agreement.

1.94 "Preliminary Approval Order" means the preliminary approval order as attached hereto at Exhibit ____.

1.95 "Pre-Service Appeal" shall have the meaning assigned to that term in § 7.11(c)(i) of this Agreement.

1.96 "Product Network" means a network of Participating Healthcare Providers who, pursuant to contracts with Company, provide Covered Services to Plan Members for one or more products or types of products offered by Company (*e.g.*, HMO, PPO, POS, Indemnity) in exchange for a specified type of compensation (*e.g.*, Fee-for-Service, Capitation).

1.97 "Provider Track" shall have the meaning assigned to that term in the recitals of this Agreement.

1.98 "Provider Website" means the secure (password protected) online resources for Participating Healthcare Providers to obtain information about Company, its products and policies and other information described in more detail in this Agreement.

1.99 "Public Website" means the online resources for the public to obtain information about Company, its products and policies and other information.

1.100 "Published Notice" means the form of notice attached hereto as Exhibit ____.

1.101 "Qualified Reviewer" shall have the meaning assigned to that term in § 7.11(c)(ii)(A) of this Agreement.

1.102 "Released Parties" shall have the meaning assigned to that term in § 13.1(a) of this Agreement.

1.103 "Released Claims" shall have the meaning assigned to that term in § 13.1(b) of this Agreement.

1.104 "Releasing Parties" shall have the meaning assigned to that term in § 13.1(a) of this Agreement.

1.105 "Remittance Advice" means the form sent by Company to Healthcare Providers, Healthcare Provider Group or Healthcare Providers Organizations explaining Company's computation of benefits and payment amounts on a claim. The Remittance Advice is sometimes referred to as an "Explanation of Benefits" form or "EOB."

1.106 "Representative Plaintiffs" means collectively, to the extent each executes this Agreement, Dr. Orland Armstrong, Scott J. Ashton, D.P.M., Charles P. Barnwell, D.C., Dr. Amy Hoffman, Hubbard Health Clinic, Inc., Dr.

Allen Knecht, Mick M. Mahan, D.C., Dr. David Milroy, Dr. Robin O'Neal, Dr. LaVerne A. Saboe, Jr., Dr. Jeffrey Solomon, Kathy Tisko, P.T., and Dr. Robert Vranes.

1.107 "Retained Claims" shall have the meaning assigned to that term in § 13.6 of this Agreement.

1.108 [This section intentionally left blank]

1.109 "Second Alternate" shall have the meaning assigned to that term in § 12.1(b) of this Agreement.

1.110 "Self-Insured Plan" means any Plan other than a Fully-Insured Plan.

1.111 "Senior Management" shall have the meaning assigned to that term in § 12.7 of this Agreement.

1.112 "Settlement Administrator" shall have the meaning assigned to that term in § 8.3 of this Agreement.

1.113 "Settlement Amount" means the three million five hundred thousand dollars ($3,500,000) to be deposited by Company in accordance with § 8.1 of this Agreement.

1.114 "Settlement Fund" shall have the meaning assigned to that term in § 8.1 of this Agreement.

1.115 "Settlement Hearing Date" shall have the meaning assigned to that term in § 6.2 of this Agreement.

1.116 "Settlement Website" means the online resources available to the Class and the public to obtain information concerning this Agreement.

1.117 "Signatory Healthcare Provider Specialty Societies" means the Association Plaintiffs as defined in § 1.8 of this Agreement and those Healthcare Provider societies that have executed and delivered to Class Counsel the Healthcare Provider Society Agreement referred to in § 23 of this Agreement and attached hereto as Exhibit ____.

1.118 "Sold Business" shall have the meaning assigned to that term in § 24 of this Agreement.

1.119 "*Solomon*" means *Solomon, et al. v. Anthem, Inc.*, Case No. 03-22804-CIV-MORENO.

1.120 "Subsidiary" or "Subsidiaries" shall mean 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 Preliminary Approval Date, or were prior thereto, directly or indirectly owned by Company, but only during the period that 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 or were directly or indirectly held by Company.

1.121 "Tag-Along Action" means any action consolidated as part of *In re Managed Care Litigation*, MDL No. 1334, pursuant to 28 U.S.C. § 1407.

1.122 "Termination Date" shall have the meaning assigned to that term in § 14.6 of this Agreement.

1.123 "Third Alternate" shall have the meaning assigned to that term in § 12.1(b) of this Agreement.

2. The Actions and Class Covered by This Agreement

This Agreement sets forth the terms of an agreement with respect to the Actions 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 *Solomon* and *Ashton* actions.

3. Commitment to Support and Communications with Class Members

The Parties agree that it is in their best interests to consummate this Agreement and all the terms and conditions contained herein, and 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. They also agree to support this Agreement in accordance with and subject to the provisions of this Agreement.

Class Counsel and Representative Plaintiffs and Association Plaintiffs shall make all reasonable efforts to answer questions of Class Members concerning the Settlement, shall accurately describe settlement benefits provided through the Settlement, and shall make all reasonable efforts to enforce the Compliance Dispute resolution provisions set forth in § 12 of this Agreement.

Representative Plaintiffs, Association Plaintiffs, Class Counsel and Company agree that Company may communicate with putative Class Members regarding the provisions of this Agreement, so long as such communications are not inconsistent with the Mailed Notice or other agreed upon communications concerning the Agreement. Company will encourage the filing of any claims allowed under § 8.2 of this Agreement or advise Class Members with respect to the category or categories of such claims that the Class Members should or should not file under this Agreement. Company will refer to the Settlement Administrator or to Class Counsel any inquiries from Class Members about such claims to be filed under this Agreement.

4. Preliminary Approval of Settlement

Pursuant to Rule 23(e) of the Federal Rules of Civil Procedure, the Parties shall submit this Agreement, together with the exhibits attached hereto, to the Court at a hearing (the "**Preliminary Approval Hearing**") for, among other things, its conditional certification of a settlement class, preliminary approval of the Agreement, the Mailed Notice, the Published Notice and the Claim Form, and shall apply to the Court for an Order of Preliminary Approval and Conditional Class Certification, substantially in the form of Exhibit ____ ("**Preliminary Approval Order**").

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 Healthcare Providers, Healthcare Provider Groups, and Healthcare Provider Organizations. The Mailed Notice shall request that any Class Member who has assigned a claim covered by this Agreement to another Person, in whole or in part, deliver the Mailed Notice to such Person.

Class Counsel and Company shall be jointly responsible for identifying names and addresses of Class Members 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 ____. 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 the cost to publish the Published Notice no more than three times, 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 Class Counsel and Company jointly may apply to the Court for alternative notice by publication to reach equal nationwide circulation. Company agrees to permit additional dissemination of the Published Notice at no expense to Company by any additional Signatory Healthcare Provider Specialty Societies, via listserves newsletters, or other means of their choosing. Company and Class Counsel agree that the summary notice will be displayed on the website of any Class Counsel who wish to do so, and on the websites of all of the Association Plaintiffs, the Associations listed on Exhibit __ hereto, and on any Signatory Healthcare Provider Specialty Society website, at no further cost to Company. Company shall publish the Published Notice on its Public Website such that Class Members will be able to access the notice via link from Company's home page.

All notices to any Party required under this Agreement (including, without limitation, any designations made by Class Counsel pursuant to 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 Healthcare Provider Specialty Societies: Notice to be given to Class Counsel on behalf of Representative Plaintiffs and Signatory Healthcare Provider Societies.

Class Counsel:

Class Counsel for *Solomon v. Anthem, Inc., et al:*

JoBeth Halper
JoBeth Halper Litigation Group, PC
160 Chesterfield Drive, Suite 2
Cardiff by the Sea, CA 92007

Andrew S. Friedman
Bonnett Fairbourn Friedman & Balint, PC
2901 N. Central Ave, Suite 1000
Phoenix, AZ 85012-3311

Class Counsel for *Ashton v. Anthem, Inc., et al.*:

Michael C. Dodge
David Dodge
Dodge & Associates, P.C
Regency Plaza
3710 Rawlins, Suite 1600
Dallas, TX 75219

Dennis Reich
Debra Hayes
Reich & Binstock
4265 San Felipe
Suite 1000
Houston, TX 77027

Company:

K. Lee Blalack & Brian D. Boyle
O'Melveny & Myers LLP
1625 Eye Street, N.W.
Washington, D.C. 20006

With copies to:

Kathleen Pellegrino, Esq.
Humana Inc.
500 West Main Street
Louisville, KY 40202

In the event that any Party receives a notice from any other Party (in accordance with the provisions of § 5 of this Agreement and as required by any other provision of this Agreement) pertaining to procedures provided for by this Settlement Agreement, for which there is a written acknowledgement of receipt, and such receiving Party does not respond to such notice within thirty (30) days of receipt thereof, such receiving Party shall be deemed to have accepted any proposal concerning same 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 of this Agreement, Representative Plaintiffs, Association 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 Notice, on or before a date set by the Court as the Opt-Out Deadline. Representative Plaintiffs, Association Plaintiffs, Class Counsel and Company agree to urge the Court to set the Opt-Out Deadline for the date that is forty-five (45) days after the Notice Date (the "**Opt-Out Deadline**").

Class Members individually 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. Healthcare Provider Groups and Healthcare Provider Organizations shall be entitled to exclude themselves, as distinct legal entities, from the Class, but shall have no right to Opt Out individual Healthcare Providers practicing under their auspices; instead, in order to Opt Out, individual Healthcare Providers must timely submit individual requests to Opt Out. 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 ten (10) days before the Settlement Hearing Date 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 the 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 (a) relating to more than 3,000 individual Healthcare Providers, or (b) 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 2005.

6.2 Setting the Settlement Hearing Date and Settlement Hearing Proceedings

Representative Plaintiffs, Association Plaintiffs, Class Counsel and Company agree to urge the Court to hold the Settlement Hearing on the date that is ninety (90) 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. At the Settlement Hearing, the Representative Plaintiffs, Association Plaintiffs, 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.

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 Healthcare Provider 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 or contemplated by this § 7 of this Agreement after the Actions began and/or while the Parties were engaged in discussions to resolve the Actions. Such initial and partial implementation, which shows the Parties' good faith desire to resolve the Actions, 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 described in or contemplated by this § 7 to such Class Members, if any, who Opt Out of the Agreement. Without in any way qualifying or limiting the foregoing, Company (a) is informed that it is not uncommon for some members of a class 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, in whole or in part, 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 Actions and governed by the provisions of this Agreement, except changes to such business practices that are contemplated by, or otherwise consistent with, this Agreement.

Company shall be obligated to commence implementing each commitment set forth in this § 7 of this Agreement from and after the date set forth on Exhibit _____ attached hereto, across from the relevant section number on such Exhibit (the "**Implementation Date**"), and shall continue implementing each such commitment until the Termination Date, except as modified by § 14.6 of this Agreement (the earliest of such dates, 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 Implementation Date shown on Exhibit ____ 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, except as provided in § 14.6.

7.1 Automated Adjudication of Claims

Company, recognizing the desirability of making investments to improve its business relationships with Healthcare Providers providing health care services and supplies to Plan Members through, *inter alia*, efficiency in the processing of claims, has made substantial investments and will continue to make investments in its claims systems and processes until the Conclusion Date in an effort to improve the overall efficiency of the claim adjudication process.

7.2 Increased Internet and Clearinghouse Functionality

Company has made substantial investments, and will continue to make investments, to enhance the ability of Healthcare Providers, via the internet or clearinghouses, or via facsimile, 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 or other group customers), and to check the status of claims for Covered Services. Company shall allow any Participating Healthcare Provider, at the healthcare provider's election, to engage in any HIPAA-required electronic transaction for which a standard transaction has been established by the HIPAA Standard Transactions and Code Sets Rule. Company shall attempt to include in its contracts with each clearinghouse, a requirement that such clearinghouse transmit claims to Company within twenty-four (24) hours after such clearinghouses' receipt thereof.

7.3 Availability of Fee Schedules and Scheduled Payment Dates

Company shall implement a plan not later than the Effective Date, reasonably designed to permit a Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization that, in each case, has entered into a written contract directly with Company, to the extent the Participating Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization is compensated on a Non-Capitated basis, to view, by CD-ROM or electronically (at Company's option), on a confidential basis, complete fee information showing the applicable fee schedule amounts for such Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization pursuant to that Participating Healthcare Provider's, Healthcare Provider Group's, or Healthcare Provider Organization's direct written agreement with Company. A Participating Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization may elect to receive a hard copy of the fee schedule in lieu of the foregoing. The fee schedule information to be provided will be the Fee-for-Service dollar amount allowable for each CPT® Code for those CPT® Codes that a Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization in the same specialty typically uses in providing Covered Services. A Participating Healthcare Provider, Healthcare Provider Group

or Healthcare Provider Organization may request and Company will provide the Fee-for-Service dollar amount allowable for other CPT® Codes that a Participating Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization actually bills Company. Compensation to Participating Healthcare Providers compensated on a Non-Capitated basis shall be based on a maximum allowable amount, which equals the lesser of the Participating Healthcare Provider's actual billed charge or the applicable fee schedule amount.

7.4 Investments in Initiatives to Improve Provider Relations

Since the inception of these Actions and through the Termination Date, Company has and will expend significant amounts of money and other resources to improve its relations with those providing health care services and supplies to Plan Members, including but not limited to the initiatives described in §§ 7.1, 7.2, 7.3, 7.7, 7.23 and 7.24 of this Agreement.

7.5 Reduced Precertification Requirements

Company has reduced, and will continue to attempt to limit the number of services and supplies requiring Precertification, and has standardized the services and supplies for which Precertification is required within each geographic market, line of business (*e.g.*, group, individual, *etc.*) or product for its Fully-Insured and Self-Insured Plans. Company will continue to review its Precertification requirements for further opportunities to reduce the number of services and supplies requiring Precertification. Company may continue to require Precertification for services and supplies, and may alter or amend the number of services and supplies requiring Precertification in response to changes in market conditions, medical technology, and utilization patterns. Company shall post to its Provider Website not later than three (3) months after the Final Order Date those services or supplies for which Precertification is routinely required for its products, and Company shall update such posting to the extent the services or supplies for which Precertification is routinely required changes. Notwithstanding the above, Company's Self-Insured Plan customers may specify services or supplies for which Precertification is required that differ from, or are in addition, to the services or supplies for which Company routinely requires Precertification for its Fully-Insured Plans, and such Self-Insured Plans may contract with a different entity to provide Precertification services. Company will propose to its Self-Insured Plan customers that they utilize Company's standard list of services or supplies for which Precertification is required. With a Self-Insured Plan's approval, Company will post such Self-Insured Plan's customized Precertification requirements to Company's Provider Website.

7.6 Greater Notice of Policy and Procedure Changes

Company shall, if it intends to make a material adverse change(s) in the terms of contracts (including policies and procedures incorporated by reference therein) with Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations, give at least ninety (90) days written notice to each Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization affected thereby with whom Company has directly contracted (except to the extent that a shorter notice period is required to comply with changes in applicable law), which notice shall reasonably apprise the Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization of such change(s), and the change(s) shall become effective at the conclusion of the notice period. If a Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization objects to the change(s) that is subject to the notice, the Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization must, within thirty (30) days of the date of the notice (which shall be the date the notice is sent by United States mail, by facsimile, or, if Company offers it, electronically, at the option of the Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization), give written notice to terminate his, her, or its contract with Company, which termination shall be effective at the end of the notice period of the material adverse change(s) unless, within sixty-five (65) days of the date of the original notice of change(s), Company gives written notice to the objecting Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization that it will not implement, as to the objecting Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization, the material adverse change(s) to which the Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization objected. The continuation of care provisions in § 7.13(c) of this Agreement shall apply to any contract termination pursuant to this § 7.6 of this Agreement.

7.7 Initiatives to Reduce Claim Resubmissions

Company has implemented a series of initiatives designed to increase the percentage of claim issues resolved on initial review and thereby reduce the percentage of resubmitted claims. Such initiatives include, but are not limited to, implementation of or improvement in virtual processor technologies that analyze pended claims and identify and adjudicate those pended claims that can be decided without further review by Company personnel, implementation of additional automated processes for completing otherwise incomplete claims in order to avoid rejection of such claims, implementation of changes in processes and work flows, enhancement of capabilities to better identify duplicate claims and avoid unnecessary rejections, implementation of improvements in Company's communications with Healthcare Providers regarding Company's billing requirements, and analysis of the reasons claims are rejected or pended

and appropriate responsive action, all of which are designed to improve Company's ability to resolve issues arising from defective or missing information on claims. Company agrees to continue these or comparable business practices during the Effective Period.

7.8 Disclosure of and Commitments Concerning Claims Payment Practices

(a) Company recognizes the benefit of greater standardization in its claims systems and, to that end, Company expects to consolidate its claims systems to two primary platforms, which will result in greater consistency with respect to its automated Edits and other claims payment rules. Company's two primary platforms comprise approximately seventy-eight percent (78%) of claims, which are processed using claims payment rules that are consistent in all material respects across ongoing claims systems and products.

(b) Company will describe with particularity any single Edit that is not compliant with CPT® Codes, Guidelines and Conventions, or sourced to the CCI, that Company reasonably judges, based on its experience with submitted claims, will cause, on the initial review of submitted claims, the denial of, or reduction in, payment for a CPT® Code or HCPCS Level II Code more than five hundred (500) times per year ("**Significant Edit**"). Company agrees to disclose its Significant Edits on the Provider Website by not later than six (6) months after the Final Order Date, or as soon thereafter as practicable. Company agrees to update its disclosure of Significant Edits once per calendar year to reflect changes in Company's Significant Edits and Company's experience with submitted claims; provided that Company shall promptly disclose newly-adopted Significant Edits.

(i) Not later than six (6) months after the Final Order Date, or as soon thereafter as practicable, Company shall publish on the Provider Website, for each commercially available claims editing software product then in use by Company, a list identifying each customized Edit added to the standard claims editing software product at Company's request.

(ii) Not later than the Final Order Date, Company shall not routinely require submission of Clinical Information, before or after payment of claims, in connection with Company's adjudication of a Healthcare Provider's claims for payment, 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 determines that

routine review of Clinical Information is appropriate; provided that Company shall disclose any such categories on the Public Website and the Provider Website. Notwithstanding the foregoing, Company may require submission of Clinical Information in connection with Company's adjudication of a Healthcare Provider's claims for payment for the purpose of investigating fraudulent or abusive (whether intentional or unintentional) billing practices, but only so long as, and only during such times as, Company has a reasonable basis for believing that such investigation is warranted. A Healthcare Provider may contest, pursuant to § 7.10(c) of this Agreement, any requirement that the Healthcare Provider submit Clinical Information in connection with Company's adjudication of the Healthcare Provider's claims for payment for the purpose of investigating fraudulent or abusive (whether intentional or unintentional) billing practices. Nothing in this § 7.8(b)(ii) of this Agreement is intended or shall be construed to limit Company's right to require submission of Clinical Information when such requirement is not in connection with Company's adjudication of a Healthcare Provider's claims for payment, or is otherwise permitted by this Agreement, including but not limited to the right to require submission of Clinical Information for Precertification purposes consistent with § 7.5 of this Agreement.

(iii) Not later than six (6) months after the Final Order Date, Company shall publish on the Provider Website those limited code combinations 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 and Company's application of the rule differs from CPT® Codes, Guidelines and Conventions; provided that no such determination shall be inconsistent with the undertakings set forth in this Agreement.

(c) Company shall promptly update the disclosures required by §§ 7.8(b)(i)-(iii) above when changes are made to the policies, procedures, or determinations referenced therein.

(d) In furtherance of the mutual goals of proper payment and transparency in payment methodology, the Signatory Healthcare Provider Specialty Societies in States where Company does significant business (defined for purposes of this Agreement to be the States of Arizona, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Ohio, Texas and Wisconsin) agree to encourage their

Healthcare Provider members to use proper coding practices pursuant to CPT® Codes, Guidelines and Conventions.

(e) Company shall not, under any circumstances, represent in its Website disclosures, or in any other disclosure materials, or verbally that Company's Edits are endorsed by any Healthcare Provider Specialty Society or the American Medical Association, or that the American Medical Association has participated in the development of Company's Edits.

(f) Where a Signatory Healthcare Provider Specialty Society inquires about the rationale for the proposed edit or enhancement, Company will provide such signatory Healthcare Provider Specialty Society with information concerning such rationale at the same level of detail that it provides to individual Healthcare Providers making similar inquiries, including, where applicable, any documentation concerning such rationale provided by the third party or parties from which Company licensed its claim-review software, PROVIDED, that nothing in this provision shall require Company to make any disclosure that is prohibited by its license agreements with any such third parties.

7.9 Healthcare Provider Advisory Committee

(a) Prior to the later to occur of (i) three (3) months after the Final Order Date or (ii) selection of the members of the Healthcare Provider Advisory Committee in accordance with § 7.9(b) of this Agreement, Company shall take all actions reasonably necessary on its part to establish a Healthcare Provider Advisory Committee ("**Healthcare Provider Advisory Committee**") to discuss regional or national issues arising from or related to the relationships and interactions between and among Healthcare Providers, their patients, and the Company. These issues may include, but are not limited to, improvement of health care and clinical quality, improvement of communications, relations and cooperation between Healthcare Providers and the Company, and/or matters of a clinical or administrative nature that impact the interaction between Healthcare Providers and the Company. The Healthcare Provider Advisory Committee shall meet at least once every six (6) months during the Effective Period, and notice of each such meeting shall be posted on the Provider Website in a place accessible by both Participating and Non-Participating Healthcare Providers at least two months in advance. All communications to the Healthcare Provider Advisory Committee by Participating Healthcare Providers and/or Non-Participating Healthcare Providers shall be accomplished through members of the Healthcare Provider Advisory Committee who shall represent

the interests of such Participating and/or Non-Participating Healthcare Providers and whose contact information shall be posted on the Provider Website.

(b) The Healthcare Provider Advisory Committee shall include seven (7) members. There shall be no more than one representative of any Healthcare Provider discipline appointed to the Healthcare Provider Advisory Committee at any one time. The Company shall appoint its Chief Medical Officer or his or her designee, who shall serve as chairperson of the Healthcare Provider Advisory Committee. Except as provided in this § 7.9(b) of this Agreement, the remaining members shall be Healthcare Providers in active clinical practice who are not employees of the Company. The other six (6) members shall be selected as follows: Class Counsel, on behalf of, and after consultation with, the Association Plaintiff from the relevant discipline, or, where there is no Association Plaintiff for the relevant discipline, with the relevant Healthcare Provider Specialty Society (if any), shall select three (3) members, one of whom shall be a psychologist, one of whom shall be a podiatrist, and one of whom shall be a chiropractor, and all of whom shall not have excluded themselves from the Settlement. Company shall select two (2) members from among the following Healthcare Provider disciplines: physical therapy, ambulance attendance, physician assistance, optometry, home health care, social work, and nursing (inclusive of nurse practitioners and registered nurses). Each member must not have excluded him or herself from the Settlement. Company and Class Counsel shall make their selections not later than thirty (30) days after the date of the entry of the Preliminary Approval Order. At least one provider selected by the Company and one provider selected by Class Counsel shall be a Participating Healthcare Provider. The Company and Class Counsel shall jointly select the remaining member in consultation with the six (6) previously selected Committee members, not later than ninety (90) days after the date of the entry of the Preliminary Approval Order. The seventh member shall be selected from the disciplines listed above, provided, however, that the selected practitioner must be in a different health care specialty or discipline than the disciplines represented by the six original members. The Company shall provide all necessary information in order for the parties to make the appropriate selection. The names of the members of the Healthcare Provider Advisory Committee and the dates of the Healthcare Provider Advisory Committee meetings shall be posted on the Company's Website in a place where both participating and non-participating providers may access the name and contact information for each such member. If any member discontinues serving on the Healthcare Provider Advisory Committee, that

member's position shall be filled in the same manner as the member who was originally selected, provided, however, that at all times at least two of the members selected by the Company and Class Counsel shall be Participating Healthcare Providers.

(c) Any motion for the Healthcare Provider Advisory Committee to consider an issue must be proposed by the chairperson or any other voting member of the Healthcare Provider Advisory Committee. The issue shall be heard only if, at a meeting at which a quorum exists, a majority of the voting members of the Healthcare Provider Advisory Committee present vote in favor of hearing the issue.

For purposes of this subparagraph (c), "quorum" shall mean four (4) or more voting members of the Healthcare Provider Advisory Committee.

Upon a majority vote of the voting members of the Healthcare Provider Advisory Committee, the Healthcare Provider Advisory Committee may make recommendations to the Company, provided that such recommendations are within the Healthcare Provider Advisory Committee's purview as described in § 7.9(a) of this Agreement.

Company shall consider whether the implementation of any recommendation of the Healthcare Provider Advisory Committee is: (i) reasonable considering the opportunities and constraints of the current health care financing/administration marketplace; (ii) consistent with the best interests of Company's Participating Healthcare Providers, Plan Members, customers, shareholders and other constituents; and (iii) in furtherance of scientifically and clinically sound medical care. If Company decides not to accept a recommendation of the Healthcare Provider Advisory Committee, Company shall communicate that decision in writing to the Committee with an explanation of Company's reasons, and Company shall also disclose the recommendation and response on the Provider Website. Company agrees to post on the Provider Website a listing of all Healthcare Provider Advisory Committee recommendations made to Company and Company's responses to such recommendations.

(d) Each member of the Healthcare Provider Advisory Committee shall agree to maintain and treat as confidential any proprietary information reasonably designated as such by the Company. No member of the Healthcare Provider Advisory Committee shall serve as a member of an advisory or similar committee established by any other managed care company or health insurer, but this provision is not meant to exclude Healthcare Providers who serve

on credentialing or similar committees for other companies.

(e) Company shall develop and implement reasonable payment provisions for the expenses of members of the Healthcare Provider Advisory Committee, including, without limitation, a reasonable per diem to be set by the Company.

7.10 New Dispute Resolution Process for Healthcare Provider Billing Disputes

(a) Not later than four (4) months after the Final Order 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 Healthcare Providers and Healthcare Provider Groups concerning (i) application of Company's coding and payment rules and methodologies for Fee-for-Service claims (including, without limitation, any bundling, Downcoding, application of a CPT® modifier, and/or other reassignment of a code by Company) 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) whether Company has complied with the provisions of this Agreement, including, without limitation, § 7.8(b)(ii) of this Agreement, in requiring that a Healthcare Provider submit records, either prior to or after payment, in connection with Company's adjudication of such Healthcare Provider's claims for payments, or (iii) any Retained Claims, so long as such Retained Claims are submitted by the Healthcare Provider to the Billing Dispute External Review Board prior to the later to occur of (A) ninety (90) days after the Final Order Date or (B) thirty (30) days after exhaustion of Company's internal appeals process. Each such matter shall be a "**Billing Dispute**." The Billing Dispute External Review Board(s) shall not have jurisdiction over any other disputes, including, without limitation, those disputes that fall within the scope of the External Review process set forth in § 7.11 of this Agreement, Compliance Disputes and disputes concerning the scope of Covered Services; nor shall such Board(s) have jurisdiction or authority to revise or establish any reimbursement policy of the Company or any Plan or any policy regarding requests for submission of Clinical Information. Nothing contained in this § 7.10 of this Agreement is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Plan Member under § 502(a) of ERISA or to supersede in any respect the claims procedures for Plan Members of § 503 of ERISA, or required by applicable state or federal law or regulation. In the case of a state

or federally-required External Review process for billing disputes that is different than the process herein set forth, only the state or federally-required program shall be utilized for disputes subject to the state or federally-required process.

(b) Any Healthcare Provider or Healthcare Provider 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(h) of this Agreement, and in accordance with the provisions of § 7.10(b)(iii), after the Healthcare Provider or Healthcare Provider 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 Five Hundred Dollars ($500). Billing disputes may be submitted only by individual Healthcare Providers and Healthcare Provider Groups. Company shall post a description of its provider internal appeals process on the Provider Website.

(i) Notwithstanding the foregoing, a Healthcare Provider or Healthcare Provider Group may submit a Billing Dispute if less than $500 is at issue and if such Healthcare Provider or Healthcare Provider Group intends to submit additional Billing Disputes during the one-year (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 Healthcare Provider or Healthcare Provider Group, defer consideration of such Billing Dispute while the Healthcare Provider or Healthcare Provider Group accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the Conclusion Date, the Healthcare Provider or Healthcare Provider Group has not accumulated the requisite amount of Billing Disputes and Company has chosen not to continue the Billing Dispute process following the Conclusion Date, then any rights the Healthcare Provider or Healthcare Provider 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 Conclusion Date.

(ii) In any event, a Healthcare Provider or Healthcare Provider Group will have one (1) year from the date he, she or it 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.

(iii) The Healthcare Provider or Healthcare Provider Group must exhaust Company's internal appeals process before submitting a Billing Dispute to the Billing Dispute External Review Board; provided that a Healthcare Provider or Healthcare Provider 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 thirty (30) days of receipt of all documentation reasonably needed to decide the internal appeal. In the event Company and a Healthcare Provider or Healthcare Provider 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(b)(ii), all Billing Disputes must be submitted to the Billing Dispute External Review Board no more than ninety (90) days after a Healthcare Provider or Healthcare Provider 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 ninety (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 thirty (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 five hundred dollars ($500).

(iv) Except to the extent otherwise specified in this § 7.10(b) of this Agreement, 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 the Company and Class Counsel, or their designee,

with input from the Billing Dispute External Review Board. Such procedures shall provide that (A) a Healthcare Provider or Healthcare Provider Group submitting a Billing Dispute to the Billing Dispute External Review Board shall state in the documents submitted to the Billing Dispute External Review Board the amount in dispute, and (B) that the Billing Dispute External Review Board shall not be permitted to issue an award that exceeds the greater of the amount stated by such Healthcare Provider or Healthcare Provider Group in the documents submitted to the Billing Dispute External Review Board to be in dispute or the amount payable under the terms of the applicable contract (or in the case of Non-Participating Healthcare Providers, the amount payable under the applicable Plan).

(c) Any Healthcare Provider who contests the appropriateness of Company's requirement that such Healthcare Provider submit records, either prior to or after payment, in connection with Company's adjudication of such Healthcare Provider'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 Healthcare Provider demonstrates to the Billing Dispute External Review Board that Company's requirement has a significant adverse economic effect on the Healthcare Provider which justifies expedited review. In the event that the Billing Dispute External Review Board determines that such Healthcare Provider has not so demonstrated, the Billing Dispute External Review Board shall dismiss such claim without prejudice, pending the exhaustion by such Healthcare Provider of Company's internal appeals process.

(d) Company and Class Counsel, or their designees, shall select the organization(s) that shall constitute the Billing Dispute External Review Board or Boards. If Company and Class Counsel, or their designees, cannot agree on members of the Billing Dispute External Review Board or Boards within one hundred twenty (120) 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 Healthcare Providers, the members of the Billing Dispute External Review Board or Boards shall be bound by the terms of the applicable Plan, any applicable agreement between the Healthcare Provider and Company, and the provisions of this Agreement. If the dispute cannot be resolved by reference to the foregoing documents, then the Billing Dispute External Review Board(s)

shall resolve Billing Disputes by determining, first, whether the billing was coded and submitted properly based on generally accepted medical coding standards, including but not limited to CPT® Coding and CCI/CMS guidelines, and second, whether applicable Company reimbursement policies were properly applied, including those reimbursement policies required or permitted under this Agreement, including, without limitation, reimbursement policies posted by the Company pursuant to § 7.8(b) of this Agreement.

(e) 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 thirty (30) days after receipt of the documents necessary for the review and notice of such decision be provided to the parties promptly thereafter.

(f) In the event that the Billing Dispute External Review Board issues a decision requiring payment by Company, Company shall make such payment within fifteen (15) days after Company receives notice of such decision.

(g) Any decision by the Billing Dispute External Review Board shall be binding on Company and the Healthcare Provider or Healthcare Provider Group. For Retained Claims, all Billing Disputes shall be directed neither 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(d). Retained Claims as defined in § 13.6 shall not be barred as untimely, so long as they are submitted within thirty (30) days of the establishment of the Billing Dispute External Review Board.

(h) For any Billing Dispute that a Healthcare Provider submits to the Billing Dispute External Review Board, the Healthcare Provider submitting such Billing Dispute shall pay to Company a filing fee calculated as follows: (i) if the amount in dispute is one thousand dollars ($1,000) or less, the filing fee shall be fifty dollars ($50), or (ii) if the amount in dispute exceeds one thousand dollars ($1,000), the filing fee shall be equal to $50, plus five percent (5%) of the amount by which the amount in dispute exceeds one thousand dollars ($1,000), but in no event shall the fee be greater than fifty percent (50%) of the cost of the review. The Company shall refund the applicable filing fee paid by a Healthcare Provider who

submits a Billing Dispute to the Billing Dispute External Review Board in the event the Healthcare Provider is the prevailing party with respect to such Billing Dispute.

(i) The determination made with respect to any Billing Dispute pursuant to this section shall not act as precedent as to any other Billing Dispute under this section.

7.11 Determinations Related to Medical Necessity or the Experimental or Investigational Nature of Any Proposed Health Care Service or Supply

(a) Initial Determinations

A Physician or Healthcare Provider designated by Company with knowledge of the applicable health care specialty, or experience with the relevant condition or treatment under review, shall be responsible for making the initial determination for Company, of whether proposed health care services or supplies are Medically Necessary or experimental, or investigational in nature. A nurse or other health care professional, acting for a medical director, may approve any proposed health care service or supply as being Medically Necessary, but only a Physician or Healthcare Provider designated by Company may deny any such service or supply as being not Medically Necessary or experimental, or investigational in nature.

(b) Plan Member Internal Appeal and External Review Process

(i) Company currently maintains and will continue to maintain an internal appeal and External Review process permitting Plan Members to seek internal and independent External Review of any determination made by Company that certain services are not Covered Services because they are not Medically Necessary or are experimental, or investigational in nature ("**Adverse Determination**") where Company both makes the Adverse Determination and administers the Plan Member appeals and External Review processes.

(ii) As set forth in this § 7.11 of this Agreement, Company will establish and maintain an internal appeal and External Review process for Healthcare Providers with respect to Adverse Determinations to the extent Company both makes the Adverse Determination and administers the Plan Member appeals and/or External Review processes.

(iii) Except where any applicable law or regulation requires a

different definition, Company shall use the definition of Medical Necessity set forth in § 7.16(a) of this Agreement in the internal appeal and External Review processes set forth in this § 7.11. PROVIDED, however, that nothing in this Agreement shall limit or prevent Company from denying coverage on the grounds that services are experimental or investigational, or alter or restrict Company's rights under contracts with Participating Healthcare Providers to restrict or prohibit them from billing a Plan Member for services determined to be not Medically Necessary or experimental, or investigational. Company agrees that a Participating Healthcare Provider may bill a Plan Member for services determined to be not Medically Necessary or experimental, or investigational, when the Participating Healthcare Provider provides the Plan Member with advance written notice that (A) identifies the proposed services, (B) informs that Plan Member that such services may be deemed by Company to be not Medically Necessary or experimental, or investigational, and (C) provides an estimate of the cost to the Plan Member for such services and the Plan Member agrees, in writing, in advance of receiving such services to assume financial responsibility for such services.

(iv) In applying experimental and investigational exclusions in a Plan to either proposed health care services or as part of a Post-Service Appeal to the Company, Company shall consider credible scientific evidence published in medical literature generally recognized by the relevant medical community (peer-reviewed, if available), published Physician and Healthcare Provider Specialty Society recommendations and opinions, the views of Physicians (with sufficient knowledge, training, and expertise in the relevant condition and treatment under review) and Healthcare Providers (practicing in the same or similar discipline), the individual clinical circumstances of the particular Plan Member, the views of the treating Physician and Healthcare Provider and any other relevant factors.

(c) Healthcare Provider Internal Appeals of Adverse Determinations.

(i) Pre-Service Appeals.

Healthcare Providers shall have the right to file an appeal of an Adverse Determination prior to rendering the service ("**Pre-Service Appeals**"), if they are appealing on the Plan

Member's behalf. For urgent Pre-Service Appeals, the Healthcare Provider shall be automatically deemed the authorized representative of the Plan Member. For all other Pre-Service Appeals, authorization must be obtained from the Plan Member in writing. Pre-Service Appeals filed by Healthcare Providers on behalf of a Plan Member will be handled by the Company under the appeal process available to the Plan Member based on the terms of the Plan Member's health benefit plan and the applicable state and federal laws and regulations.

(ii) Post-Service Appeals

(A) With respect to an appeal of an Adverse Determination made after the service has been rendered ("**Post-Service Appeals**"), Company shall adopt a one-level internal appeal process for Healthcare Providers. That process shall ensure that only a Physician (with sufficient knowledge, training, and expertise in the relevant clinical condition or treatment under review) or a Healthcare Provider (practicing in the same or similar discipline or specialty) (hereinafter "**Qualified Reviewer**"), other than the Healthcare Provider who made the initial Adverse Determination, may deny the appeal of the Healthcare Provider who treated the condition. A nurse or other health care professional employed by Company may review the internal appeal and may grant, but not deny, the appeal. If the nurse or other healthcare professional does not grant the appeal, then a Qualified Reviewer, designated by Company, other than the one that made the initial Adverse Determination, shall review and decide the internal appeal in accordance with applicable Company health care clinical guidelines.

(B) For purposes of this section and § 7.16(a) of this Agreement, "same or similar discipline or specialty" shall mean a Healthcare Provider with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal, or a Healthcare Provider who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

(C) Prior to requesting internal Post-Service Appeal, Healthcare Provider shall use best efforts to first seek written authorization to proceed as the Plan Member's representative. If Healthcare Provider obtains the Plan Member's consent to proceed on his or her behalf, then Healthcare Provider's appeal rights are those of the Plan Member, and Healthcare Provider is bound by the decision rendered in the Plan Member's appeal process. If the Post-Service appeal or External Review decision is favorable to the Non-Participating Healthcare Provider, then payment by Company will be subject to the terms, conditions and limitations of the applicable health benefit plan. However, payment will be issued directly to the Non-Participating Healthcare Provider.

(d) Timeframes for Healthcare Provider Internal Appeals of Adverse Determinations

All internal Post-Service Appeals filed by Healthcare Providers shall be adjudicated within the time limits established under regulations issued by the Department of Labor regardless of whether ERISA applies.

(e) Adverse Determination External Review Process for Healthcare Providers

Company shall make available to Plan Members whose health care benefits are provided through a Fully-Insured Plan, and to Plan Members whose health care benefits are provided through a Self-Insured Plan and whose Plan sponsors have elected to participate in the program established by this provision (or in each case, by a Class Member when authorized in writing by the Plan Member), the option, following exhaustion of Company's internal appeal process, to appeal directly, an adverse determination based upon lack of Medical Necessity or the characterization of the relevant service or procedure as experimental or investigational, to an independent External Review organization identified by Company (the "**Independent Review Organization**"); provided that, where there has been a denial based upon Medical Necessity of services already provided, no authorization from the Plan Member shall be required. The cost of the External Review shall be borne by Company, and the decision of the Independent Review Organization shall be binding upon Company and the Class Member. Election to pursue review under this § 7.11(e) is at the option of the Class Member, who may instead choose any other

remedy available as a matter of law or contract. Company shall require that the Independent Review Organization issue its decision within thirty (30) days of the request for External Review. The external reviewer designated by the Independent Review Organization to conduct the review shall be one of the following, provided that such person has sufficient knowledge, experience or information about the condition or treatment under review: (1) a Physician who is a specialist in the same specialty (but not necessarily the same sub-specialty) as the referring, prescribing, or treating Physician, or (2) a Physician with sufficient knowledge, training, and expertise in the relevant clinical condition or treatment under review, or (3) a Healthcare Provider who practices in the same or similar discipline or specialty as the appealing Healthcare Provider. The External Review process offered by Company shall not supersede any state-required program for external review inconsistent with Company's External Review process. In the case of a state-required external review process that is different than the process herein set forth, only the state-required program shall be utilized where applicable.

(i) The Independent Review Organization must meet the standards for external review entities under applicable federal and state law. The External Review entity will be contracted to conduct an independent *de novo* review of the case consistent with applicable Medical Necessity standards as set forth in § 7.16(a) of this Agreement; however, for coverage issues other than a determination of Medical Necessity, the Plan Member's health benefit Plan Documents will control. The External Review entity shall have the authority to review any adverse determination related to the Medical Necessity of a particular health care service or supply after the Plan Member or his or her Healthcare Provider, where appropriate, has exhausted the internal appeal process or after Company and the Plan Member or his or her Healthcare Provider, where appropriate, agree to forego any level of internal appeal and proceed directly to External Review. The Plan Member or his or her Healthcare Provider, where appropriate, shall have the option to select this review within sixty (60) days from the date of the final denial decision by Company. The Independent Review Organization's compensation shall not be tied to the outcome of the reviews performed. Likewise, the selection process among qualified External Review entities will not create any incentives for external review entities to make decisions in a biased manner. Company shall cause its contract with the Independent Review Organization to be consistent with the terms of this § 7.11.

(ii) Notwithstanding the provisions of this § 7.11, Class Members may not seek review of any denial for which the Plan Member (or his or her representative) seeks review through the External Review program. In the event that both a Plan Member (or his or her representative) and a Healthcare Provider seek review before a service is rendered, the Plan Member's appeal shall go forward and the Healthcare Provider's appeal shall be dismissed and may not be brought by or on behalf of the Healthcare Provider in any forum.

(iii) Notwithstanding the provisions of this § 7.11, Class Members may not seek review of any denial for which the Plan Member (or his or her representative) has filed suit under § 502(a) of ERISA or other lawsuit over the denial of health care services or supplies on Medical Necessity grounds. In that event, or if such a suit is subsequently initiated, the Plan Member's lawsuit shall go forward and the Class Member's appeal shall be dismissed and may not be brought by or on behalf of the Class Member in any forum; provided, that such dismissal shall be without prejudice to any Class Member seeking to establish that the rights sought to be vindicated in the Plan Member's lawsuit belong to such Class Member and not to such Plan Member.

(iv) Nothing contained in this § 7.11 is intended, or shall be construed, to supersede, 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.

(v) In the event the External Review process is initiated, the Independent Review Organization shall request documentation from Company promptly, but in any event, no later than five (5) business days after the Plan Member or Class Member initiates the External Review process, and Company shall provide such requested documentation within ten (10) business days of receiving the request and provide copies of all such documentation to the Class Member initiating such review. The Independent Review Organization may in its sole discretion, accept responsive materials from the Class Member, where copies of such materials have been provided to Company, as long as such materials are submitted prior to any decision by the Independent Review Organization. The Independent Review Organization shall provide a decision within thirty

(30) days of Company's submission of all necessary information. In the event that a decision in favor of the Class Member is rendered as a result of an appeal regarding services already PROVIDED, Company shall make payment to the Class Member, consistent with § 7.18 of this Agreement, less any portion of allowed charges that is payable by the Plan Member under his or her Plan Documents; provided, that the interest described in § 7.18 of this Agreement will be payable unless the Class Member introduces material new information to the Independent Review Organization that was not provided to Company during the internal appeal process.

(f) Precedential Effect

The determination made with respect to any Adverse Determination pursuant to any internal appeal and External Review process referenced in this § 7.11 shall not act as precedent as to any other Medical Necessity or experimental or investigational determination under this § 7.11.

7.12 [This section intentionally left blank.]

7.13 Participating in Company's Network

(a) Credentialing of Healthcare Providers

Company will allow Healthcare Providers to submit credentialing applications (including, as relevant, licensure and hospital privileges or other required information) and will begin to process such applications prior to the time that the Healthcare Provider formally changes or commences employment or changes location, provided that the Healthcare Provider must represent that he or she has new employment or intends to move to a new location. Company shall complete primary source verification and notify the Healthcare Provider as to whether he or she is credentialed within ninety (90) days of receiving a Healthcare Provider's completed application to be a Participating Healthcare Provider unless, in spite of Company's best efforts and because of a failure of a third party to provide necessary documentation, Company cannot obtain the necessary information to make a decision within ninety (90) days. In such an event, Company shall make every effort to obtain the information as soon as possible. Company commits that the Credentialing Committee for each market shall meet at least once every forty-five (45) days to consider credentialing applications for which primary-source verification has been completed. If a Healthcare Provider is already credentialed by

Company but changes employment or changes location, Company will require the submission of only such additional information, if any, as is necessary to continue the Healthcare Provider's credentials based upon the changed employment or location. Nothing herein shall be deemed to require Company to accept applications from or to award credentials to Non-Participating Healthcare Providers.

(b) All Products Clauses

Company agrees that it shall not require a Participating Healthcare Provider to participate in a Capitated Fee arrangement in order to participate in Product Networks in which the Participating Healthcare Provider is compensated on a Fee-for-Service basis. Company further agrees that it shall not require a Participating Healthcare Provider to participate in its workers' compensation, Medicare Advantage or Medicaid Product Networks in order to participate in its commercial Product Networks. Except where a Participating Healthcare Provider (or Healthcare Provider Group comprised of Participating Healthcare Providers or Healthcare Provider Organizations) has agreed in an Individually Negotiated Contract to participate in more than one Product Network for a specified period of time (in which case the terms of the Individually Negotiated Contract shall govern), if a Participating Healthcare Provider (or Healthcare Provider Group comprised of Participating Healthcare Providers or Healthcare Provider Organizations) either (i) chooses not to participate in all Company Product Networks or (ii) terminates participation in some Company Product Networks, then the reimbursement levels (*e.g.*, Fee-for-Service maximum allowable amount, Capitation rate, or other reimbursement methodology) offered to, or applied by, Company to, the Participating Healthcare Provider (or Healthcare Provider Group comprised of Participating Healthcare Providers or Healthcare Provider Organizations) for the Product Network(s) in which such Healthcare Provider (or Healthcare Provider Group comprised of Participating Healthcare Providers or Healthcare Provider Organizations) continues to participate shall not be lower than Company's standard reimbursement levels (*e.g.*, Fee-for-Service maximum allowable amount, Capitation rate, or other reimbursement methodology) in that geographic market unless the Healthcare Provider (or Healthcare Provider Group comprised of Participating Healthcare Providers or Healthcare Provider Organizations) shall have already agreed to a nonstandard reimbursement level, which level shall continue to apply for the term of such agreement. Notwithstanding the foregoing, Company may offer a higher reimbursement level (*e.g.*, Fee-for-Service maximum allowable amount, Capitation rate, or other

reimbursement methodology) or other incentive to any Participating Healthcare Provider (or Healthcare Provider Group comprised of Participating Healthcare Providers or Healthcare Provider Organizations) who elects to participate (or elects to continue participation) in more than one of Company's Product Networks. Nothing in this paragraph shall obligate Company to pay more than the lesser of the Healthcare Provider's billed charges or the Company's applicable Fee-for-Service amount.

(c) Termination by Company, Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization

In the event of a contract termination by either party, the following obligations shall apply with respect to the continuation of care for those patients of a Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization who are entitled to continuation of care as reasonably defined under the Participating Healthcare Provider's, Healthcare Provider Group's, or Healthcare Provider Organization's contract with Company or under applicable law. In the case of a continuation-of-care situation as defined in the preceding sentence, the Participating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization shall continue to render necessary care to the Plan Member consistent with contractual or legal obligations; provided that, if, upon notice from the Healthcare Provider, Healthcare Provider Group, Healthcare Provider Organization, or Plan Member that a Plan Member is in a continuation-of-care situation, the Company does not use due diligence to make alternative care available to the Plan Member within ninety (90) days after receipt of such notice, then for continuation-of-care services provided after termination, Company shall process claims submitted by the Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization based on the standard rates the Company pays to Non-Participating Healthcare Providers in that geographical area. Other than as specified in this § 7.13(c), the contractual provisions applicable to continuation of care shall apply.

Notwithstanding the foregoing obligations, Company's obligations under this § 7.13(c) shall not apply to the extent that other Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations are not available to replace the terminating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization due to (i) geographic or travel-time barriers; or (ii) contractual provisions between the terminating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization and a facility at which Plan Member

receives care that limits or precludes other Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations from rendering replacement services to Plan Members (*e.g.*, an exclusive services agreement between the terminating Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization and a facility where Plan Member receives services).

(d) Rights of Class Members to Refuse to Accept Additional Patients

Company will not prevent Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations from closing their practices to all new patients from all third-party payors with whom they contract.

7.14 Fee-Schedule Changes

(a) Notices Regarding Fee Schedules

Company agrees, effective January 1 of the year following the Effective Date, not to reduce the fees set forth in fee schedules of Participating Healthcare Providers more than once per calendar year except as otherwise provided in this § 7.14(a). Company further agrees that it shall give notice of any such reductions in fees as a material adverse change, subject to the provisions of § 7.6 of this Agreement; provided, however, that to the extent a fee schedule is directly tied to the CMS fee schedules or state Medicaid fee schedules currently in effect, it shall adjust automatically to reflect applicable interim and annual revisions made by CMS or the state Medicaid agency without notice to the Healthcare Provider. If an annual revision made by CMS or a state Medicaid agency results in a reduction in the fees in a fee schedule that is directly tied to the CMS fee schedules or state Medicaid fee schedules, a Participating Healthcare Provider shall have the right to terminate his or her contract with Company by giving Company written notice of termination within thirty (30) days of the date on which CMS or the state Medicaid agency published notice of the annual revision, which termination shall be effective ninety (90) days after the date that such notice was published. Notwithstanding the foregoing, Company may increase or reduce the fees set forth in such fee schedules by updating its fee schedules at any time (i) to reflect changes in market prices for vaccines, injectables, pharmaceuticals, durable medical supplies, other goods, and non-Healthcare Provider Services, (ii) to add payment rates for newly adopted CPT® Codes, (iii) to add payment rates for new technologies and new uses of established

technologies that Company concludes are eligible for payment, and (iv) to reflect applicable interim revisions made by CMS. Nothing contained in this § 7.14(a) shall prevent Company from maintaining, altering or expanding the use of Capitation or other compensation methodologies. The requirements in this § 7.14(a) shall not apply to Individually Negotiated Contracts to the extent those requirements are inconsistent with the terms relating to reductions in fee schedules or termination in such contracts.

(b) Payment Rules for Injectables, Durable Medical Equipment ("DME"), Administration of Vaccines, and Review of New Technologies

Company agrees to pay a fee for the administration of any vaccines and injectables by Healthcare Providers where such services are within their licensed professional expertise, and, where applicable, within the scope of the services authorized by the Participating Healthcare Providers' contract with Company. Company also agrees to pay for or arrange to supply the vaccines and injectables themselves. Company shall pay for newly recommended vaccines as of the effective date of a recommendation made by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics, and the Advisory Committee on Immunization Practices. Other than as specified in the preceding sentence with respect to newly recommended vaccines, if a Healthcare Provider Specialty Society recommends as an appropriate standard of care a new technology or treatment, or a new use for an established technology or treatment, Company shall evaluate the recommendation and issue a coverage statement not later than one hundred twenty (120) days after Company learns of such Healthcare Provider Specialty Society recommendation. With respect to capitated primary-care Participating Healthcare Providers, Company shall continue to pay separate fees (in addition to contractually agreed-upon Capitation payments) for vaccines administered pursuant to the schedules recommended by the U.S. Preventive Services Task Force, the American Academy of Pediatrics, or the Advisory Committee on Immunization Practices, unless Company and the capitated Participating Healthcare Providers have entered into an Individually Negotiated Contract that includes payment for such vaccines and their administration in the Capitation amount. Nothing herein shall prohibit Company from requiring, in a non-emergent situation, that injectables and vaccines be obtained from a dedicated source.

(c) "Usual, Reasonable, and Customary" Appeals

At least until the Termination Date, if a Non-Participating Healthcare Provider initiates a dispute using Company's internal dispute-resolution procedures over how Company has determined the usual, reasonable, and customary amount for a given healthcare service or supply and, consequently, over how Company has computed the amount payable for that health care service or supply, Company shall disclose to the Non-Participating Healthcare Provider initiating the dispute the general methodology, including the percentile of included charge data on which the maximum allowable amount is based, and the source of data used by Company to determine the usual, reasonable, and customary amount for that service or supply.

7.15 [This section intentionally left blank.]

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

(a) Patient-Specific Issues Involving Clinical Judgment.

Medical Necessity/Medically Necessary Definition

Except where any applicable law or regulation requires a different definition, Company shall apply to its current agreements and include in its future agreements with Participating Healthcare Providers the following definition of "Medically Necessary" or comparable term in each such agreement: "**Medically Necessary**" or "**Medical Necessity**" shall mean healthcare services that a Healthcare Provider, 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 (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, or Healthcare Provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results concerning 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 medical literature generally recognized by the relevant medical community (peer-reviewed, if available), written Healthcare Provider Specialty Society opinions and recommendations, the views of Healthcare Providers practicing in the same or similar discipline or specialty, and any other relevant factors.

Adverse-Determination Denial Rate

For the calendar year beginning after the Final Order Date, and thereafter during the Effective Period, Company shall make an annual, aggregate disclosure of the number of Adverse Determinations sent to External Review for final determination in the preceding calendar year and the percentage of such Adverse Determinations that are upheld or reversed. Company shall make this disclosure by means of the Provider Website or other comparable electronic medium.

(b) Policy Issues Involving Clinical Judgment.

In formulating and adopting medical policies with respect to Covered Services, Company shall rely on and take into account credible scientific evidence published in medical literature generally recognized by the relevant medical community (peer-reviewed, if available), written Healthcare Provider Specialty Society opinions and recommendations, the views of Healthcare Providers practicing in the same or similar discipline or specialty, the outcomes of External Review with respect to the Covered Services in question, and any other clinically relevant factors, and shall continue to make such policies readily available to Plan Members and Participating Healthcare Providers via the Public Website or by other electronic means. Promptly after adoption, Company shall file a copy of each new policy or guideline with the Healthcare Provider Advisory Committee.

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

Company shall consider the feasibility and desirability of exempting certain Participating Healthcare Providers from certain administrative requirements based on criteria such as the Participating Healthcare Providers' delivery of quality and cost-effective medical care and the 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, to 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

Company shall not contest the timeliness of bills for Covered Services provided under a Fully-Insured Plan if such bills are received by Company within one hundred eighty (180) days after the later of (i) the date of service and (ii) the date of the Healthcare Provider's receipt of the EOB from the primary payor, when Company is the secondary payor. Company shall propose to Self-Insured Plan sponsors that they adopt the one hundred eighty (180) day time period referenced in the preceding sentence, in the event that a Self-Insured Plan has a more restrictive time period. Company shall extend the one-hundred-eighty-day (180-day) time period for a reasonable period, on a case-by-case basis, in the event that a Healthcare Provider provides notice to Company, along with appropriate evidence, of circumstances reasonably beyond the Healthcare Provider's control that resulted in the delayed submission. Company shall determine the circumstances and the reasonableness of the submission date. Nothing in this § 7.17(a) shall limit Company's ability to provide incentives for prompt submission of bills.

(b) Claims Submission

Company agrees to accept from Participating Healthcare Providers and Non-Participating Healthcare Providers properly completed paper claims submitted on Form CMS-1500 or the equivalent. Company also agrees to accept electronic claims populated with similar information in HIPAA-compliant format using HIPAA-compliant code sets, subject to Company's reasonable requirements pertaining to the exchange of electronic transactions. If a Healthcare Provider elects not to be compliant with the portions of HIPAA relating to the electronic submission of claims, Company shall not require such Healthcare Provider to use electronic transactions or otherwise require such Healthcare Provider to become compliant with HIPAA. Instead, Company will maintain reasonable non-electronic systems to serve the information needs of such Healthcare Providers. Notwithstanding the above, Company may continue to require submission of Clinical Information and other additional information in connection with its review of specific claims and as contemplated elsewhere in this Agreement, including, without limitation, §§ 7.5 and 7.8(b)(ii); provided, however, 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 Clinical Information 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 Clinical Information.

7.18 Timelines for Processing and Payment of Complete Claims

(a) Company shall post on its Provider Website its requirements to render a Complete Claim. Beginning not later than nine (9) months after the Final Order Date, Company shall mail a check or make an electronic funds transfer in payment for Complete Claims for Covered Services within thirty (30) calendar days following the later of Company's receipt of a claim or the date on which Company is in receipt of all necessary information in a format required for the claim to constitute a Complete Claim. Beginning one year following the Effective Date, Company shall mail a check or make an electronic funds transfer in payment for Complete Claims for Covered Services that are submitted electronically by Healthcare Providers within fifteen (15) calendar days following the later of Company's receipt of a claim or the date on which Company is in receipt of all necessary information in a format required for the claim to constitute a Complete Claim. Beginning one year following the Effective Date, with respect to claims submitted on the Company's Metavance platform which are submitted in real time using the Company's selected website, Company will mail a check or make an electronic funds transfer in payment for Complete Claims for Covered Services within ten (10) calendar days following the later of Company's receipt of such a claim or the date on which Company is in receipt of all necessary information in a format required for the claim to constitute a Complete Claim. If payment for Complete Claims for Covered Services is not made within the time periods specified in this § 7.18(a), Company shall pay interest pursuant to §§ 7.18(b) or (c), as applicable. With respect to any claims for Covered Services governed by the laws of a state that provides a definition or other similar provision for determining whether a claim is a Complete Claim, Company shall determine whether a claim is a Complete Claim, for both Fully-Insured Plans and Self-Insured Plans, using the description set forth in that state's laws or regulations. This section is intended to govern the timeliness of payment only. Nothing in this Section shall be deemed to require payment of any claim for which no payment is due or which is not appropriate for payment, or to prohibit company from appropriately denying a claim.

(b) With respect to any claims for Covered Services governed by the laws of a state that requires interest to be computed and paid on claims for Covered Services, Company shall compute and pay interest using the time periods specified in § 7.18(a) above on claims for Covered Services under both Fully-Insured Plans and Self-Insured Plans using the interest calculation methodology and interest rates set forth in that state's laws or regulations.

(c) With respect to any claims for Covered Services governed by the laws of a state that does not require interest to be computed and paid on claims for Covered Services, Company shall compute and pay interest on claims for Covered Services under both Fully-Insured Plans and Self-Insured Plans using the methodology set forth in this § 7.18(c). For each Complete Claim with respect to which Company mails a check or makes an electronic funds transfer later than the applicable period specified in § 7.18(a) above, Company shall pay simple interest at six percent (6%) per annum on the balance due on each such claim computed from the eleventh (11th), sixteenth (16th), or the thirty-first (31st) day (as appropriate based on the circumstances described in § 7.18(a) above) following the later of Company's receipt of such a claim or the date on which Company is in receipt of all necessary information in a format required for such a claim to constitute a Complete Claim, up to but excluding the date on which Company mails the check (or makes the electronic funds transfer) for payment of such Complete Claim. Interest paid pursuant to this § 7.18(c) shall, at Company's election, either be included in the claim payment check or wire transfer or be remitted periodically (but at least quarterly) in a separate check or wire transfer along with a report detailing the claims for which interest is being paid.

(d) Company shall have no obligation to make any interest payment pursuant to § 7.18(b) or (c) above (i) with respect to any Complete Claim if, within thirty (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 Healthcare Provider who balance-bills a Plan Member in violation of the Participating Healthcare Provider's agreement(s) with Company with respect to the same claim; (iii) with respect to any time period during which a **Force Majeure**, as defined in § 7.32 of this Agreement of this Agreement, prevents adjudication of claims; or (iv) where payment is made to a Plan Member.

(e) Company shall affix to paper claims for Covered Services the date such claims are received by Company. Company shall send an electronic acknowledgement of claims for Covered Services submitted electronically identifying the date such claims are received by Company. If Company determines that there is any defect or error in a claim that prevents the claim from entering Company's adjudication system, it shall so notify the Healthcare Provider within fifteen (15) days of receipt of such claim. Nothing contained in this § 7.18 is intended or shall be construed to alter Company's ability to request Clinical Information consistent with the provisions of § 7.8(d)(ii) of this Agreement or any other provision of this Agreement.

(f) Notwithstanding anything in the Agreement to the contrary, the requirements of this § 7.18 shall not apply to (i) claims for Covered Services that are processed under any program in which Company participates but is not solely responsible for the processing and payment of the claim, and (ii) claims for Covered Services under a program offered or sponsored by any state or federal governmental entity other than in its capacity as an employer.

7.19 No Automatic Downcoding of Evaluation and Management Claims

As of the Final Order Date, Company shall not automatically reassign or reduce the code level of evaluation and management codes billed for Covered Services ("**Downcoding**"), except that Company may reassign a new patient visit code to an established patient visit code based solely on CPT® Codes, Guidelines and Conventions. Notwithstanding the foregoing sentence, Company shall continue to have the right to deny, pend or adjust such claims for Covered Services on other bases and shall have the right to reassign or reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by selected Healthcare Providers or Healthcare Provider Groups or Healthcare Provider Organizations) based on a review of the Clinical Information at the time the service was rendered for the particular claims or a review of information derived from Company's fraud-detection or abuse-billing-detection programs that create a reasonable belief of fraudulent or abusive (whether intentional or unintentional) billing practices; provided that the decision to reassign or reduce is based primarily on a review of Clinical Information.

7.20 Bundling and Other Computerized Claim Editing

Company agrees to take actions necessary on Company's part to cause the claim-editing software program it uses to continue to produce editing results consistent with the standards set forth in this § 7.20 and, if Company has actual knowledge of non-conformity with such standards, to take reasonable actions necessary on its part to promptly modify the 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, pend, or adjust claims based on a reasonable belief of fraudulent or abusive (whether intentional or unintentional) billing practices (so long as the Healthcare Provider has been given the opportunity to provide Clinical Information and Company has reviewed any Clinical Information so provided before denying or adjusting the claims). For purposes of this § 7.20 only, if any change to CPT® affects Company's obligations hereunder, Company will promptly develop plans

to cause its Healthcare Provider payment practices to be consistent with the commitments set forth in this § 7.20. Except as set forth below, the obligations in this § 7.20 shall take effect on the date set forth in Exhibit ___. The parties agree that all references to the AMA CPT® book and to CPT® Codes in this § 7.20 refer to the AMA CPT® book and the CPT® Codes listed in the AMA CPT® book in effect at the time the services were provided.

(a) Company will process and separately reimburse those codes listed in the AMA CPT® book as modifier 51 exempt CPT® Codes without reducing payment under Company's Multiple Procedure Logic, provided that the AMA CPT® book provides that such services are appropriately reported together.

(b) Company will process and separately reimburse codes listed in the AMA CPT® book as add-on billing codes without reducing payment under Company's Multiple Procedure Logic; provided that the AMA CPT® book provides that such add-on CPT® Codes are appropriately billed with proper primary procedure codes.

(c) (i) Company shall not routinely require a Healthcare Provider to submit Clinical Information of their patient encounters solely because the Healthcare Provider seeks payment for both surgical procedures and CPT® evaluation and management services for the same patient on the same date of service, provided that the correct CPT® evaluation and management code, surgical code, and modifier (*e.g.*, CPT® modifiers 25 or 57) are included on the initial claim submission.

(ii) If a bill contains CPT® Codes for two evaluation and management services for a single date of service, and one of the two evaluation and management codes is appended with CPT modifier 25, both codes shall be recognized and separately eligible for payment if appropriate under CPT® Codes, Guidelines, and Conventions; provided, however, that if Company requires submission and review of Clinical Information in connection with such claims pursuant to § 7.8(b)(ii) of this Agreement, both codes shall be recognized and separately eligible for payment only if both are supported by the Clinical Information. If a bill contains a CPT® Code for an evaluation and management service appended with CPT® modifier 25 and a CPT® Code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and separately eligible for payment, unless the Clinical Information indicates that use of CPT® modifier 25 was

inappropriate or unless Company has disclosed pursuant to § 7.8(b)(iii) of this Agreement the limited number of finite code combinations that are not appropriately reported together.

(iii) Company will remove from its claim review and payment systems those Edits that generally deny payment for CPT® evaluation and management codes with CPT® modifier 25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service except for a limited number of exceptions, consistent with § 7.20(c)(ii) above, which will be disclosed on Company's Provider Website.

(iv) Nothing in this Agreement shall (A) prohibit Company from requiring the use of the appropriate CPT® Code modifiers, according to CPT® Codes, Guidelines and Conventions, for evaluation and management billing codes (*e.g.*, CPT® modifiers 25 or 57) on their original claim forms, or (B) preclude Company from requiring Participating Healthcare Providers and Non-Participating Healthcare Providers (to the extent the audit is limited to claims submitted under an assignment of benefits) to submit to an audit of their submitted claims (including claims for surgical procedures and evaluation and management services on the same date of service submitted with the appropriate modifier) and to provide their Clinical Information in connection with such an audit.

(d) A CPT® Code for supervision and interpretation or radiologic guidance (*e.g.*, fluoroscopic, ultrasound or mammographic) shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that (i) the associated procedure code does not include supervision and interpretation or radiologic guidance according to AMA CPT® Codes, Guidelines, and Conventions and (ii) for each such procedure (*e.g.*, review of x-ray or biopsy analysis or ultrasound guidance), Company shall not be required to pay for supervision or interpretation or radiologic guidance by more than one qualified healthcare professional.

(e) With respect to indented codes, Company shall not reassign any CPT® Code into any other CPT® Code or deem a code ineligible for payment based solely on the format of the published CPT® descriptions.

(f) CPT® Codes submitted with modifier 59 attached will be eligible

for payment to the extent they follow the AMA CPT® book and they designate a distinct or independent procedure performed on the same day by the same Healthcare Provider, unless Company has disclosed pursuant to § 7.8(b)(iii) of this Agreement the limited number of finite code combinations that are not appropriately reported together, but only to the extent that (i) although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances and (ii) it would not be more appropriate to append any other CPT® recognized modifier to such codes.

(g) No global periods for surgical procedures shall be longer than the period then designated by CMS.

(h) Company shall not automatically change a code to one reflecting a reduced intensity of the service when the CPT® Code is one among or across a series that includes, without limitation, codes that differentiate among simple, intermediate and complex; complete; or limited, and/or size.

(i) Not later than six (6) months after the Final Order 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 claims-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 claims-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 clauses (A) and (B) above be completed at the same time; provided that the updates identified in clauses (A) and (B) above are each completed once each year.

(j) Nothing contained in this § 7.20 shall be construed to limit Company's recognition of CPT® modifiers to those CPT® modifiers specifically addressed in this § 7.20.

(k) **No Differentiation Among Provider Specialties**

Company represents and warrants that its claims processing and claim payment policies and practices do not distinguish among

provider types or specialties with respect to the application of Edits to the same reported CPT® Codes. Company will not change its current policies and practices during the Effective Period.

7.21 EOB and Remittance Advice Content

(a) Not later than six (6) months after the Final Order Date or as soon thereafter as practicable, Company's EOB forms shall contain at least the following information: (i) the name of and a number identifying the Plan Member, (ii) the date of service, (iii) the amount of payment for services provided, (iv) any adjustment to the invoice submitted, and (v) a generic explanation of any adjustment to the invoice submitted. Either each EOB form, or the documents provided by Company to a Plan Member along with each EOB form also shall specify an address and phone number for questions regarding the claim described on the EOB form. EOB contents must include the total amount originally billed by the Healthcare Provider. Consistent with the desire for Plan Members to receive accurate communications that do not disparage Non-Participating Healthcare Providers, each such EOB form shall indicate the amount, if any, for which the Healthcare Provider may bill the Plan Member; shall state "Healthcare Provider may bill you" that amount, if any, or contain substantially similar language; and shall not characterize disallowed amounts, if any, as unreasonable.

(b) Not later than six (6) months after the Final Order Date or as soon thereafter as practicable, the Healthcare Provider Remittance Advice or similar forms that Company sends to Healthcare Providers communicating the results of claims adjudications shall contain at least: (i) the name of, and a number identifying the Plan Member, (ii) the date of service, (iii) the amount of payment per line item, (iv) the procedure code(s), (v) the amount of payment, (vi) any adjustment to the invoice submitted, (vii) a generic explanation of any adjustment of the invoice submitted that complies with HIPAA requirements, and (viii) any adjustment or change in any code on a line-by-line basis. Either the Healthcare Provider Remittance Advice or similar form, or the documents provided by Company to the Healthcare Provider along with each Healthcare Provider Remittance Advice or similar form also shall specify an address and telephone number for questions by the Healthcare Provider regarding the claim described on the Healthcare Provider Remittance Advices or similar form. This paragraph is not intended and shall not be construed to limit Company's right to replace Healthcare Provider Remittance Advice or similar forms with electronic Remittance Advices or the equivalent, to the extent such electronic Remittance Advices or the

equivalent provide similar information, so long as Company complies with § 7.17(b) of this Agreement.

(c) Healthcare Providers, Class Counsel, and Company agree that this Agreement is not intended to alter or change rights of a Non-Participating Healthcare Provider to balance-bill or bill the Plan Member at rates and on terms that are agreed to between the Non-Participating Healthcare Provider and the Plan Member to the extent permitted by law.

7.22 Overpayment Recovery Procedures

As of the Final Order 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 the construction and maintenance of one or more common healthcare provider databases for use in connection with payment of Healthcare Provider invoices. Company shall publish on the Public Website and the Provider Website an address and procedures for Healthcare Providers to return Overpayments. In addition, other than for recovery of duplicate payments, Company shall initiate Overpayment recovery efforts by providing Healthcare Providers with at least thirty (30) days' written notice before engaging in additional Overpayment recovery efforts. Such notice shall include (a) the patient's name, (b) the service date, (c) the payment amount received by Healthcare Provider, and (d) a reasonably specific explanation of the proposed adjustment (including, without limitation, procedure code where appropriate). Company shall not initiate Overpayment recovery efforts more than eighteen (18) months after the payment was received by Healthcare Provider; provided, however, that no time limit shall apply to the initiation of Overpayment recovery efforts (a) based on a reasonable belief of fraud or other intentional misconduct, (b) required by a Self-Insured Plan, or (c) required by a state or federal government program. Notwithstanding the above, in the event that a Healthcare Provider asserts a claim of underpayment, Company may defend or set off the claim based on Overpayments going back in time as far as the claimed underpayment. If a Healthcare Provider requests an appeal within thirty (30) days of receipt of a request for repayment of an Overpayment, Company shall not require the Healthcare Provider to repay the alleged Overpayment before the appeal is concluded. Other than as set forth in this Section, nothing in this Agreement, including but not limited to the provisions of § 13, shall be deemed to limit Company's right to pursue recovery of Overpayments that occurred prior to the Effective Date.

7.23 Efforts to Improve Accuracy of Information about Eligibility of Plan Members

Commencing on the Final Order Date, Company shall initiate or continue to take actions reasonably designed to reduce Overpayments and claim denials resulting from inaccurate information about the eligibility of Plan Members. Such actions include, without limitation:

(a) Working collaboratively with large third-party administrators who handle customer eligibility, to develop systems for collecting and transmitting eligibility information on a timely and accurate basis.

(b) Developing scorecards for large third-party administrators, to track the timeliness of the information they deliver to Company.

(c) Working collaboratively with large third-party administrators to develop systems that extract Plan Member termination information directly from a payroll system.

(d) Working collaboratively with Plan sponsors and other group customers to increase (i) the percentage of customers transmitting eligibility information to Company in an electronic format and (ii) the frequency of the transmissions of eligibility files from the customer to Company.

(e) Contracting large group customers prior to their contract renewal date to determine, to the extent practicable, whether the customer intends to terminate or renew coverage.

(f) Offering to Healthcare Providers, and encouraging the use of, the ability to verify eligibility electronically.

(g) Enhancing responses to eligibility inquiries to include co-pay and deductible information.

(h) Offering employers, and encouraging the use of, electronic maintenance capabilities to facilitate updating of eligibility information.

It is understood that the foregoing activities may be effected by the Company in discrete geographic regions or portions of the Company's business, with a view to evaluating their effectiveness in achieving the desired objectives. Company may reduce, discontinue, or expand such activities commensurate with their demonstrated effectiveness.

7.24 Responses to Healthcare Provider Inquiries

Company has consolidated its service centers and has established a provider resolution unit responsible for consolidating and coordinating the identification of problems encountered in claims submissions and processing, researching the causes of such problems, and developing and

implementing appropriate solutions. In addition, Company has developed interactive voice response ("IVR") and internet mechanisms through which Healthcare Providers can communicate with Company and access information regarding the status of their claims. Company has taken these and other actions and expended significant amounts of money and other resources reasonably designed to improve the speed, accuracy, and efficiency of responses to Healthcare Provider inquiries and concerns. Such actions and expenditures include investments in new technology, enhanced employee training, departmental restructuring, and redesigned work processes. Company shall continue with these and other efforts, where appropriate, to further improve the speed, accuracy, and efficiency of responses to Healthcare Provider inquiries and concerns, and shall make expenditures reasonably necessary to achieve these goals.

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

Company agrees that if Company certifies that a proposed service 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 a material change in the Plan Member's health condition between the date that the certification was provided and the date of the service that makes the proposed service no longer Medically Necessary for the 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 services 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.

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.

7.27 Information about Healthcare Providers Provided by Company

The information about office locations, telephone numbers, facsimile numbers, office hours, plans accepted, hospital admitting privileges, group affiliations, gender, and practice specialties currently posted on the Public Website about individual Healthcare Providers or contained in printed materials prepared by Company is derived from data supplied by those Healthcare Providers and from applicable agreements between Company and Participating Healthcare Providers or their Healthcare Provider Groups or Healthcare Provider Organizations. Upon written notice of an inaccuracy sent to Company (pursuant to the direction as to how to give

such notice that will be posted on the Provider Website), if Company does not dispute that there is an inaccuracy Company shall take steps reasonably necessary to ensure that the Public Website is updated within ten (10) business days after receipt of such notice and that written materials are revised before the next edition of the materials is printed (to the extent there is sufficient time to make such revisions before the next printing) to reflect any corrections in the Healthcare Provider information to make it accurate. Upon written notice that a Healthcare Provider is incorrectly listed as a Participating Healthcare Provider on the Public Website or in printed materials prepared by Company (pursuant to the direction as to how to give such notice that will be posted on the Provider Website), if Company does not dispute that there is an inaccuracy, Company shall take steps reasonably necessary to delete any such erroneous reference from the Public Website within fifteen (15) business days after receipt of such notice and from any written materials before the next edition of the materials is printed (to the extent there is sufficient time to make such revisions before the next printing), and Company shall make corresponding changes in systems affecting the level of payments and generation of EOBs within twenty (20) business days after receipt of such notice. If Company disputes that there is an inaccuracy, it will so notify the Healthcare Provider within the same time periods specified above, including the basis on which it disputes that there is an inaccuracy.

7.28 Capitation and Healthcare Provider Organization Specific Issues

(a) Capitation Reporting

Not later than one hundred twenty (120) days after the Final Order Date, Company agrees to provide monthly reports to Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations that receive Capitation. These monthly reports will include membership information to allow reconciliation by Participating Healthcare Providers, Healthcare Provider Groups, and Healthcare Provider Organizations, as applicable, of per-member per-month Capitation payments, including Plan Member identification numbers or the equivalent, names, ages, genders, monthly Capitation amounts, primary care Healthcare Providers, Enrollment Dates, and, in the monthly reports following an applicable change (*e.g.*, selection of new primary care Healthcare Provider) a report of such change, as well as an explanation of any deductions. Nothing in this Agreement shall prohibit the continuation or subsequent negotiation of different reporting requirements in an Individually Negotiated Contract.

7.29 Miscellaneous

(a) Gag Clauses

Company does not and shall not include in its contracts with Participating Healthcare Providers any provision limiting the free, open and unrestricted exchange of information between Participating Healthcare Providers and Plan Members regarding the nature of the Plan Member's medical conditions or treatment and provider options; and the relative risks, benefits and costs to the Plan Member of such options, whether or not they are covered for such treatment 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 Healthcare Providers in any way for engaging in any free, open and unrestricted communication with a Plan Member with respect to the foregoing subjects or for advocating for any service on behalf of a Plan Member.

(b) Ownership of and Access to Clinical Information

Company agrees that it does not own Clinical Information kept by Healthcare Providers; however, nothing in this provision or this Agreement is intended to or should be construed to convey to a Healthcare Provider any property interest in (i) Company's data or intellectual property, (ii) products or services offered or provided by Company now or in the future, or (iii) any business, systems or information management process that incorporates any such medical records or related data obtained by Company from such Healthcare Providers or any reports or data resulting from any such data or processes; PROVIDED, however, that nothing in this provision is intended to or should be construed to limit or expand Company's right to request and receive Clinical Information from Healthcare Providers.

(c) Arbitration

(i) With respect to any arbitration proceeding between Company and a Participating Healthcare Provider who practices individually or in a Healthcare Provider Group of less than six (6) Healthcare Providers, Company agrees that it shall refund any applicable filing fees or arbitrators' fees paid by the Healthcare Provider in the event the Healthcare Provider is the prevailing party in the arbitration proceeding; PROVIDED, however, that this paragraph shall not apply with respect to any arbitration proceeding in which the Participating Healthcare Provider purports to represent any Healthcare Provider outside of his or her

Healthcare Provider Group.

(ii) Company agrees not to include language in any agreement with a Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization (A) requiring that any arbitration panel have multiple members, (B) preventing the recovery of any statutory or otherwise legally available damages or other relief in an arbitration proceeding, (C) restricting the statutory or otherwise legally available scope or standard of review, (D) completely prohibiting discovery, (E) shortening any statute of limitations, or (F) requiring that any arbitration proceeding occur more than fifty (50) miles from the principal office of the Healthcare Provider, Healthcare Provider Group, or Healthcare Provider Organization.

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

(i) Company's future standard form agreements with Participating Healthcare Providers shall not be inconsistent with the commitments and undertakings Company makes in this Agreement. To the extent that Company's existing standard form agreements with Participating Healthcare Providers contain provisions inconsistent with the terms hereof, Company shall administer such agreements consistent with the terms set forth in this Agreement.

(ii) Where Company and a Participating Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization have an Individually Negotiated Contract, this Agreement shall not modify or nullify the inconsistent terms of the Individually Negotiated Contract that deviate from the terms of this Agreement relating to higher or customized rates, the length of term of the contract, or other customized payment methodologies as otherwise permitted under §§ 7.13(b), 7.13(c), 7.14(a), 7.14(b), 7.28(a), and 7.28(c). In addition, Company may agree with individual Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations on terms that deviate from any other terms of this Agreement upon request of the individual Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations; provided, however, that (A) with respect to Company's use of Edits, Company shall administer Individually Negotiated Contracts consistent with the terms set forth in this Agreement, and (B) the

Agreement shall not modify or nullify the terms of Individually Negotiated Contracts with respect to those terms the Agreement expressly states either are unaffected by the Agreement or are controlled by Individually Negotiated Contracts.

(iii) With respect to Individually Negotiated Contracts executed after the Final Order Date, Company may agree with individual Participating Healthcare Providers, Healthcare Provider Groups or Healthcare Provider Organizations on terms that deviate from the terms of this Agreement relating to higher or customized rates, the length of term of the contract, or other customized payment methodologies as otherwise permitted under §§ 7.13(b), 7.13(c), 7.14(a), 7.14(b), 7.28(a), and 7.28(c). In addition, Company may agree with individual Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations on terms that deviate from any other terms of this Agreement upon request of the individual Participating Healthcare Providers, Healthcare Provider Groups, or Healthcare Provider Organizations.

(e) Impact of This Agreement on Covered Services

Notwithstanding anything to the contrary contained in this Agreement, nothing contained in this Agreement shall supersede or otherwise alter the scope of Covered Services of any Plan or require Company or any Plan to pay for services that are not Covered Services. In determining whether services provided to a Plan Member are Covered Services under a Self-Insured Plan, Company shall apply the definition of "Medically Necessary" (or any comparable term) contained in § 7.16(a) except with respect to the limited number of large Self-Insured Plans that require that a different definition of "Medically Necessary" (or any comparable term) be applied. With respect to such Self-Insured Plans, Company shall recommend that the definition of "Medically Necessary" (or any comparable term) contained in § 7.16(a) apply.

(f) Privacy of Records

Company shall safeguard the confidentiality of Plan Member Clinical Information in accordance with HIPAA, any state and other federal law, and any other applicable legal requirements. This undertaking shall not be the subject of a Compliance Dispute, provided, however, that Healthcare Providers may resort to remedial measures, if any, provided by HIPAA and any state and other federal law and regulations to protect Healthcare Providers'

interests in the confidentiality of Plan Member Clinical Information.

(g) Pharmacy Provisions

Company shall disclose to Plan Members whether that Plan Member's health plan uses a drug list and, if so, explain what a drug list is, how Company determines which prescription medications are included in the drug-list, and how often Company reviews the drug list. When Company provides pharmacy coverage, Company shall make drug list information available to Plan Members. Company shall maintain the process that is in place on the Effective Date, as reasonably amended by Company from time to time, for covering medications not included in the drug list when Medically Necessary. Company will continue to provide coverage for off-label uses of pharmaceuticals that have been approved by the FDA (but not approved for the prescribed use), provided that the drug is not contraindicated by the FDA for the off-label use prescribed and that the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by supporting documentation in any one of the following: (i) the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information; or (ii) results of controlled clinical studies published in at least two peer-reviewed national professional medical journals. Company shall retain the right to pre-certify coverage of specific medications for non-approved use. Company's disclosure concerning Precertification and potential restrictions on non-approved use of prescription medications shall be similar in substance to its disclosure concerning drug lists, as described above.

(h) Restrictive Endorsements

Where Company's reimbursement of a Healthcare Provider for services performed by that Healthcare Provider is a partial payment of allowable charges, a Healthcare Provider may negotiate a check with a "Payment in Full" or other restrictive endorsement without waiving the right to pursue a remedy available under this Agreement.

(i) 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, its employees, and third parties (other than Delegated Entities) performing functions or activities

on Company's behalf. Company shall make a good-faith effort to include in, contracts entered into with Delegated Entities subsequent to the Final Order Date, terms that are substantially equivalent to the terms of this Agreement; provided that Company shall not be liable under this Agreement in the event any Delegated Entity acts in a manner inconsistent with the terms of this Agreement.

(j) Copies of Contracts

Company shall provide a copy of its contract with a particular Participating Healthcare Provider (including, without limitation, a contract with a Healthcare Provider Organization or a Healthcare Provider Group in which the Participating Healthcare Provider participates) to the Participating Healthcare Provider, upon receipt by Company of a written request by the Participating Healthcare Provider to provide a copy, except in circumstances where Company is restricted from providing a Participating Healthcare Provider with a copy of Company's contract with a Healthcare Provider Organization or Healthcare Provider Group specifically because of terms contained in that contract. Company will not require that a restriction as described in the previous sentence be included in its contracts with Healthcare Provider Organizations or Healthcare Provider Groups.

(k) State and Federal Laws and Regulations

Nothing contained in § 7 of this Agreement is intended to or shall, in any way reduce, eliminate, or supersede any Party's obligation to comply with applicable provisions of relevant state and federal law and regulations. To the extent, with respect to a specific obligation created by § 7, that state or federal law or regulation imposes a greater obligation than that specifically set forth in § 7, Company shall comply with said law or regulation. The Compliance Dispute resolution procedures contained in § 12 shall apply with respect to any alleged breach of an obligation created by the preceding sentence. Nothing in this § 7.29(k) is intended to give rise to or should be construed as giving rise to any private right of action for any violation of any federal or state law or regulation (whether under a breach of contract theory or any other theory) where federal or state law or regulation does not allow a Healthcare Provider a right of action for such violation. The Compliance Dispute Review Officer shall not take any action inconsistent with any ruling, determination, or directive by any court or regulatory agency. Any action taken by the Compliance Dispute Review Officer that is inconsistent with any subsequent ruling, determination, or directive by any court or regulatory

agency shall not be binding on Company as of the effective date of such subsequent ruling, determination or directive.

(l) 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.

(m) Limitations on Obligations of Non-Participating Healthcare Providers

No affirmative obligation that § 7 of this Agreement imposes on Healthcare Providers shall apply to any Non-Participating Healthcare Provider unless and until, and then only to the extent that, the Non-Participating Healthcare Provider pursues with Company a claim for payment on the Non-Participating Healthcare Provider's own behalf or the Non-Participating Healthcare Provider pursues benefits under this Agreement, in which case any affirmative obligations that § 7 imposes on Healthcare Providers shall apply to the Non-Participating Healthcare Provider with respect to the claim or benefits.

(n) Limitation on Rental Networks

(i) Limitation on Renting the Company's Networks Disclosures Regarding Networks

Company agrees that it shall disclose on the applicable Provider Websites the identities of those entities to which it provides access to its network of Participating Healthcare Providers and for which (A) Company does not adjudicate claims or (B) Company adjudicates claims but does not provide the EOB or Remittance Advice. The foregoing shall not apply to arrangements between or among the Company's subsidiaries.

(ii) Limitation on Use of Rental Networks or Discounted Fee Schedules

Company agrees that, whenever it pays a Non-Participating Healthcare Provider based on a fee schedule established by another entity, (A) Company shall, upon request by such Non-Participating Healthcare Provider, provide the name, address and telephone number of the entity and

(B) Company shall disclose on each EOB or Remittance Advice, the identity of the entity in sufficient detail for the Healthcare Provider to identify it; provided, however, that this obligation shall not apply where the identity of the entity is contained on a Plan Member's identification card. Within sixty (60) days of a written request by the Healthcare Provider, Company will provide the Healthcare Provider with a copy of the signed authorization to use the fee, or else Company will not be entitled to the fee based on that contract. Company also agrees that it will not require Healthcare Providers to participate in its rental networks as a condition of participation in Company's other networks or products.

The Parties are precluded from using anything in this § 7.29(n) in connection with efforts to obtain legislative or regulatory changes, including but not limited to the subject of this section, the content of this section, or the relief in this section. The parties are free to pursue, support, or oppose any proposed legislative or regulatory changes related to the subject matter of this section.

(o) Effect of Assignment of Benefits

The existence, submission, or acceptance of an assignment of benefits authorization in favor of a Non-Participating Healthcare Provider shall not preclude the Non-Participating Healthcare Provider from collecting from the Plan Member the difference between the Non-Participating Healthcare Provider's full fee and the payment (if any) received by the Non-Participating Healthcare Provider from the Company to the extent permitted by law.

(p) Healthcare Provider Specialty Society Guidelines.

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

(q) Application of Plan Member Co-Payments

Unless specified by the applicable Plan Documents, Company shall not apply more than one office-visit co-payment in computing the reimbursement for services received by a Plan Member from the same Healthcare Provider on the same date of

service.

(r) Operation of Clinical Edit Review Team

Company acknowledges that its current practice is to convene its Claim Edit Review Team ("CERT") to review the clinical justification for existing Edits as to which the Company has received complaints from Physicians and Healthcare Providers and for new or prospective Edits that the Company reasonably believes will result in denials of or reductions in payment on a significant number of Physician and/or Health Care Provider Claims. This Agreement does not impose an obligation on Company to continue to use the CERT or a substantially similar internal committee for this purpose. However, if Company continues during the Effective Period to convene its CERT or a substantially similar internal committee for this purpose, then in its review of any Edit that applies to CPT® Codes, HCPCS Level II Codes, or other procedure codes that are uniquely or primarily used by a particular Healthcare Provider discipline, Company will cause the CERT to make reasonable efforts to obtain from that discipline's national association or society any position papers or statements concerning the Edit prior to completing its review of that Edit. Nothing in this provision requires Company to reach a judgment consistent with the position of that association or society.

(s) Operation of Technology Assessment Forum

Company acknowledges that its current practice is to convene its Technology Assessment Forum ("TAF") to consider the application of Medical Necessity standards to experimental or investigational procedures or courses of treatment, or to existing procedures or courses of treatment whose efficacy has been questioned. This Agreement does not impose an obligation on Company to continue to use its TAF or a substantially similar internal committee for this purpose. However, if Company continues during the Effective Period to convene its TAF or a substantially similar internal committee for this purpose, then in its review of a medical policy that uniquely or primarily impacts a particular Healthcare Provider discipline, Company will cause its TAF to make reasonable efforts to obtain from that discipline's national association or society any position papers or statements concerning the medical policy in question prior to completing its review. Nothing in this provision requires Company to reach a decision on any medical policy consistent with the position of that association or society.

7.30 Compliance with Applicable Law and Requirements of Government

Contracts

The requirements of this Agreement apply to all of the Company's Plans, including those Plans operated pursuant to a contract with a federal or state government (for example, Medicare Advantage, Medicaid, FEHBP, Children's Health, *etc.*) except as set forth in this § 7.30.

The obligations undertaken in § 7 of this Agreement shall be fulfilled by Company to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives. If, and during such time as, Company is unable to fulfill an obligation under § 7 to the extent contemplated by this Agreement because to do so would require governmental approval or action, Company shall perform such obligation to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives, and Company shall continue to fulfill its other obligations under § 7 to the extent permitted under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives. To the extent that any governmental approval is required for any Party to fulfill an obligation under § 7, such Party shall make all reasonable efforts to obtain any necessary approvals from the appropriate governmental entities. For any obligation under § 7 that cannot be undertaken without governmental approval, the Effective Date as to that obligation shall be delayed until such approval is granted or has been denied. Nothing in § 7 shall apply to Company's business in Puerto Rico.

The Company will present the requirements of § 7 of this Agreement to the Tricare Management Activity ("TMA") for consideration of incorporating such requirements into the Company's Tricare South Region Contract pursuant to the changes clause of such contract. Unless and until such time that the Company and TMA so amend the South Region Contract, including appropriate administrative and health care cost modifications, the Company's Tricare Program is exempted from the requirements of this Agreement. The Tricare Program is regulated by the United States Department of Defense. The Department of Defense provides rules, regulations, and contract provisions applicable to that Program, including certain mechanisms to enforce those rules, regulations, and contract provisions. Company agrees to comply with those rules, regulations, and contract provisions, including the mechanisms to enforce those rules, regulations, and contract provisions.

7.31 Estimated Value of § 7 Initiatives

Company estimates that the approximate aggregate value of the initiatives and other commitments regarding Company's business practices set forth

in § 7 of this Agreement is no less than Fifteen Million Dollars ($15,000,000).

7.32 Force Majeure

The Parties shall not be liable for any delay or non-performance of their respective obligations under § 7 of this Agreement arising from any act of God, governmental act, act of terrorism, war, fire, flood, hurricanes, earthquake or other natural disaster, explosion or civil commotion. The performance of the Parties' obligations under this § 7, to the extent affected by the delay, shall be suspended for the period during which the cause, or the Parties' substantial inability to perform arising from the cause, persists.

7.33 Managed Care Issues Relating to Mental Health and Substance Abuse

(a) Except where any applicable law or regulation requires a different definition, Company shall apply as to its current agreements and include in its future agreements with Participating Healthcare Providers the definition of Medical Necessity in § 7.16(a) with respect to mental health services, including treatment for psychological illness and substance abuse, subject to the terms and conditions of the Plan Member's Plan; provided that in determining the clinical appropriateness of care, the following minimum standards relevant to mental health care must be met:

(i) There is a diagnosis as defined by standard diagnostic nomenclatures (DSM IV or its equivalent in ICD-9-CM) and an individualized treatment plan appropriate for the Plan Member's illness or condition; and

(ii) There is a reasonable expectation that the Plan Member's illness, condition, or level of functioning will be stabilized, improved, or maintained through ambulatory care, and through treatment known to be effective for the Plan Member's illness;

(iii) custodial care is not typically a Covered Service; and

(iv) The mental health services are not primarily for the avoidance of incarceration by the Plan Member.

(b) Company will allow its participating Healthcare Providers to make direct referrals to the Company's Mental Health and Behavioral Health's in-network Healthcare Providers, or to those who participate in the network of the Company's contracted Mental and Behavioral Health Organization (MBHO), provided that any such referral is subject to the same Precertification provisions for other

participating Company Mental Health and Behavioral Health's Healthcare Providers.

(c) Company agrees that, where a Psychologist has not entered into a different agreement with Company, MBHO or the hospital or other mental health care facility where the services are rendered, and where Company has not entered into a different agreement with such hospital or mental health care facility or MBHO, Company will separately consider and pay for Medically Necessary Covered Services provided to a Plan Member by the Psychologist, in accordance with the terms and conditions of the Member's Plan.

(d) Company adheres to applicable state "prudent layperson" laws which require payment of benefits for mental health services in the event of an emergency under prudent layperson standards. An emergency department Physician or other Healthcare Provider licensed to do so can make a decision regarding admission or physical or chemical restraints. Company agrees that, where a Physician or Healthcare Provider has not entered into a different agreement with Company, MBHO or the hospital or other mental health care facility where the services are rendered, and where Company has not entered into a different agreement with such hospital or mental health care facility or MBHO, in the event of an emergency, Company will pay for Medically Necessary emergency care mental health Covered Services provided by Physicians or Healthcare Providers in accordance with applicable prudent layperson standards, the definition of Medical Necessity in § 7.16(a), and the terms and conditions of the Plan Member's Plan, and Company will pay for Medically Necessary mental health Covered Services provided by Physicians or Healthcare Providers resulting from the admission in accordance with the definition of Medical Necessity in § 7.16(a) and the terms and conditions of the Plan Member's Plan.

(e) Company will post on its Provider Website an authorization form that Healthcare Providers providing mental health services to Plan Members may print or download to obtain Plan Member consent for release of Clinical Information to Company.

7.34 Annual Compliance Reporting

Company shall file annually a **Certification** that Company is in compliance with its obligations under § 7. If Company is not in compliance, Company shall identify how Company is not in compliance. In addition, Company shall file annually and within thirty (30) days after the Termination Date, a Certification containing or attaching the following information relating to the following sections of this Agreement:

Section	Requirement
7.5	Company's standard Precertification lists.
7.6	A list of the dates on which Company mailed notices of material adverse changes to Participating Healthcare Providers.
7.7	A summary of the initiatives Company implemented or employed to reduce claim resubmissions.
7.8(b)	A summary of the efforts made by Company to cause its automated bundling and other claims payment rules to be consistent.
7.8(b)	A list of Company's Significant Edits.
7.8(b)(i)	A list of each customized Edit added to any standard claims editing software product at Company's request.
7.8(b)(ii)	A list of categories of claims as to which Company has determined that routine review of Clinical Information is appropriate.
7.8(b)(iii)	A list of any circumstances as to which Company has determined that particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers.
7.9(b)	A list of the dates of meetings of the Healthcare Provider Advisory Committee and of the members of the Healthcare Provider Advisory Committee.
7.9(c)	A summary of any recommendations made to Company by the Healthcare Provider Advisory Committee and Company's response.
7.10(b)(4)	The procedures for review developed by the Billing Dispute External Review Board.
7.10(g)	A summary of any decisions issued by the Billing Dispute External Review Board.
7.14(a)	A list of the dates of any annual revisions to Company's standard fee schedules.

Section	Requirement
7.14(b)	A list of the dates on which Company issued coverage statements with respect to any new technology or treatment or new use for an established technology or treatment recommended by a Healthcare Provider Specialty Society.
7.16(a)	The number of Adverse Medical Necessity Determinations sent to External Review for final determination for the preceding calendar year and the percentage of such Adverse Medical Necessity Determinations that are upheld or reversed.
7.17(b)	A summary of Company's policies and procedures regarding the appropriate format for claims submissions and requests for Clinical Information.
7.21(a)	Copies of the forms of Company's standard EOB form and Remittance Advice.
7.22	Copies of the forms of written notice provided to Healthcare Providers before initiating Overpayment recovery efforts.
7.22	Copies of the forms of written notice provided to Healthcare Providers before initiating Overpayment recovery efforts.
7.23	A summary of the actions initiated or continued to be taken by Company to improve accuracy of information about eligibility of Plan Members.
7.24	A summary of the actions initiated or continued to be taken by Company to further improve the speed, accuracy and efficiency of responses to Healthcare Providers' inquiries and concerns.
7.26	A list of the dates (if any) that the Provider Website was substantially inoperable during the Effective Period.

8. Other Settlement Consideration

In addition to the business initiatives set forth in § 7 of this Agreement, the settlement consideration shall include a Settlement Fund for payment of claims to Class Members, which will be established and operated in accordance with the

provisions of § 8.1 below.

8.1 Settlement Fund

(a) Within five (5) business days after the Preliminary Approval Date, Company shall create the Settlement Fund by making a deposit in the amount of three million five hundred thousand dollars ($3,500,000.00) by wire transfer into an interest-bearing account at a financial institution selected by the Settlement Administrator. The Settlement Administrator shall hold the funds so deposited in trust for the benefit of Class Members.

(b) All Class Members who submit valid Claims to the Settlement Administrator in accordance with this § 8.1 will have the right to receive compensation from the Settlement Fund. The amount each such Class Member receives shall be determined by the Settlement Administrator based on the total dollar amount of the billed charges submitted to Company between January 1, 1990 and the Notice Date by Class Members as derived from information included on valid Claim Forms. Each Class Member who submits a Claim Form must estimate in good faith the total dollar amount of the billed charges he, she or it submitted to Company during that period. The allocation from the Settlement Fund will be determined based on the following chart:

Total Billed Charges Submitted Between January 1, 1990 and the Notice Date	Points	Amount
$0-25,000	1	Base Amount
$25,001-100,000	2	Base Amount x 2
$100,001-250,000	3	Base Amount x 3
$250,001-500,000	4	Base Amount x 4
$500,001-1,000,000	6	Base Amount x 6
Over $1,000,000	8	Base Amount x 8

(c) In order to receive payment from the Settlement Fund, a Class Member must submit a Claim to the Settlement Administrator either by mail, overnight express, or via electronic submission on the **Settlement Website**, using the Claim Form distributed with the Notice and available from the Settlement Administrator and on the Settlement Website. Class Members who submit Claims via

electronic submission will receive from the Settlement Administrator an automatic reply verifying that the Claim has been received and will be processed. Healthcare Provider Groups and Healthcare Provider Organizations may submit Claims on behalf of Healthcare Providers who billed through them during the Class Period, without the necessity of individual signatures from the individual Healthcare Providers. No individual Class Member may submit a Claim Form covering charges for Covered Services that are encompassed by a Claim Form submitted by a Healthcare Provider Group or a Healthcare Provider Organization through which such Covered Services provided by individual Class Members were billed to Company, and he or she shall aver on the Claim Form that he or she is not knowingly doing so; provided, however, that individual Class Members may submit Claim Forms covering charges billed to Company during the Class Period that are not encompassed by Healthcare Provider Group or Healthcare Provider Organization Claim Forms. Any Claim Form postmarked more than one hundred twenty (120) days after the commencement of the Claims Period shall not be a valid Claim and shall be denied by the Settlement Administrator.

(d) No Claim Form will be accepted by the Settlement Administrator as a valid Claim unless the Class Member signs the certification on the Claim Form, or makes an electronic certification, under penalty of perjury, (i) representing that he, she, or it is a Class Member (or the legal representative of a Class Member) and has not Opted Out of the Class; (ii) stating that he, she or it submitted to Company the estimated dollar amount of billed charges set forth on the Claim Form; and (iii) where applicable, the Claim Form is submitted by a Healthcare Provider Group or Healthcare Provider Organization on behalf of the individual Class Members listed in the Claim Form.

(e) Class Members are expected to make a reasonable good faith effort to determine that the estimated dollar amount of claims set forth in the Claim Form is accurate.

(f) If the Settlement Administrator finds, upon review of a timely submitted Claim Form, that required information is missing (*e.g.*, the estimated dollar amount of billed charges submitted to Company between January 1, 1990 and the Notice Date is not indicated, the Claim Form is not signed, *etc.*) or is otherwise not valid, the Settlement Administrator shall notify the Class Member by mail that the Claim Form has been rejected, with identification of the reason(s) for such rejection. The Settlement Administrator must provide such notification within fifteen (15) days of receipt of the Claim. The notification shall state that the Class Member has the right to resubmit the Claim Form within thirty (30) days of the

date the notification was postmarked. The Settlement Administrator shall be obliged to send only one notification of deficiency to a Class Member. If a revised Claim Form is not timely resubmitted by the Class Member, or if a resubmitted Claim Form is still deficient, the Claim will not be a valid Claim and no payment will be made thereon by the Settlement Administrator. Where additional information was submitted by a Class Member based on a notice of denial or insufficiency by the Settlement Administrator, and the Claim is determined to be invalid, the Settlement Administrator shall send a final notice to the Class Member within ten (10) days of receipt of the additional information. Decisions by the Settlement Administrator as to the validity of Claim Forms shall be final and shall not be subject to review by the Court or any other court or tribunal.

(g) Each Class Member entitled to payment from the Settlement Fund may elect, by indicating on the Claim Form, either to receive such payment or to direct that fifty percent (50%) of such amount, or the entire such amount, be contributed on his, her, or its behalf to one of the following organizations: American Academy of Nurse Practitioners, American Chiropractic Association, American Optometric Association, American Physical Therapist Association, American Podiatric Medical Association, American Psychological Association, or National Hospice and Palliative Care Organization. Where the Class Member elects to make a contribution rather than receive the payment directly, the Settlement Administrator shall provide the association to whom the donation was made a list identifying the donor name and address and the donation amount, within fifteen (15) business days of the distribution of the Settlement Fund.

(h) Upon determining that a Class Member has submitted a Claim Form in a timely manner, and that the Claim Form contains all required information and has been properly certified by the Class Member, the Settlement Administrator shall deem the Claim Form a valid Claim. The Settlement Administrator shall direct that payment be made from the Settlement Fund to the Class Member, or to the organization designated by the Class Member, in accordance with §§ 8.1(i) through (m) below.

(i) In accordance with the chart in § 8.1(b) above, the Settlement Administrator shall determine the number of points to be assigned to each valid Claim submitted by an individual Class Member or a Healthcare Provider Group or Healthcare Provider Organization. For each valid Claim submitted by an individual Class Member, the Settlement Administrator shall assign a number of points based on the estimated total dollar amount of claims submitted to

Company as set forth in the Claim Form and the number of points corresponding to that total amount as set forth in the chart in § 8.1(b). For each valid Claim submitted by a Healthcare Provider Group or Healthcare Provider Organization, the Settlement Administrator will: (A) determine the average amount billed per individual Class Member by dividing the total dollar amount of billed charges set forth in the Claim Form by the number of individual Class Members identified in the Claim Form; and (B) determine the total number of points assigned to the Claim of the Group or Organization by multiplying the number of points assigned to the average amount billed per individual Class Member in accordance with the chart set forth in § 8.1(b) by the number of such individual Class Members identified in the list attached to the Claim Form; provided, however, that no Group or Organization Claim may be assigned more than ten percent (10%) of the total points assigned to all valid Claims.

(j) On the first business day following sixty (60) days after the last day of the Claims Period, the Settlement Administrator shall determine the **Base Amount** by (A) aggregating the total number of points assigned to all valid Claims submitted by individual Class Members and the total number of points assigned to all valid Claims submitted by Healthcare Provider Groups and Healthcare Provider Organizations, and (B) dividing that number into the amount of the Settlement Fund on the date of the calculation (reflecting the withdrawal of the Attorneys' Fees and expenses awarded by the Court to Class Counsel pursuant to § 9 of this Agreement), less any amount the Settlement Administrator estimates will be owed for the payment of taxes. The quotient resulting from that calculation shall represent the Base Amount.

(k) The Settlement Administrator shall determine the amount payable to each Class Member who or which submits a valid Claim according to the estimated total billed charges the Class Member submitted to Company as set forth in § 8.1(b) and as certified on the Claim Form and, where applicable, the number of individual Class Members on whose behalf the Claim Form was submitted. The Settlement Administrator shall multiply the Base Amount by the number of points assigned to the Class Member's Claim, according to the chart set forth in § 8.1(b) as multiplied by the number of Class Members on whose behalf the Claim Form was submitted. The result of that calculation shall be the amount payable to the Class Member.

(l) Upon the later of the Effective Date or the twentieth (20th) day following completion by the Settlement Administrator of the calculations of the amounts that are payable, the Settlement

Administrator shall issue payment to Class Members who or which submitted valid Claims in accordance with this § 8.1, or to the organizations listed in § 8.1(g) above, as directed by such Class Members. Each check issued by the Settlement Administrator shall bear an expiration date of ninety (90) days from the date of the check, after which the check will no longer be valid and cannot be cashed.

(m) Any funds remaining in the Settlement Fund (*e.g.*, as a result of checks not being cashed or resulting from additional accrued interest) one hundred and twenty (120) days after the distribution made in accordance with § 8.1(l) shall be paid in equal amounts to the organizations listed in § 8.1(g).

8.2 Submission to Jurisdiction of Court

Any Class Member submitting a Claim shall, through the act of submitting a Claim Form, agree to be subject to the jurisdiction of the Court for any related proceedings.

8.3 Other Settlement Administration Provisions

(a) The Company's payment of the Settlement Amount plus accrued interest into the escrow administered by the Settlement Administrator shall be treated as a payment to a Qualified or Designated Settlement Fund under the Internal Revenue Code ("I.R.C.") § 468B and the regulations or proposed regulations promulgated thereunder (including, without limitation, Treasury Regulation § 1.468B-1-5 or any successor regulation).

(b) The Parties, Class Counsel and Company's counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to the investment of or distribution of the Settlement Fund. Parties, Class Counsel and Company's counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to the determination, administration, calculation, or payment of proofs of claim from the Settlement Fund (except as specifically described in this Agreement) or any losses incurred in connection therewith.

(c) The Settlement Administrator shall invest the monies in the Settlement Fund solely in interest bearing investments which the Settlement Administrator consider(s) to involve no substantial risk to payment of principal at maturity.

(d) No Person shall have any cause of action against the Representative Plaintiffs, Association Plaintiffs, Class Counsel, the Settlement Administrator, Company, the Released Persons, or

Company's counsel, including any counsel representing Company in connection with these Actions, based on the administration or implementation of the Agreement or orders of the Court or based on the distribution of monies under the Agreement. In such circumstances, the sole remedy (other than those provided pursuant to the terms of the Agreement) is application to this Court for enforcement of the Agreement or order pursuant to § 12 of this Agreement.

(e) The Settlement Administrator shall make appropriate reports under I.R.C. § 1099 with respect to all payments it makes to Class Members under this Agreement. The Settlement Administrator shall file any tax returns necessary with respect to any income earned by the Settlement Fund and shall pay, as and when legally required to do so, any tax payments (including interest and penalties) due on income earned by such Fund, and shall request refunds, when and if appropriate, and shall apply any such refunds that are issued to the Settlement Fund to become a part thereof.

(f) If the Final Order and Judgment is set aside or reversed in whole or in part for any reason (except for a matter found to be severable under § 13.8(c) of this Agreement), then at such time as the time for any further appellate review of the order reversing or setting aside the Final Order 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, all funds in the Settlement Fund, including interest accrued thereon, shall be released forthwith to Company.

9. Attorneys' Fees and Expenses and Plaintiff Incentive Awards

9.1 Attorneys' Fees and Expenses By Common Fund

Class Counsel intend to apply to the Court for an award of Attorneys' Fees to be paid exclusively out of the Settlement Fund created pursuant to § 8.1, including interest accrued thereon. In no event shall Company be required to pay a separate award of Attorneys' Fees and expenses to Class Counsel.

9.2 Timing of Fee Payments

(a) Class Counsel may seek an order from the Court permitting that the Attorneys' Fee awarded by the Court be paid out of the Settlement Fund set forth in § 8.1 of this Agreement, within ten (10) business days of the entry of the Final Order and Judgment (or any Amended Order or Amended Final Judgment). If there is an

appeal of the portion of the Final Order and Judgment (or any Amended Order or Amended Final Judgment) that pertains to Attorneys' Fees, and if, as a result of an appeal, the amount of Class Counsels' ultimate award is less than the Court's award entered in the Final Order and Judgment, Class Counsel shall refund to the Settlement Fund the difference between the amount initially awarded by the Court and the amount ultimately awarded, plus interest earned on that differential amount, within thirty (30) days of entry of an order by the appellate court. If the Final Order and Judgment is reversed, vacated, modified and/or remanded for further proceedings or otherwise disposed of in a manner other than one resulting in an affirmance of the Final Order and Judgment (other than on the issue of Attorneys' Fees), Class Counsel shall refund to the Settlement Fund the full amount of Class Counsels' award within thirty (30) days of the entry of an order by the appellate court.

(b) An appeal related solely to the Attorneys' Fees shall not delay the Effective Date, and in such event the Settling Parties shall proceed with the implementation of all portions of this Agreement except the distribution of the Settlement Fund pursuant to § 8.1 of this Agreement.

9.3 Plaintiff Incentive Awards

At the Settlement Hearing, Class Counsel shall petition the Court for incentive awards not to exceed two thousand five hundred dollars ($2,500) for each Plaintiff, the exact amount to be determined at the Settlement Hearing. Company shall not oppose this petition. If approved by the Court, Company shall pay the amounts awarded over and above any other compensation contained in this Agreement.

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 as otherwise specified in this Agreement or 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 any party to this Agreement. The Parties shall ask the Court to grant the Billing Dispute External Review Board (and its members and agents, if any), the Compliance Dispute Facilitator (and his or her agents, if any), the Internal Compliance Officer

(and his or her agents, if any), and the Compliance Dispute Review Officer (and his or her 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 Final Order and 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. Members may contact the Compliance Dispute Facilitator directly by accessing the contact information on the Provider Website.

(b) Compliance Dispute Review Officer

Pursuant to §§ 12.3 and 12.6, and subject to §§ 12.4 and 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 appointed by mutual agreement of Company and Class Counsel within thirty (30) days of the Preliminary Approval Date, or such later date as may be mutually agreed by Company and Class Counsel. 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 (the "**Third Alternate**").

(c) Fees and Costs

Company shall pay the reasonable hourly fees and costs of the Compliance Dispute Facilitator and the Compliance Dispute Review Officer for services on compliance disputes with Company. If the parties are unable to reach agreement regarding the fees and costs of the Compliance Dispute Facilitator and the Compliance Dispute Review Officer, either party may 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 who 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 of this Agreement; and

(b) any Signatory Healthcare Provider Specialty Society which contends that Company has materially failed to perform specific obligations under § 7 of this Agreement and that Class Members who belong to the Signatory Healthcare Provider Society are adversely affected by Company's failure to comply with such specific obligations under § 7.

(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 and court-approved Compliance Dispute Claim Form, attached hereto as Exhibit ___, to the Compliance Dispute Facilitator, who shall promptly provide a copy of such Compliance

Dispute Form to Company. The Compliance Dispute Claim Form may include supporting documentation or affidavit testimony. The Compliance Dispute Claim Form attached hereto as Exhibit ___ 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) or (b) 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 ninety (90) days after such Compliance Dispute arose or after the Petitioner reasonably became aware of the Compliance Dispute, whichever is later; and

(iii) in the Compliance Dispute Facilitator's judgment, the Petitioner's Compliance Dispute:

(A) is not frivolous;

(B) cannot be easily resolved by the Compliance Dispute Facilitator without the intervention of the Compliance Dispute Review Officer; and

(C) 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 alternative dispute resolution 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) Optional Initial Negotiation and Mediation

In the event the Compliance Dispute Facilitator has determined, pursuant to §§ 12.2 through 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 thereof. 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. If the Petitioner, the Facilitator and the Company agree, 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 ninety (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 or if the parties have not agreed to participate in the optional initial negotiations and mediation under § 12.6(a), 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 fifteen (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 fifteen (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 and shall be granted only for good cause shown. The filing of such a request shall toll the time for submitting a memorandum and supporting exhibits until such time as the request for extension has been granted or denied.

(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 the Petitioner or Company 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, and shall accept and consider any evidence relevant to the Compliance Dispute introduced at the hearing.

(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 relevant evidence that the Compliance Dispute Review Officer in his or her sole discretion deems necessary, (i) whether the Compliance Dispute Facilitator properly determined pursuant to §§ 12.3 and 12.4 that the Compliance Dispute should be heard by the Compliance Dispute Review Officer and, if so, (ii) 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 to obtain compliance. 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 for any violations of this Agreement, including, without limitation, any systemic violation under § 12.6(f) of this Agreement. The Compliance Dispute Review Officer must base his or her decision solely on the evidence received with respect to the Compliance Dispute and not on anything outside the record, and 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) of this Agreement, 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 only as necessary and designed to obtain compliance with the terms of this Agreement.

(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 the Compliance Dispute Review Officer's decision shall not be appealed by Petitioner or Company to any other federal court, any state court, any state medical or healthcare provider 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/or whether the decision was contrary to or inconsistent with the

second sentence of § 12.6(d). 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 Compliance 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 final decision issued or remedy ordered by the Compliance Dispute Review Officer following any appeal as provided in § 12.6(g) above, such Person shall have thirty (30) days from the date of such certification to cure the non-compliance. If after such thirty-day (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 thirty-day (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 a member of Company's **Senior Management** and shall take whatever steps and conduct whatever compliance checks and investigations as he or she and Senior Management deem reasonably necessary and appropriate to monitor Company's compliance with this Agreement. The Company's Internal Compliance Officer may, at Company's sole discretion, be the same person designated as Internal Compliance Officer pursuant to the Company's settlement of parallel class action litigation with Physicians. Within thirty (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 Dispute Facilitator, and Class Counsel summarizing the Internal Compliance Officer's activities during the prior year and containing the information specified in § 7.34 of this Agreement, and shall simultaneously provide a copy of such report to the Healthcare Provider 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 the prior years' reports that remain operative and have not been amended during the interim.

12.8 Access to Websites for Compliance Review

Company will provide Class Counsel, Representative Plaintiffs, Association Plaintiffs and Signatory Healthcare Provider Societies with access to all website pages containing settlement benefits or disclosures required by § 7 of this Agreement, for the purpose of monitoring Company's compliance with § 7.

13. Release, Covenant Not to Sue, and Bar Order

13.1 Discharge of All Released Claims

(a) Upon the Effective 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 and each of their respective current or former officers, directors, employees, agents, insurers and attorneys (and the predecessors, heirs, executors, administrators, legal representatives, successors and assigns of each of the foregoing), and all Persons who provided claims processing services, software, proprietary guidelines or technology to Company or its Subsidiaries and Affiliates, and those contracted agents processing claims on their behalf, together with each such Person's or entity's predecessors or successors (but only to the extent of such Person's or entity's services and work done pursuant to contract with Company or its Subsidiaries or Affiliates), but excluding all Delegated Entities, shall be released and forever discharged by the Association Plaintiffs, the Signatory Healthcare Provider Specialty 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 prior to the Effective Date, that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referenced in the Actions, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons, or to the business practices that are the subject of § 7 of this Agreement. This includes, without limitation and as to Released Parties only, any aspect of any Fee-

for-Service Claim submitted by any Class Member to Company, and any claims of any Class Member related to or based upon any Capitation agreement between Company and any Class Member or other Person or entity, or the delay, nonpayment or amount of any Capitation payments by Company, and any allegation that other defendants in the Actions and/or Company have conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, Delegated Entities and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Actions, or with regard to Company's liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, Delegated Entities and/or other third parties.

(b) The claims released and discharged pursuant to § 13.1(a) above, subject to the exception regarding Retained Claims contained in § 13.6 of this Agreement, shall be referred to collectively as "**Released Claims**."

13.2 Covenant Not to Sue

(a) The Releasing Parties agree and covenant not to sue or prosecute, or institute or cooperate in the institution, commencement, filing, or prosecution of any suit or proceeding, in any forum based upon or related to any Released Claim against any Released Party.

(b) Upon entry of the Final Order and Judgment and through the Termination Date, each Releasing Party shall be deemed to have covenanted and agreed not to sue or to assert or to prosecute, institute, or cooperate in the institution, commencement, filing, or prosecution of any proceeding against any Released Person, in any forum, 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 is based on any of the matters for which this Agreement provides an adequate remedial process. This Covenant Not to Sue does not apply to any future claim for which this Agreement does not provide an adequate remedial process, except for any such future claim relating to the subject matter of a § 7 commitment, which claim arises between the Preliminary Approval Date and the Implementation Date of that commitment.

13.3 Bar Order

It is an essential element of the Agreement that Company obtain the fullest possible release from further liability to anyone relating to the Released Claims, and it is the intention of the parties to this Agreement that the Agreement eliminate all further risk and liability of Company relating to the Released Claims. Accordingly, the Parties agree that the Court shall include in the Final Order and Judgment a Bar Order that meets all of the following requirements:

(a) The Releasing Parties are permanently enjoined from: (i) filing, commencing, prosecuting, intervening in, participating in (as class members or otherwise) or receiving any benefits from any lawsuit, arbitration, administrative or regulatory proceeding or order in any jurisdiction based on any or all Released Claims against one or more Released Parties; (ii) instituting, organizing class members in, joining with class members in, amending a pleading in or soliciting the participation of class members in, any action or arbitration, including but not limited to a purported class action, in any jurisdiction against one or more Released Parties based on, involving, or incorporating, directly or indirectly, any or all Released Claims, and (iii) filing, commencing, prosecuting, intervening in, participating in (as class members or otherwise) or receiving any benefits from any lawsuit, arbitration, administrative or regulatory proceeding or order in any jurisdiction based on an allegation that an action taken by Company, which is in compliance with the provisions of the Settlement Agreement, violates any legal right of any member of the Class.

(b) All Persons, including, without limitation, all defendants named in the Complaints other than Released Parties, who are, have been, could be, or could have been alleged to be joint tortfeasors, co-tortfeasors, co-conspirators, or co-obligors with the Released Parties or any of them respecting the Released Claims or any of them, are hereby, to the maximum extent permitted by law, barred and permanently enjoined from making, instituting, commencing, prosecuting, participating in or continuing any Claim, claim-over, cross-claim, action, or proceeding, however denominated, regardless of the allegations, facts, law, theories or principles on which they are based, in this Court or in any other court or tribunal, against the Released Parties or any of them with respect to the Released Claims, including, without limitation, equitable, partial, comparative, or complete contribution, set-off, indemnity, assessment, or otherwise, whether by contract, common law or statute, arising out of or relating in any way to the Released Claims. All such claims are hereby fully and finally barred, released, extinguished, discharged, satisfied, and made unenforceable to the maximum extent permitted by law, and no such claim may be commenced, maintained, or prosecuted against

any Released Party. Any judgment or award obtained by a Class Member against any such defendant or third party shall be reduced by the amount or percentage, if any, necessary under applicable law to relieve Company or any Released Party of all liability to such defendants or third parties on such barred claims. Such judgment reduction, partial or complete release, settlement credit, relief, or setoff, if any, shall be in an amount or percentage sufficient under applicable law as determined by the Court to compensate such defendants or third parties for the loss of any such barred claims against Company or any Released Party. Nothing in this paragraph shall be construed to bar any Person who is alleged to be a joint tortfeasor, co-tortfeasor, co-conspirator, or co-obligor with any of the Released Parties from instituting, commencing, prosecuting, or participating in any claim, claim-over, cross-claim, action, or proceeding, however denominated, against a Released Party in any litigation in which claims against the Released Party are not released and discharged pursuant to this order ("**Non-Released Litigation**"); provided, however, that such Persons may serve discovery on a Released Party in Non-Released Litigation only to the extent such discovery is directed solely to the allegations in such litigation. Where the claims of a person who is, has been, could be, or could have been alleged to be a joint tortfeasor, co-tortfeasor, co-conspirator or co-obligor with a Released Party respecting the Released Claims have been barred and permanently enjoined by this § 13.3, the claims of Released Parties against that person respecting those Released Claims are similarly fully and finally barred, released, extinguished, discharged, satisfied and made unenforceable to the maximum extent permitted by law.

13.4 Dismissal With Prejudice

The Releasing Parties shall take all steps necessary to dismiss the Actions with prejudice as to Released Parties. It is the Parties' intention that such dismissal shall constitute a final judgment on the merits to which the principles of *res judicata* shall apply to the fullest extent of the law as to the Released Parties.

13.5 Waiver of California Civil Code § 1542

With respect to all Released Claims, the Releasing Parties and each of them agree that they are expressly waiving and relinquishing to the fullest extent permitted by law (a) the provisions, rights, and benefits conferred by § 1542 of the California Civil Code, which provides:

"A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS

OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

and (b) any law of any state or territory of the United States, federal law or principle of common law, or of international or foreign law, which is similar, comparable or equivalent to § 1542 of the California Civil Code. Each Class Member who has not validly and timely requested to Opt Out of this Agreement and each Signatory Healthcare Provider Specialty 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 of this Agreement, but each such Class Member and each Signatory Healthcare Provider Specialty Society hereby expressly waives and fully, finally and forever settles and releases, upon the entry of the 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.

13.6 Retained Claims

Notwithstanding the foregoing, the Releasing Parties are not releasing claims for payment (each a "**Retained Claim**" and, collectively, the "**Retained Claims**") for Covered Services provided to Plan Members prior to or on the Effective Date as to which, as of the Effective Date, (a) no claim with respect to such Covered Services has been submitted to Company; provided that the applicable period for filing such claim has not elapsed; or (b) 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 this clause (b), above, final adjudication shall mean completion of Company's internal appeals process. In the event that a claim referred to in this clause (b) is finally adjudicated less than thirty (30) days prior to the Effective Date, such claim shall constitute a Retained Claim if a Healthcare Provider seeks relief under § 7.10 of this Agreement not later than ninety (90) days after notice of such final adjudication, but otherwise such claim shall constitute a Released Claim. Retained Claims shall be resolved pursuant to the appropriate remedial provisions of this Agreement.

13.7 Covenant Not to Sue in Any Other Forum

Upon the Effective Date and through the Termination Date, each Releasing Party shall be deemed to have covenanted and agreed not to sue with respect to, or assert, against any Released Person, in any other forum (a) any Retained Claim or (b) any Compliance Dispute, which respectively shall be asserted and pursued only pursuant, to the provisions of this

Agreement (it being understood that this § 13.7 shall not apply to any claims that arise within twenty (20) days before the Termination Date that could not reasonably be presented or resolved pursuant to the procedures set forth in this Agreement; provided that any such claim shall be prosecuted on an individual basis only and not otherwise).

13.8 Non-Released Persons and Non-Released Claims

(a) Nothing in this Agreement is intended to relieve any Person that is not a Released Party from responsibility for its own conduct or conduct of other Persons who are not Released Parties for claims that are not Released Claims. Nothing in this Agreement is intended to preclude any Representative Plaintiffs from introducing any competent and admissible evidence to the extent consistent with §§ 13.8(d), 14.5, and 16 of this Agreement.

(b) Nothing in this Agreement prevents the Representative Plaintiffs and Class from pursuing claims to hold any Person or Party that is not a Released Party, liable for damages caused by any Released Party.

(c) If § 13.8(b) of this Agreement should be found illegal or invalid by any court for any reason, it shall be severable from the remainder of this Agreement, and the remainder of this Agreement shall be unchanged and shall be read as if it did not contain § § 13.8(b).

(d) If Plaintiffs, the Class or any Class Members pursue claims against any Person or Party for damages allegedly caused by any Released Person, any finding, judgment, opinion or other result from such proceeding under any circumstances (i) shall not be deemed, construed or asserted as a finding, judgment, opinion or result against any Released Person; (ii) shall not be deemed, construed or asserted as *res judicata*, collateral estoppel or similar doctrines against any Released Person; and (iii) shall not be admitted or considered as evidence against or used for any purpose against any Released Party in any judicial, administrative, regulatory, arbitration proceeding or any other forum.

13.9 Irreparable Harm

The Parties agree that Company shall suffer irreparable harm if a Releasing Party takes action inconsistent with §§ 13.1, 13.2, 13.3, 13.4 and/or 13.7 of this Agreement, and that in such event Company may seek an injunction from the Court as to such action without further showing of irreparable harm.

13.10 Legislative Changes

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

14.1 Suspension of Discovery

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

(b) Upon entry of the Preliminary Approval Order, all proceedings against or concerning Company in the Actions, other than proceedings as may be necessary to carry out the terms and conditions of the Settlement, shall be stayed and suspended until further order of the Court. The Preliminary Approval Order shall also bar and enjoin all members of the Class from commencing or prosecuting any action asserting any Released Claims, and stay any actions or proceedings brought by any member of the Class asserting any Released Claims. In the event the Final Order and Judgment is not entered or is reversed for any reason, or this Agreement terminates for any reason, the Parties shall not be deemed to have waived any rights with respect to proceedings in the Actions that arise during the period of the stay and shall have a full and fair opportunity to present any position in any such proceedings.

14.2 Right to Terminate this Agreement

If, at the Preliminary Approval Hearing or within thirty (30) 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 _____, 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. 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.

14.3 Notice of Termination

If the Court has not entered the Final Order and Judgment substantially in the forms attached hereto as exhibits _____ before one hundred eighty (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.

14.4 Effective Date

If the Final Order and Judgment is entered by the Court and the time for appeal from 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 next business day after the last date on which notice of appeal could have been timely filed. If the Final Order and Judgment is entered and an appeal is filed as to either of them, the "**Effective Date**" shall be the next business day after the Final Order and Judgment is affirmed, all appeals are dismissed, and the time for taking further appeals to, or petitioning for discretionary review in, any Court has expired.

14.5 Suspension of Discovery After Preliminary Approval Date

From and after the Preliminary Approval Date, the Releasing Parties and Class Counsel covenant and agree that the Releasing Persons and Class Counsel shall not pursue discovery or any other proceedings 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 non-Released Parties and non-Released Claims.

14.6 Termination Date of Agreement

This Agreement shall terminate (the "**Termination Date**") upon the earlier to occur of (a) termination of this Agreement by any Party pursuant to the terms hereof and (b) October 19, 2009. 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 under this Agreement 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 (b) of this § 14.6: (i) the provisions of §§ 13.1, 13.2 (except 13.2(b)), 13.3 13.4, 13.5, 13.7 and 13.8 and §§ 15, 16, 17, 18, and 19 of this Agreement shall survive such termination indefinitely, (ii) the provisions of §§ 7.10 and § 7.11 of this Agreement 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 that are being resolved pursuant to the External Review process as of the date of such termination and (iii) the provisions of §§ 12.1 through 12.6 of this Agreement 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. On the Termination Date, all of Company's obligations under this Agreement shall be satisfied. Except as provided in this § 14.6, 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. Company also may, where it has a good faith basis, and notwithstanding any Implementation Date in § 7 of this Agreement or in exhibit ___ hereto, delay the implementation, in whole or in part, of any provision of this Agreement upon notice to Class Counsel, in which case, and only to the extent that implementation of a provision of this Agreement has been delayed, the term of the Agreement shall be extended with respect to the delayed provision for a period of time equal to the length of the delay. If Class Counsel believe that Company has willfully delayed implementation, in whole or in part, of any material provision of this Agreement without providing notice to Class Counsel pursuant to the preceding sentence, then they may petition the Compliance Dispute Resolution Officer for a recommendation that, to the extent implementation of such a provision was delayed, the term of the Agreement be extended with respect to the delayed provision for a period of time equal to the length of the willful delay. Upon a finding of willful delay and a recommendation by the Compliance Dispute Resolution Officer, Class Counsel may petition the Court for an extension of the Effective Period equal to the length of the willful delay with respect to the delayed provision, but only to the extent that implementation of such provision was delayed.

15. Related Provider Track Actions

15.1 Ordered Stays and Dismissals in Tag-Along Actions

If any action brought by or on behalf of Class Members that asserts any claim that as of the Effective Date would constitute a Released Claim against Company is in the future consolidated as a tag-along action or otherwise with the Provider Track actions under MDL No. 1334 (the "**Tag-Along Actions**"), Representative Plaintiffs, Association Plaintiffs,

Class Counsel and Company shall cooperate to obtain an order of the Court dismissing such action with prejudice as to Company; provided that no such dismissal order shall operate to dismiss the claim of any named plaintiff in such Tag-Along Action who has timely submitted an Opt-Out request.

15.2 Certain Related State Court Actions

As to any action that is now pending, or hereafter may be filed in or remanded to any state court that asserts any Released Claim against Company on behalf of any Releasing Party, the Representative Plaintiffs, the Association Plaintiffs, 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 in such action that has submitted a valid and timely Opt Out request.

15.3 Other Related Actions

As to any action not referred to in §§ 15.1 or 15.2 of this Agreement 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 a valid and timely Opt-Out request, Representative Plaintiffs, Association Plaintiffs, and Class Counsel agree that they will cooperate with Company, to the extent reasonably practicable, in Company's efforts 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.

16. Not Evidence; No Admission of Liability

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 Actions, 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 other defendants in the Actions, the Representative Plaintiffs or the Association Plaintiffs, or as a waiver by Company, the other defendants in the Actions, the Representative Plaintiffs or the Association Plaintiffs 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. This provision shall survive the termination of this Agreement.

17. Entire Agreement; Amendment

17.1 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 Association Plaintiffs regarding the subject matter of the Actions or this Agreement. This Agreement shall not be modified in any respect except by a writing executed by Class Counsel and the Company.

17.2 Amendment Generally

This Agreement may be amended or modified only as provided in a written instrument signed by or on behalf of Company and Class Counsel (or their successors in interest) and approved by the Court, or as set forth in § 17.3 of this Agreement.

17.3 Amendment for Change in Circumstances

In the event Company encounters a change in circumstances that will cause performance or maintenance of one or more provisions of this Agreement to become impractical, it will provide notice thereof to Class Counsel with an explanation of the changed circumstances and the proposed change in the Agreement. For this purpose, "impractical" shall mean a change in circumstances that would place Company at a meaningful competitive or operational disadvantage, or would make performance or maintenance unduly burdensome, or would, on account of new technology, make continued performance or maintenance inefficient or less cost-effective relative to use of the new technology. A settlement in the Actions at any time following Preliminary Approval on terms materially more favorable for the other settling defendant than for Company, including but not limited to terms relating to coding and payment, exclusions of government programs or treatment of Delegated Entities and/or Individually Negotiated Contracts, may constitute such a change of circumstances and Company may initiate the process described in this § 17.3 at that time. Within thirty (30) days of the date of such notice, counsel for Company and Class Counsel will meet and confer regarding the proposed change and will attempt in good faith to reach an

agreement thereon. In this process, Company and Class Counsel will consider whether there is a more efficient way in which to fulfill the intent of the applicable aspect of the Agreement. If agreement is reached, Company and Class Counsel will jointly apply to the Court for a modification of this Agreement. If within thirty (30) days after the date of the initial meeting of Company and Class Counsel, agreement has not been reached, then Company may apply to the Court for a modification of this Agreement.

18. 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. The Parties agree that this fully integrated Agreement shall be construed by its own terms and not by referring to, or considering, the terms of any other settlement agreement between the Representative Plaintiffs and/or Association Plaintiffs and another defendant in the Actions.

19. Captions and Headings

The use of captions and headings in this Agreement is solely for convenience and shall have no legal effect in construing the provisions of this Agreement.

20. Continuing Jurisdiction and Exclusive Venue

20.1 Continuing Jurisdiction

(a) 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.

(b) Except as otherwise provided in this Agreement, Company, each Signatory Healthcare Provider Specialty 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.

20.2 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, and 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 § 20 of this Agreement in its Final Order and Judgment approving this Agreement.

21. Discovery

Representative Plaintiffs, Association Plaintiffs, Class Counsel and Company agree to move the Court for 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.

22. 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.

23. Additional Signatory Healthcare Provider Specialty Societies

The Parties agree that, from and after the date of this Agreement, additional Healthcare Provider Specialty 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 Healthcare Provider Specialty Societies. Upon such execution of a signature page, each such additional healthcare provider society shall be deemed to be a Signatory Healthcare Provider Specialty Society for all purposes of this Agreement and shall be bound by all of the provisions of this Agreement that are applicable to Signatory Healthcare Provider Specialty Societies.

24. Successors and Assigns

24.1 No Assignment Without Consent

(a) The provisions of this Agreement shall be binding upon and inure

to the benefit of Company and its respective successors and assigns; provided that Company may not assign, delegate or otherwise transfer any of its rights or obligations under this Agreement to a third party that is not a successor or affiliate without the consent of Class Counsel.

(b) Under no circumstances shall this Agreement create a right of Class Members or Class Counsel to review, approve or consent to any business transaction involving the Company, including, without limitation, any sale, purchase, merger or other business combination transaction.

(c) Notwithstanding any other provision herein, if Company shall sell or otherwise dispose of any portion of its business during the Effective Period of this Agreement that represents in the aggregate less than ten percent (10%) of Company's consolidated revenues ("**Sold Business**"), the purchaser or other recipient of the Sold Business shall not be bound by the provisions of this Agreement with respect to itself or the Sold Business.

24.2 Acquisition or Change of Control Transactions

Notwithstanding any other provision of this Agreement, in the event of (i) an acquisition or change of control of Company whereby all or substantially all of Company's assets or stock are acquired by a third person by way of merger or transfer of stock or assets, or (ii) Company consolidates with, or merges with or into, another person or any other person consolidates with, or merges with or into, Company (any such other person being referred to hereinafter as a "**Combining Person**"), the following provisions apply (with the term "**Acquirer**" referring to and including any acquiring person referred to in the foregoing clause (i) and any Combining Person referred to in the foregoing clause (ii)):

(a) The provisions of the Agreement shall continue to apply only to Company (or Company's successor by merger) and not to the Acquirer or other Affiliates of the Acquirer, so long as Company (or Company's successor by merger) remains a separate Affiliate of the Acquirer.

(b) If the Acquirer enters or has entered a settlement agreement with plaintiffs in the Action, the Acquirer and/or Company may seek at any time to modify the provisions of this Agreement by giving notice under the procedure set forth in § 17.3 of this Agreement. A modification triggered under this § 24.2(b) shall not shorten the term of this Agreement as to Company, but Class Counsel and Company and/or Acquirer shall meet and confer in good faith to achieve consistency with respect to the operational requirements

under § 7 and the compliance procedures under § 12 while maintaining the overall material benefits of this Agreement for Class members. If agreement is reached, Company and/or Acquirer and Class Counsel will jointly apply to the Court for a modification of this Settlement Agreement. If within thirty (30) days after the date of the initial meeting of Company and/or Acquirer and Class Counsel, agreement has not been reached, then Company and/or Acquirer may apply to the Court for a modification of this Settlement Agreement.

(c) Notwithstanding § 13.8(b) of this Agreement or any other provision of this Agreement, the Acquirer shall be deemed a Released Party with respect to any claims that arise from or are based on conduct by any other Released Party under this Agreement that occurred on or before the Effective Date and are or could have been alleged in the Complaint, but not as to claims that arise from or are based on conduct by the Acquirer.

(d) An entity that is an Acquirer under condition (i) or (ii) above shall remain an Acquirer unless and until the written agreement for change of control or transfer of stock or assets is terminated, revoked, abandoned, or enjoined by final order of a court of competent jurisdiction.

24.3 Acquisitions by the Company

The provisions of this Agreement shall not apply with respect to any corporation, business or other entity acquired by Company after the Preliminary Approval Date, and Company shall have no obligations under this Agreement with respect to such corporation, business, or entity or the business operations of such corporation, business, or entity after the Preliminary Approval Date so long as such corporation, business or entity remains a separate affiliate of the Company.

25. Governing Law

This Agreement and all agreements, exhibits, and documents relating to this Agreement shall be construed under the laws of the State of Florida, excluding its choice-of-law rules.