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CLARENCE MADDOX
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
Miami Division

IN RE: MANAGED CARE LITIGATION MDL NO. 1334

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

MASTER FILE NO.
00-1334-MD MORENO

CHARLES B. SHANE, MD, et al.

Plaintiffs,

v.

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

Defendants.

JOINT MOTION FOR PRELIMINARY APPROVAL OF HEALTH NET SETTLEMENT

Class Representative Plaintiffs and Defendant Health Net, Inc. ("Health Net") respectfully move this Court to enter the proposed Order Preliminary Approving Proposed Settlement Among Health Net and Physicians, Physician Groups and Physician Organizations, Setting Form and Content of Notice to the Class and Scheduling Settlement Hearing, a copy of which is attached hereto as Exhibit A.

In support of this motion, Class Representative Plaintiffs and Health Net state as follows:

1. Class Representative Plaintiffs and Health Net have entered into a settlement agreement, a copy of which is attached hereto as Exhibit B.

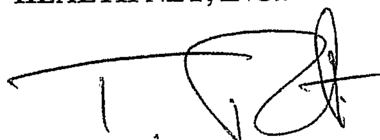
2. Class Representative Plaintiffs and Health Net respectfully request that this Court grant preliminary approval to the settlement agreement as fair, adequate and reasonable.

3. Class Representative Plaintiffs and Health Net respectfully request that this Court approve the notice plan set forth in Section 5 of the settlement agreement, and the forms of notice attached to the settlement agreement as Exhibits D and F.

4. Class Representative Plaintiffs and Health Net respectfully request that this Court proceed with the hearing scheduled for May 6, 2005 to consider the settlement agreement and to enter the proposed order.

Respectfully submitted this 3 day of May, 2005.

HEALTH NET, INC.:

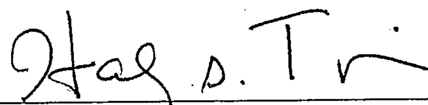


Edward Crane / R. Ryan Stoll / Todd Frankel
SKADDEN ARPS SLATE MEAGHER & FLOM, LLP
333 W. Wacker Drive, Ste 2100, Chicago, IL 60606

William A. Helvestine / Michael T. Horan
EPSTEIN BECKER & GREEN, PC
1 California St., 26th Fl, San Francisco, CA 94111

Eduardo Palmer
201 S. Biscayne Blvd., Ste 1450, Miami, FL 33131

PROVIDER PLAINTIFFS:

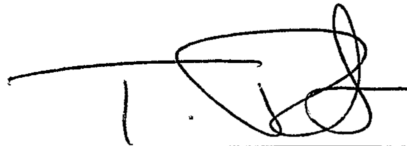


Harley S. Tropin
KOZYAK TROPIN & THROCKMORTON, P.A.
2525 Ponce de Leon, 9th Floor
Miami, Florida 33134
305-372-1800

2957/101/252595.1

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 4th day of May, 2005, a true copy of the foregoing was served via hand-delivery to: Edward Soto, Esq., Weil Gotshal & Manges, LLP, 1395 Brickell Avenue, 12th Floor, Miami, FL 33131 (Defense Liaison Counsel); and via e-mail on all parties of record on the 2/08/05 Service List.



Tucker Ronzetti

SETTLEMENT AGREEMENT

dated as of

May 2, 2005

by and among

HEALTH NET, INC.,

THE REPRESENTATIVE PLAINTIFFS,

THE SIGNATORY MEDICAL SOCIETIES

AND CLASS COUNSEL

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SETTLEMENT AGREEMENT

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

WITNESSETH:

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Definitions

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

"**Action**" means Shane v. Humana, Inc., et al., Master File No. 00-1334-MD-MORENO. For purposes of this Agreement, "Action" shall also be construed to include Shane et al. v. Humana et al., No. 04-21589-CIV-Moreno.

"Actively Practicing Physician" means a Physician Class Member who is not a Retired Physician as of the Preliminary Approval Date.

"Affiliate" means with respect to any Person, any other Person controlling, controlled by or under common control with such first Person. The term "control" (including without limitation, with correlative meaning, the terms "controlled by" "under common control with"), as used with respect to any Person, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and Policies of such Person, whether through the ownership of voting securities or otherwise.

"Agreement" shall have the meaning assigned to that term in the preamble of this Agreement.

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

"Bar Order" means an order of the Court barring the assertion of claims against the Released Parties for contribution, indemnity or other similar claims by the non-settling defendants in the Action or other Persons in the form included as part of the Final Order and Judgment.

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

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

"Business Day" means any day on which commercial banks are open for business in New York City.

"Capitation" means the payment by Company to Physicians, Physician Groups or Physician 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.

"Claim Coding and Bundling Edits" means adjustments to CPT® Codes or HCPCS Level II Codes included in claims in which (a) Company denied or changed one or more of the CPT Codes or HCPCS Level II Codes included in the claim; (b) Company's payment was based on different billing codes than those billed to Company; (c) Company's payment for one or more CPT® Codes is or was reduced by application of Multiple Procedure Logic; or (d) any combination of the above.

"Claim Form" means a CMS-1500 (or successor standard form) or a document in substantially the form of a CMS-1500 or successor or a HIPAA "837" or successor.

"Class" means any and all Physicians, Physicians Groups and Physician Organizations who provided Covered Services to any Plan Member or any individual enrolled in or covered by a plan offered or administered by any Person named as a defendant in the Complaint or by any of their respective current or former subsidiaries or affiliates, in each case from August 4, 1990 through the Preliminary Approval Date.

"Class Counsel" means those Persons set forth in Section 5.

"Class Member" means any Person who is or was a member of the Class and who does not timely opt out.

"Clinical Information" means clinical, operative or other medical records and reports kept by the Physician, Physician Group or Physician Organization in the ordinary course of a Physician's business with respect to a Plan Member's treatment.

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

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

"**Company**" means Health Net, Inc. and each of its Subsidiaries.

"**Complaint**" shall have the meaning assigned to that term in the recitals of this Agreement.

"**Complete Claim**" means a claim for Covered Services that (a) is timely received by Company, (b)(i) when submitted via paper has all the elements of the UB-92 or CMS-1500 (or successor standard) forms or (ii) when submitted via an electronic transaction, uses only permitted standard code sets (e.g., CPT®-4, ICD-9, HCPCS) and has all the elements of the standard electronic formats, as required by applicable Federal authority and state regulatory authority, (c) is a claim for which Company is a responsible payor, (d) is a claim for which Company is the primary payor or Company's responsibility as a secondary payor has been established by agreement of Company or by order no longer subject to appeal or review (in the context of coordination of benefits), (e) contains no material defect or error; and (f) Company has received such other information as may be reasonably necessary for the adjudication of the claim consistent with Section 7.8(c).

"**Compliance Dispute**" means (i) any claim that Company has failed in any manner to carry out any of its obligations under § 7 of this Agreement and (ii) any claim of the type described in § 13(e)(2) of this Agreement that is not also any of the following: (A) a Released Claim, (B) a Retained Claim, (C) a Billing Dispute (except that a Billing Dispute that evidences a violation of Sections 7.19 and 7.20 may also constitute a Compliance Dispute); or (D) a claim for which the Medical Necessity External Review Process is available.

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

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

"**Compliance Dispute Review Officer**" means the person chosen pursuant to § 12 of this Agreement and charged with the administration of Certifications and Compliance Disputes under this Agreement.

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

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

"**Covered Services**" means those health care services and supplies for which a Plan Member is entitled to receive coverage under the terms and conditions of his or her Plan.

"**CPT®**" and "**CPT® Codes**" mean medical nomenclature published by the American Medical Association containing a systematic listing and coding of procedures and services provided to patients by physicians and non-physician health professionals. When used herein, "**CPT®**" and "**CPT® Codes**" refer to such medical nomenclature as it exists as of the date of this Agreement and as it may be amended, modified or superceded thereafter during the term of this Agreement.

The word "**day**" means a calendar day, unless otherwise noted herein.

"**Delegated Entity**" means (A)(i) a risk-bearing organization, organized delivery system, limited or specialized licensed health plan or other risk-bearing entity as defined by state law in the state where the service is provided, or (ii) a full service licensed health plan where it is reasonably necessary because Company does not have the reasonable capacity to provide or administer coverage in those geographic

areas or specialty services; or (B) if the state law does not provide a definition of one or more of these risk bearing entities, a Physician Group, Physician Organization or other entity that provides or arranges for health care services, and that (i) contracts directly with Company to accept financial risk for designated health care services or supplies for Plan Members and (ii) performs some or all of the functions with respect to Plans which otherwise would be performed by Company, including without limitation claims adjudication, utilization review, utilization management and/or Physician credentialing and contracting.; or (C) a Physician Group, Physician Organization or other entity that (i) is at least 51% owned or, in the case of a nonprofit entity, controlled by Physicians or other licensed health care providers or facilities, and (ii) performs some or all of the functions with respect to Plans which otherwise would be performed by Company, including without limitation claims adjudication, utilization review, utilization management and/or Physician credentialing and contracting.

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

"Effective Date" shall have the meaning assigned to that term in § 14 of this Agreement.

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

"EOB" means Explanation of Benefit or any comparable form or statement communicating to Plan Members the results of Company's adjudication of claim(s) submitted by, with respect to or on behalf of such Plan Members.

"ERA/EFT Software" shall have the meaning assigned to that term in § 7.12 of this Agreement.

"ERISA" means the Employment Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated thereunder.

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

"Fee for Service Claim" means any submission by a Class Member to Company (or to Company's claims payment agent) using CPT® Codes or HCPCS Level II Codes and seeking payment on a fee for service basis for the provision of one or more Covered Services to a Plan Member.

"Final Order and Judgment" means the order and form of judgment approving this Agreement and dismissing Company with prejudice, in each case in the form attached hereto as Exhibit C.

"Foundation" shall have the meaning assigned to that term in § 8.4(g) of this Agreement.

"Fully Insured Plan" means a Plan as to which Company, as opposed to the subscriber or Plan sponsor, assumes all or substantially all of the healthcare cost and the Company's coverage product is approved as the product of a licensed insurer or HMO under state law.

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

"Individually Negotiated Contract" means a contract pursuant to which the parties to the contract, as a result of negotiation either at the inception of the contractual relationship or at a renewal thereof, agreed to substantial modifications to the terms of Company's standard form agreement to individually suit the needs of a particular Participating Physician, Physician Group or Physician Organization.

"Interest Rate" means a blended rate of return based on the quarterly Federal Funds rate ("FFR") and the quarterly Merrill Lynch U.S. Domestic Master Index (1-5 years)("MLI") blended (0.4 x FFR) + (0.6 x MLI) and compounded quarterly.

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

"Material Adverse Change" means any change in Policies that could reasonably be expected to have a material adverse impact on (i) the aggregate level of payment by Company to a significant number of Participating Physicians (or specialty or subspecialty of Participating Physicians) for Covered Services, or (ii) a significant number of Participating Physicians' (or specialty or subspecialty of Participating Physicians) administration of their practices.

"Medical Necessity" or **"Medically Necessary"** shall have the meaning assigned to that term in § 7.16 of this Agreement.

"Medical Necessity External Review Process" shall have the meaning assigned to that term in § 7.11 of this Agreement.

"Multiple Procedure Logic" means the adjustment(s) to payment(s) for one or more procedures or other services, in each case constituting Covered Services (excluding evaluation and management CPT® Codes), when multiple such procedures or services are performed at the same session.

"Non-Participating Physician" means any Physician other than a Participating Physician.

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

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

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

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

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

"Participating Physician" means any Physician who has entered into a valid written contract with Company (directly or indirectly through a Physician Organization, Physician Group or other entity authorized by physician) to provide Covered Services to Plan Members and, where applicable, has been credentialed by Company or by a Delegated Entity pursuant to Company's credentialing policies in effect at the time of such credentialing, during the effective period of such a contract. The fact that a Physician has entered into an agreement with a rental network accessed by Company (section 7.29(p)) does not make that Physician a Participating Physician.

"Parties" shall have the meaning assigned to that term in the preamble of this Agreement.

"Person" and **"Persons"** means all persons and entities (including without limitation natural persons, firms, corporations, limited liability companies, joint ventures, joint stock companies, unincorporated organizations, agencies, bodies, governments, political subdivisions, governmental agencies and authorities, associations, partnerships, limited liability partnerships, trusts, and their predecessors, successors, administrators, executors, heirs and assigns).

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

"Physician" means an individual duly licensed by a state licensing board as a Medical Doctor or as a Doctor of Osteopathy and shall include both Participating Physicians and Non-Participating Physicians.

"Physician Group" means two or more Physicians, and those claiming by or through them, who practice medicine and bill under a single taxpayer identification number.

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

"Physician Organization" means any association, partnership, corporation or other form of organization (including without limitation independent practice associations and physician hospital organizations) that arranges for care to be provided by Physicians organized under multiple taxpayer ID numbers, to Plan Members.

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

"Physician Specialty Society" means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

"Plan" means a Plan Member's health care benefits as set forth in the Plan Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document.

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

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

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

"Preliminary Approval Order" means the preliminary approval order, in the form attached hereto as Exhibit E.

"Proof of Claim Form" means the form attached hereto as Exhibit A that eligible Class Members must submit to participate in the Settlement Fund referenced in § 8 of this Agreement.

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

"Provider Website" means the secure (password protected) online resource for Participating Physicians to obtain information about Company, its products and policies and other information described in more detail in this Agreement, and which is currently located at https://www.healthnet.com/portal/provider/home.do.

"Public Website" means the online resource for the public to obtain information about Company, its products and policies and other information and which is currently located at www.healthnet.com.

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

"Released Parties" or "Released Persons" means

(a) Health Net, Inc. and each of its Affiliates (whether direct or indirect) as of December 31, 2004, and any and all of their respective officers, directors, employees, insurers and attorneys, together with each such individual's or entity's predecessors and successors (subject to the provisions of Section 23 regarding successors);

(b) Each former Affiliate of Health Net, Inc.(whether direct or indirect) as of December 31, 2004, and any and all of their respective officers, directors, employees, insurers and attorneys, together with each such individual's or entity's predecessors and successors, but only as to claims that arise from or relate to acts or omissions that occurred prior to the time the Affiliate (and other persons listed above) were no longer affiliated with Health Net, Inc.;

(c) Persons who provided claims processing services, software, proprietary guidelines or technology to Health Net, Inc. or its Affiliates, 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 Health Net, Inc. or its Affiliates. Such persons are expressly not "Released Persons" as to services provided to any person or entity other that Health Net Inc. or its Affiliates. Nothing herein is intended to release Delegated Entities.

"Released Rights" or **"Released Claims"** means and includes any and all claims that have been or could have been asserted by or on behalf of any or all Class Members against the Released Persons, or any of them, and which arise prior to the Preliminary Approval Date and which arise out of or relate to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Litigation, except as otherwise provided for by this Agreement. This includes, without limitation and as to Released Persons 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 Defendants 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 Litigation, 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.

"Releasing Parties" (each a "Releasing Party") means Class Members who have not submitted a valid and timely Opt-Out, Representative Plaintiffs and Signatory Medical Societies. "Releasing Parties" also includes any and all Subsidiaries, affiliates, members, shareholders, parents, directors, officers, employees, professional corporations, agents, administrators, executors, legal representatives, partners and partnerships, heirs, predecessors, successors and assigns of such Class Members, and shall also include Representative Parties and Signatory Medical Societies, to the extent such persons or entities have claims against Company derived by contract or operation of law from the claims of such Class Members, Representative Parties and Signatory Medical Societies.

"Representative Plaintiffs" means collectively Kevin Lynch, M.D., Karen Laugel, M.D., Manual Porth, M.D., Glenn Kelly, M.D., Leonard Klay, M.D., Charles B. Shane, M.D., Jeffrey Book, M.D., Andres Taleisnik, M.D., Julio Taleisnik, M.D., Roger Wilson, M.D., Susan R. Hansen, M.D., Thomas Backer, M.D., Martin Moran, M.D., H. Robert Harrison, Ph.D., M.D., and Lance R. Goodman, M.D.

"Retained Claims" shall have the meaning assigned to that term in § 13.4 of this Agreement.

"Retired Physician" means a Physician Class Member who, subsequent to August 4, 1990, has become an inactive Physician, has retired from the practice of, or has otherwise ceased to practice, medicine or has died, as of the date of Preliminary Approval.

"Self-Insured Plan" and **"Self-Funded Plan"** means any Plan other than a Fully Insured Plan.

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

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

"Settlement Amount" shall have the meaning assigned to that term in § 8 of this Agreement.

"Settlement Fund" shall have the meaning assigned to that term in § 8 of this Agreement.

"Settlement Hearing" means the hearing at which the Court shall consider and determine whether to enter the Final Order and Judgment and make such other orders as are contemplated by this Agreement.

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

"Signatory Medical Societies" shall have the meaning assigned to that term in the preamble of this Agreement.

"State Medical Society" means a state medical society or association that is recognized by the American Medical Association.

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

"Subsidiary" means any entity of which securities or other ownership interests having ordinary voting power to elect a majority of the board of directors or other persons performing similar functions are, as of Preliminary Approval Date, directly or indirectly owned by Health Net, Inc., but only so long as

such securities or other ownership interests having ordinary voting power to elect a majority of the board of directors or other persons performing similar functions are, directly or indirectly, held by Health Net, Inc..

"Tag-Along Actions" shall have the meaning assigned to such term in § 15.1 of this Agreement.

"Termination Date" shall have the meaning assigned to that term in § 14.7 of this Agreement.

2. The Action and Class Covered by This Agreement

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

3. Commitment to Support and Communications with Class Members

The Settling 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 Plaintiffs shall make every reasonable effort to encourage putative Class Members to participate and not to Opt Out. In addition, Class Counsel shall make all reasonable efforts to enforce the Compliance Dispute resolution provisions of this Agreement set forth in Section 15.

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 Initial Notice, the Notice of Commencement of the Claims Period or other agreed upon communications concerning the Agreement. Company will not discourage the filing of any claims allowed under this Agreement or advise Class Members with respect to the category or categories of 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 claims to be filed under this Agreement.

4. Preliminary Approval of Settlement

Pursuant to Rule 23(e), the Settling 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 and Plan of Notice and scheduling of a Fairness Hearing, and shall apply to the Court for an Order of Preliminary Approval and Conditional Class Certification, substantially in the form of Exhibit E ("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 Physicians. The Mailed Notice shall request and require that any Class Member who has assigned a claim covered by this Agreement to another Person, in whole or in part, to deliver the Mailed Notice to such Person.

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

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

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

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

Class Counsel:

Archie C. Lamb, Jr.
Law Offices of Archie C. Lamb, LLC
2017 Second Avenue North
Birmingham, AL 35203

Aaron S. Podhurst
Barry L. Meadow
Podhurst Orseck, PA
25 W. Flagler Street, Suite 800
Miami, FL 33130-1780

Nicholas B. Roth
Eyster Key Tubb Weaver & Roth, LLP
402 East Moulton Street, SE
Eyster Building
Decatur, AL 35601

Harley S. Tropin
Janet L. Humphreys
Adam M. Moskowitz
Kozyak Tropin & Throckmorton, PA
200 S. Biscayne Boulevard, Suite 2800
Miami, FL 33131-2335

Joe R. Whatley, Jr.
Charlene P. Ford
Othni J. Lathram
Whatley Drake, LLC
2323 Second Avenue North
Birmingham, AL 35203-3807

Edith M. Kallas
Joseph P. Guglielmo
Milberg Weiss Bershad & Schulman
One Pennsylvania Plaza
New York, NY 10119

Mark Gray
GRAY WHITE & WEISS
1200 PNC Plaza
500 West Jefferson
Louisville, KY 40202

Robert Foote
FOOTE & MEYERS
416 S. 2nd Street
Geneva, IL 60134

James B. Tilghman
STEWART TILGHMAN FOX & BIANCHI
1 SE 3rd Avenue, Ste 3000
Miami, FL 33131-1764

Dennis G. Pantazis
WIGGINS CHILDS QUINN & PANTAZIS
1400 SouthTrust Tower
420 North 20th Street
Birmingham, AL 35203

J. Mark White
WHITE ANDREWS ARNOLD & DOWD
2025 3rd Avenue North, Ste 600
Birmingham, AL 35203

Guido Saveri
R. Alexander Saveri
Cadio Zirpoli
SAVERI & SAVERI
111 Pine Street, Ste 1700
San Francisco, CA 94111-5619

Kenneth S. Canfield, Esq.
DOFFERMYRE SHIELDS CANFIELD KNOWLES & DEVINE
1355 Peachtree St., Ste 1600
Atlanta, GA 30309

James E. Hartley, Jr.
DRUBNER HARTLEY & O'CONNOR
500 Chase Parkway, 4th Fl.
Waterbury, CT 06708

Company:

Mr. Jay M. Gellert
President & Chief Executive Office
Health Net, Inc.
21650 Oxnard Street, Suite 1700
Woodland Hills, CA 91367

B. Curtis Westen, Esq.
Senior Vice President, General Counsel and Secretary
Health Net, Inc.
21650 Oxnard Street, 22nd Floor
Woodland Hills, CA 91367

With copies to:

William A. Helvestine, Esq.
Epstein Becker & Green, P.C.
One California Street, 26th Floor
San Francisco, CA 94111-5427

Ed Crane, Esq.
Skadden, Arps, Slate, Meagher & Flom LLP and Affiliates
333 West Wacker Drive, Suite 2100
Chicago, IL 60606

In the event that any Party receives a notice from any another Party (in accordance with the provisions of § 5 of this Agreement and as required by any other provision of this Agreement), 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 made by the notifying Party in such notice and shall be deemed to have

waived any rights under this Agreement with respect to the matter that is the subject of such notice.

6. Procedure for Final Approval; Limited Waiver

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

6.1 Opt-Out Timing and Rights

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

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

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

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

Within ten (10) days after the Opt-Out Deadline, the Settlement Administrator shall furnish Company with a complete list in machine-readable form of all Opt-Out requests filed by the Opt-Out Deadline and not timely revoked. Company shall pay costs of obtaining a copy of the Opt-Out requests.

Notwithstanding any other provisions in this Agreement, after reviewing said list and/or copies of Opt-Out requests and revocations, Company reserves the right, in its sole and absolute discretion, to terminate this Agreement by delivering a notice of termination to Class Counsel, with a copy to the Court, prior to the commencement of the Settlement Hearing if Company determines that Opt-Out requests have been filed (i) relating to more than 25,000 individual Physicians who are Class Members or (ii) representing Class

Members who, in the aggregate, received at least five percent (5%) of the total dollar payments that Company made to Class Members in calendar year 2004.

6.2 Setting the Settlement Hearing Date and Settlement Hearing Proceedings

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

6.3 Limited Waiver

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

Nothing in this Agreement shall preclude Releasing Parties from challenging the enforceability of arbitration provisions in connection with disputes or claims not resolved by this Agreement, provided, however, that no Releasing Party may assert that by entering into this Agreement, Company has waived its right to compel arbitration of such disputes or claims. This Agreement is not intended to be, nor shall it be argued or interpreted to represent, any waiver of arbitration rights except to the limited extent expressly set forth in this Section 6.3.

7. Settlement Consideration: Business Practice Initiatives

The settlement consideration to the Class Members who have not validly and timely requested to Opt-Out of this Agreement includes, among other things, initiatives and other commitments with respect to Company's business practices. The Parties agree that the business practice initiatives and other commitments set forth below, which absent this Agreement Company would be under no obligation to undertake, constitute substantial value, and will enhance and facilitate the delivery of Physician Services by Class Members who have not validly and timely requested to Opt-Out of the Agreement. Company investigated and began to implement certain of the business practice initiatives described in this § 7 while the Parties were engaged in discussions to resolve the Action. Such initial and partial implementation, which shows the Parties' good faith desire to resolve the Action, were undertaken to form part of the consideration of the settlement. Company shall have the unilateral and unrestricted right to block access to and/or not apply any or all of the business practice initiatives set forth below to such Class Members, if any, who Opt Out. Without in any way qualifying or limiting the foregoing, Company (a) is informed that it is not uncommon for some members of a class action to opt out for a variety of reasons independent of, among other things, the substantive allegations in the complaint or the terms of a proposed settlement, and (b) states its present intention to exercise the right referred to in the immediately preceding sentence to Class Members who Opt-Out.

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

Company shall be obligated to commence implementing each commitment set forth in this § 7 from and after the date set forth on Exhibit G attached hereto across from the relevant section number on such Exhibit (the "Implementation Date") and shall continue performing each such commitment until four years following the Implementation Dates shown on Exhibit G, except as otherwise modified pursuant to Section 17 (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 set forth for such commitment on Exhibit G attached hereto and continuing through the Conclusion Date for such commitment. Company may at its option give written notice to Class Counsel that it is implementing a commitment earlier than the date for such commitment on Exhibit G, in which case the Implementation Date, Effective Period and Conclusion Date for such commitment(s) shall be advanced in accordance with the date set forth in such notice. Except for Section 14.7 of this Agreement, notwithstanding anything to the contrary contained herein, with respect to each commitment set forth in this § 7, from and after the Conclusion Date for such commitment, Company shall be under no obligation whatsoever to continue to implement such commitment.

7.1 Automated Adjudication of Claims

Company, recognizing the desirability of making investments to improve its business relationships with Physicians 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 efforts to increase the percentage of claims that are auto-adjudicated, in an effort to shorten the period for payment of claims, and to improve the overall efficiency of the claim adjudication process. Using Company's Northeast Region by way of example, and comparing improvements for the most recent years (2003-2004), electronic receipt of claims increased by approximately 6 percent and auto-processing (no manual intervention required) increased by almost 2.5 percent.

7.2 Increased Internet and Clearinghouse Functionality

(a) Company has made and will continue to make investments to enhance the ability of Physicians to 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), check the status of claims for Covered Services, receive electronic remittance advice, in each case via electronic data interchange including the Internet, the Company's provider website, and /or clearinghouses.

(b) Company will allow any Participating Physician, at the Physician's election, to engage in any electronic transaction for which a standard transaction has been established by the HIPAA Electronic Transactions and Code Sets Rule, to the extent Company has implemented electronic functionality for the transaction which will comply with the HIPAA Electronic Transactions and Code Sets Rule.

(c) Company will allow the Facilitator and General Counsel of Signatory Medical Societies access to the Provider Website to the extent necessary to perform the

Facilitator's responsibilities under this Agreement. Access to the Provider Website, and any information derived therefrom, will be used by the Facilitator and such General Counsel solely for the purpose of performing his/her responsibilities under the Compliance Section 12 of this Agreement, and will not be used or disclosed for any other purpose.

7.3 Availability of Fee Schedules

Company shall develop and implement a plan that will permit a Participating Physician or Physician Group that, in each case, has entered into a written contract directly with the Company to obtain via electronic communication, without charge and on a confidential basis, the fee for service compensation rates for Covered Services provided under such contract, as follows. Where compensation is based on a publicly available conversion/RVU formula or database such as Medicare RBRVS, the Company's Provider Website will reference the applicable formula or database and provide, either directly or through a website link, a means to apply the formula or database to obtain rate information per CPT code. In addition, Company will implement an email inquiry system reasonably designed to permit a Participating Physician or Physician Group that has entered into a written contract directly with Company to receive, without charge and on a confidential basis, the fee-for-service dollar amount allowable for each CPT code for those CPT codes that a Participating Physician or Physician Group in the same specialty reasonably uses in providing Covered Services. Company will use its best efforts to prepare and provide responsive information to such email inquiries under this Section 7.3 within ten (10) days of receiving such inquiries. Company shall not be required to respond to requests for more CPT codes than the Participating Physician or Physician Group customarily and reasonably uses for Covered Services or for more than two such requests per year by such Participating Physician or Physician Group. Company will include in its standard form agreements offered to Delegated Entities upon renewal of existing agreements or entering a new agreement, provisions that require comparable disclosure.

7.4 Investment as to §§ 7.1, 7.2 and 7.3

Since the inception of this Litigation Company has expended and will continue to expend significant amounts of money and other resources to improve its relations with those providing health care services and supplies to Plan Members, and in particular to carry out the initiatives described in Sections 7.1, 7.2, 7.3, 7.7, 7.22, 7.23, 7.24 and 7.25 of this Agreement. These expenditures are reflected in § 7.31.

7.5 Reduced Pre-Certification Requirements

Company has reduced the number of procedures requiring precertification by Physicians, and reduced the number of services requiring submission of Clinical Information for pre-certification medical review. Company has and will continue to undertake efforts to standardize the services for which precertification by the Company is required within each licensed health plan, and will make the precertification requirements and lists available on its Provider Website. As used herein, "precertification" or "preauthorization" means notification and approval from the Company that the service or supply is Medically Necessary.

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. Not later than six (6) months after the Implementation Date, Company shall disclose on the Provider Website any customized pre-certification list for one or more Self-Funded Plans applicable to Participating Physicians and shall update such disclosures as needed.

7.6 Greater Notice of Policy and Procedure Changes

Company shall provide Participating Physicians with 90 days' advance notice of all planned Material Adverse Changes to Company's policies and procedures affecting performance under contracts with Participating Physicians, except to the extent that a shorter notice period is required to comply with changes in applicable law, and such change shall become effective at the conclusion of the ninety (90) day notice period. If a Participating Physician objects to the change that is subject to the notice, the Participating Physician may, within thirty (30) days of the date of the notice, give written notice to terminate his or her contract with Company, which termination shall be effective at the end of the ninety (90) day notice period of the material adverse change unless, within sixty-five (65) days of the date of the original notice of change, Company gives written notice to the objecting Participating Physician that it will not implement the change to which the Participating Physician objected. The continuation of care provisions in Section 7.13(c) hereof shall apply to any such contract termination.

7.7 Initiatives to Reduce Claims Resubmissions

Company has developed, will implement and will maintain at least until the Termination Date processes to send next-Business Day written communications to Physicians when it is determined that additional information is necessary to process a claim, explaining the information needed, and to send two written reminders at thirty (30) days and sixty (60) days if the necessary information has not been received in response to the initial communication. If the necessary information has not been received at ninety (90) days, then the claim will be denied at that time, and the Physician may appeal pursuant to 7.10 or 7.11. If Company obtains information prior to that time showing that the claim should be denied, Company will promptly deny the claim, so that the Physician may pursue any other remedies the Physician may have. If the denial is based on eligibility of the patient, the Physician may directly bill the patient.

7.8 Disclosure of and Commitments Concerning Claim Payment Practices

(a) Consistency

The automated Claim Coding and Bundling Edits utilized by Company will conform to this Agreement and, by December 31, 2005, within each separately licensed health plan, be consistent in all material respects across all of its products, except as provided in Section 7.30.

(b) Certain Claims Bundling Logic

Company will describe with particularity any single Claim Coding and Bundling Edit that is not compliant with CPT codes, guidelines or conventions or sourced to the Correct Coding Initiative ("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 or will result in denial of $50,000.00 in submitted claims, whichever is less.

(c) Requests for Clinical Information

Effective as of the Execution Date, Company shall not routinely require submission of Clinical Information before or after payment of claims, except as to claims for unlisted codes, claims to which a CPT 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 if Company routinely requires submission of Clinical Information before or after payment of a specified category of claims, Company shall promptly disclose on the Company's Website (accessible to Participating and non-Participating Physicians) any such claim category or categories. Notwithstanding the foregoing, Company may require submission of Clinical Information before or after payment of claims for the purpose of investigating fraudulent, abusive or other billing practices which would be inappropriate according to CPT ®codes, guidelines and conventions or inconsistent with other coding and reimbursement policies required or permitted by this Agreement, but only so long as, and only during such times as, Company has reasonable basis for believing that such investigation is warranted and Physicians may contest such requirement pursuant to § 7.10(c). The Clinical Information requested must be reasonably related to the issue under review. Nothing contained in this § 7.8(c) is intended, or shall be construed, to limit Company's right to require submission of Clinical Information for pre-certification purposes consistent with § 7.5 herein or any other purpose permitted by this Agreement.

(d) Claims with Modifiers 25 and 59

Not later than six (6) months after the Implementation 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 or CCI; provided that no such determination shall be inconsistent with the undertakings set forth in this Agreement.

(e) Updates

If changes are made, Company shall update the disclosures set forth in § 7.8.

7.9 Physician Advisory Committee

(a) Company shall take all actions necessary on its part to establish a Physician Advisory Committee ("Physician Advisory Committee") to discuss agenda items of statewide or greater scope concerning the Physician-Company relationship. The Physician Advisory Committee shall meet at least once every six months during the Effective Period. Company shall establish an electronic mail box on the Provider Website or comparable mechanism to enable Participating Physicians to communicate with the Physician Advisory Committee. Non-Participating Physicians may submit written proposals to the Physician Advisory Committee concerning the Physician-Company relationship

(b) The Physician Advisory Committee shall include nine (9) members, one of whom shall be Company's Chief Medical Officer or his designee, who shall serve as chairperson of the Physician Advisory Committee. Except as provided in this § 7.9(b), the remaining members shall be Participating Physicians in active clinical practice who are Board certified primary care physicians and/or Board certified in their areas of practice. Company shall select two (2) members in addition to its Chief Medical Officer not later than 30 days after the Preliminary Approval Date; Representative Plaintiffs shall select three (3) members not later than 30 days after the Preliminary Approval Date, and those six shall select the remaining three (3) members (one of whom may be a Nonparticipating Physician) not later than 90 days after the Preliminary Approval Date. The members selected by the Representative Plaintiffs shall include at least one board-certified primary care Participating Physician and at least one board-certified specialist Participating Physician. No person shall serve on the Physician Advisory Committee for Company who also serves on any committee of a competitor of Company.

(c) Any motion for the Physician Advisory Committee to consider an issue must be proposed by the chairperson or have the support of at least three (3) Physician Advisory Committee members. The issue shall be heard only if, at a meeting at which a quorum is present, a majority of the membership votes in favor of hearing the issue. A quorum shall consist of at least two (of the appointees of the Representative Plaintiffs, two (2) of the representatives appointed by Company, and two (2) of the representatives selected by the representatives appointed by the representatives appointed by Company and the Representative Plaintiffs. The Physician Advisory Committee shall have, and is limited to, authority to recommend changes to Company's policies of statewide or greater scope concerning the Physician-Company relationship. Any recommendation made by the Physician Advisory Committee shall require the affirmative vote of a majority of the members of the full Committee. Company shall consider whether the implementation of any recommendation of the Physician Advisory Committee is commercially feasible and consistent with the best interests of Company's Participating Physicians, Plan Members, customers, shareholders and other constituents. If Company decides not to accept a recommendation of the Physician Advisory Committee, Company shall communicate that decision in writing to the Committee with an explanation of Company's reasons and disclose the recommendation and response on the Provider Website.

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

7.10 New Dispute Resolution Process for Physician Billing Disputes

(a) Not later than the Implementation Date, Company shall take all actions necessary on its part to arrange for the establishment of an independent Billing Dispute External Review Board or Boards (the "Billing Dispute External Review Board") for resolving disputes with Physicians concerning (i) application of Company's coding and payment rules and methodologies 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) or concerning whether Company has complied with the provisions of this Agreement, including without limitation § 7.8(c), in requiring that a Physician submit records, either prior to or after payment, in connection with Company's adjudication of such Physician's claims for payments or (iii) any Retained Claims, so long as such Retained Claims are submitted by the Physician to the Billing Dispute External Review Board prior to the later to occur of (x) 90 days after the Implementation Date or (y) 30 days after exhaustion of Company's internal appeals process. Each such matter shall be a "Billing Dispute." The Billing Dispute External Review Boards shall not have jurisdiction over any other disputes, including without limitation those disputes that fall within the scope of the Medical Necessity External Review Process set forth in § 7.11 of this Agreement, Compliance Disputes and disputes concerning the scope of Covered Services. Nothing contained in this § 7.10 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supercede in any respect the claims procedures of § 503 of ERISA, or required by applicable state or federal law or regulation. In the case of 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-required process.

(b) Any Physician or Physician Group may submit Billing Disputes to the Billing Dispute External Review Board upon payment of a filing fee calculated as set forth in § 7.10(e) and in accordance with the provision of this § 7.10(b)(4), after the Physician or Physician Group exhausts Company's internal appeals process, when the amount in dispute (either a single claim for Covered Services or multiple claims involving similar issues) exceeds $500 (but no more than $100,000 for claims arising pursuant to an Individually Negotiated Contract). Physicians and Physician Groups may only submit their own Billing Disputes, and Physician Groups may assert Billing Disputes on behalf of their member Physicians. Complaints for systemic violations of Sections 7.19 and 7.20 shall also qualify as Compliance Disputes under Section 12. Company shall post a description of its provider internal appeals process on the Provider Website.

(1) Notwithstanding the foregoing, a Physician or Physician Group may submit a Billing Dispute if less than $500 is at issue and if such Physician or Physician Group intends to submit additional Billing Disputes during the one (1) year period following the submission of the original Billing Dispute which involve issues that are similar to those of the original Billing Dispute, in which event the Billing Dispute External Review Board will, at the request of such Physician or Physician Group, defer consideration of such Billing Dispute while the Physician or Physician Group accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the Conclusion Date, the Physician or Physician Group has not accumulated the requisite amount of Billing Disputes and Company has chosen not to continue the Billing Dispute process following the Conclusion Date, then any rights the Physician or Physician Group had as to such Billing Disputes, including rights to arbitration, shall be tolled from the date the Billing Dispute was

submitted to the Billing Dispute External Review Board through and including the Conclusion Date.

(2) In any event, a Physician or Physician Group will have one (1) year from the date he or she submits the original Billing Dispute and notifies the Billing Dispute External Review Board that consideration of such Billing Dispute should be deferred to submit additional Billing Disputes involving issues that are similar to those of the original Billing Dispute and amounts in dispute that in aggregate exceed $500. In the event such additional Billing Disputes are not so submitted pursuant to the preceding sentence, the Billing Dispute External Review Board shall dismiss the original Billing Dispute and any such additional Billing Disputes and, in that event, the filing fee will be refunded by Company to the Physician or Physician Group.

(3) The filing fee shall be payable upon the submission of the original Billing Dispute and shall apply to all subsequent Billing Disputes submitted pursuant to the first sentence of 7.10(b)(2) until the aggregate amount at issue exceeds $1,000 at which time additional filing fees will be payable in accordance with § 7.10(e). The Physician or Physician Group may withdraw the Billing Disputes at any time before the aggregate amount in dispute reaches $1,000 and, in that event, the filing fee will be refunded by Company to the Physician or Physician Group.

(4) The Physician or Physician Group must exhaust Company's internal appeals process before submitting a Billing Dispute to the Billing Dispute External Review Board; provided that a Physician or Physician Group shall be deemed to have satisfied this requirement if Company does not communicate notice of a decision resulting from such internal appeals process within 45 days of receipt of all documentation reasonably needed to decide the internal appeal. In the event Company and a Physician or Physician Group disagree as to whether the requirements of the preceding sentence have been satisfied, such disagreement shall be resolved by the Billing Dispute External Review Board. Except as otherwise provided in § 7.10(a), all Billing Disputes must be submitted to the Billing Dispute External Review Board no more than 90 days after a Physician or Physician Group exhausts Company's internal appeals process and the Billing Dispute External Review Board shall not hear or decide any Billing Dispute submitted more than 90 days after Company's internal appeals process has been exhausted. Company shall supply appropriate documentation to the Billing Dispute External Review Board not later than 30 days after request by the Billing Dispute External Review Board, which request shall not be made, if Billing Disputes are submitted pursuant to § 7.10(b)(2), until Billing Disputes have been submitted involving amounts in dispute that in aggregate exceed $500.

(5) Except to the extent otherwise specified in this § 7.10(b), procedures for review by the Billing Dispute External Review Board, including without limitation the documentation to be supplied to the reviewers or review organizations and a prohibition on *ex parte* communications between any

party and the Billing Dispute External Review Board, shall be set by agreement between the Company and Class Counsel, or their designee, with input from the Billing Dispute External Review Board. Such procedures shall provide that (x) a Physician 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 (y) 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 Physician or Physician 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 Provider or Member contract.

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

(d) Company and Class Counsel, or their designee, shall select the organization(s) that shall constitute the Billing Dispute External Review Board or Boards. If Company and Class Counsel, or their designee, cannot agree on members of the Billing Dispute External Review Board or Boards within 30 days of the Preliminary Approval Date, the matter shall be deemed a Compliance Dispute and referred to the Compliance Dispute Review Officer. Billing Disputes shall be stayed and any time limitations shall be tolled pending resolution of such Compliance Dispute. With respect to Billing Disputes brought by Participating Physicians, the members of the Billing Dispute External Review Board or Boards shall be bound by the terms of the applicable agreement between the Participating Physician and Company and the provisions of this Agreement. If the dispute cannot be resolved by reference to the foregoing documents, then the Billing Dispute External Review Board shall resolve Billing Disputes based on generally accepted medical billing and coding standards.

(e) For any Billing Dispute that a Physician submits to the Billing Dispute External Review Board, the Physician submitting such Billing Dispute shall pay to Company a filing fee calculated as follows: (i) if the amount in dispute is $1,000 or less, the filing fee shall be $25 or (ii) if the amount in dispute exceeds $1,000, the filing fee shall be equal to $25, *plus* 5% of the amount by which the amount in dispute exceeds $1,000, but in no event shall the fee be greater than 50% of the cost of the review. If the Physician prevails on the Billing Dispute, the Billing Dispute External Review Board shall award the filing fees to the Physician as part of its decision.

(f) Company's contract(s) with the Billing Dispute External Review Board or with members of the Billing Dispute External Review Board shall require decisions to be rendered not later than 30 days after receipt of the documents necessary for the review and to provide notice of such decision to the parties promptly thereafter.

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

(h) Company agrees to record in writing a summary of the results of the review proceedings conducted by the Billing Dispute External Review Board(s), including without limitation the issues presented. Company agrees to include a summary of the dispositions of such proceedings in the Certification to be filed annually and at the end of the Effective Period. If the same issue is the subject of not fewer than twenty (20) Billing Dispute External Review Board proceedings during the Effective Period, and Company's position is overturned in at least fifty percent (50%) of such matters, the Physician Advisory Committee shall discuss such payment issue at the next scheduled meeting, and at that time shall consider recommending an appropriate policy or practice change.

(i) Except for Retained Claims, the Billing Dispute External Review Board process shall be available at the option of the Physician. If such Physician elects to utilize this process, then any decision by the Billing Dispute External Review Board shall be binding on Company and the Physician. For Retained Claims, all Billing Disputes shall be directed not to the Court nor to any other state court, federal court, arbitration panel (except as hereinafter provided) or any other binding or non-binding dispute resolution mechanism but instead shall be submitted to final and binding resolution before the Billing Dispute External Review Board so long as such Billing Dispute arises after the establishment of the Billing Dispute External Review Board pursuant to § 7.10(a).

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

Company shall maintain the following appeal process with respect to determinations that a health care service or supply is not Medically Necessary or is of an experimental or investigational nature.

(a) Initial Determinations

A Physician designated by Company shall be responsible for making the initial determination for Company whether proposed health care services or supplies are Medically Necessary or experimental or investigational (hereinafter in this Section 7.11 only, Medically Necessary and experimental or investigational shall collectively be referred to as Medically Necessary except where otherwise noted). A nurse or other health care professional, acting for a medical director, may approve any health care service or supply as being Medically Necessary, but only a Physician designated by Company may deny any such service or supply as being not Medically Necessary.

(b) Two Level Internal Appeals of Medical Necessity Denials

(1) Level One.

With respect to an appeal of a determination that a health care service or supply is not Medically Necessary, Company shall adopt a two step internal appeal process which allows Plan Members, or a Class Member when authorized in writing by a Plan Member, or without written authorization if the service has already been provided, to pursue appeals of Medical Necessity denials, including appeal by External Review. That process shall insure that only a Physician may deny the appeal of any Plan Member or Class Member. A nurse or other health care professional employed by Company shall review the internal appeal and may grant but not deny the appeal. If the nurse or other health care professional does not grant the appeal, then a Physician designated by Company, other than the one that made the initial determination of Medical Necessity, shall review and decide the Level One internal appeal in accordance with applicable Company clinical guidelines, which shall be consistent with Section 7.16.b.

(2) Level Two.

If the Physician conducting the Level One review determines that the requested health care service or supply is not Medically Necessary, and if that Physician is not a specialist in the same specialty as the appealing Physician (but not necessarily the same sub-specialty), a second Physician employed or contracted by Company who is a specialist in the same specialty (but not necessarily the same sub-specialty) as the appealing Plan Member's Physician or the Class Member shall review the appeal and shall decide the appeal in accordance with applicable Company clinical guidelines, which shall be consistent with Section 7.16.b. If the Plan Member does not pursue an appeal and the Physician employed or contracted to perform the Level One review is of the same specialty as the appealing Class Member, such that no Level Two review is required, then the appealing Class Member shall be notified that the appealing Class Member may proceed to external review. As a substitute for Level Two appeals, the Company may offer upon completion of Level One external review as set forth below in section 7.11(c).

(3) Time Limits for Completing Internal Appeals.

All internal appeals shall be completed within the time limits required by regulations issued by the Department of Labor, even those internal appeals for which ERISA is not applicable.

(c) Establishment of External Review Program and Scope

Following exhaustion of its internal appeal process, Company shall make available to Plan Members or to Class Members when authorized in writing by the Plan Member the option 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 "Medical Necessity External 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 appeal (the "Medical Necessity External Review Process") will be borne by Company and the decision of the Medical Necessity External Review Organization shall be binding upon Company and the Class Member. Election to pursue review under this Section 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 Medical Necessity External Review Organization issue its decision within thirty (30) days of the request for External Review. The external reviewer designated by the Medical Necessity External Review Organization to conduct the review shall be of the same specialty (but not necessarily the same sub-specialty) as the appealing Class Member. The Medical Necessity 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 state or federally-required external review process that is different than the process herein set forth, only the state or federally-required program shall be utilized where applicable.

(1) The Medical Necessity External 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 a de novo review of the case consistent with Section 7.16(a)(1) of this Agreement, subject to coverage exclusions and limitations in the Plan Member's Plan Documents. 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 Class Member Physician, where appropriate, has exhausted the internal appeal process or after Company and the Plan Member or his or her Class Member Physician, where appropriate, agree to forego any level of internal appeal and proceed directly to external review. The Plan Member or his or her Class Member Physician, where appropriate, shall have the option to elect this review within one hundred eighty (180) days from the date of the final denial decision by Company. The Medical Necessity External Review Organization's compensation shall not be tied to the outcome of the reviews performed. Likewise, the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make decisions in a biased manner.

(2) Notwithstanding the provisions of this Section 7.11 Class Members may not seek review of any claim 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 Physician seek review before a service is rendered, the Plan Member's claim shall go forward and the Physician's claim shall be dismissed and may not be brought by or on behalf of the Physician in any forum.

(3) Notwithstanding the provisions of this Section 7.11 Class Members may not seek review of any claim for which the Plan Member (or his or her representative) has filed suit under § 502(a) of ERISA or other suit for 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 claims 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 such lawsuit belong to such Class Member and not to such Plan Member.

(4) Nothing contained in this Section 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.

(5) In the event the Medical Necessity External Review Process is initiated, the Medical Necessity External 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 Medical Necessity External Review Process, and Company shall provide such requested documentation within ten (10) Business Days. The Medical Necessity External 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 appeal of a Medical Necessity External Review for denial of services already provided, Company shall make payment to the Class Member, consistent with Section 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 Section 7.18 of this Agreement will be payable unless the Class Member introduces material new information to the Medical Necessity External Review Process that was not provided to Company during the internal appeal process. Company shall cause its contract with the Medical Necessity External Review Organization to be consistent with the terms of this Section 7.11(c).

7.12 Electronic Remittance Advice and Electronic Fund Transfers

By December 31, 2005, Company will publicize on the Provider Website the availability of its electronic remittance advice. If Company implements electronic funds transfer provisions, Company will publicize such capabilities on the Provider Website.

7.13 Participating in Company's Network

(a) Credentialing of Physicians.

Company will allow Physicians 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 Physician formally changes or commences employment or changes location, provided that the Physician must represent that he or she has new employment or intends to move to a new location. Company shall process completed applications and notify the Physician within ninety (90) days. If a Physician is already credentialed by Company but changes employment or changes location, Company will only require

the submission of such additional information, if any, as is necessary to continue the Physician's credentials based upon the changed employment or location. Company will not require that a Participating Physician be separately credentialed by Company if the Participating Physician is credentialed under NCQA standards by a contracted Physician Group or Physician Organization that is delegated to perform such credentialing.

(b) All Products Clauses.

Company agrees that it shall not require a Participating Physician to participate in all of its products, including but not limited to products that the Company offers to workers' compensation payors. A single "product" for purposes of this paragraph may include multiple plan types or lines of business so long as they are covered by the same fee schedule based on a single payment rate per CPT code (whether stated separately by code or by reference to a formula or database) and do not differ materially in the administrative requirements for Physicians except for pre-certification or referral requirements. Moreover, Company agrees that it shall not require a Participating Physician to participate in a capitated fee arrangement in order to participate in products in which such Participating Physician is compensated on a fee for service basis. In the event that a Participating Physician (or Physician Group or Physician Organization) chooses not to participate in all Company products, or terminates participation in some Company products, the fee-for-service rate schedule offered to or applied by Company to such Participating Physician (or such Physician Group or Physician Organization) shall not be lower than (i) in the case of terminating participation in some products in an existing contract, then the existing fee-for-service contract rates in the contract for the remaining contracted products, or (ii) in the case of choosing not to participate in some products in a new contract, then the Company's standard fee-for-service rate schedule for that product for the geographic market in which such Participating Physician (or such Physician Group or Physician Organization) practices.

(c) Termination Without Cause.

Company agrees to include in its standard form contracts with individual Participating Physicians and Physician Groups consisting of fewer than six Participating Physicians a provision permitting either party to terminate such contract without cause on not less than ninety (90) calendar days prior written notice, or pursuant to the provisions of § 7.6. Company shall continue to have the right to negotiate and enter into contracts with Physician Organizations and Physician Groups consisting of six or more Participating Physicians allowing termination only for cause during the contract's initial term.

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 the Participating Physician or Physician Group consisting of fewer than six Participating Physicians who are Plan Members who suffer from a chronic condition requiring continuity of care and who are unable, prior to the date of termination, to arrange for an alternative means of receiving the necessary care. In the case of a continuity of care situation as defined in the preceding sentence, the Participating Physician or Physician Group consisting of fewer than six

Participating Physicians shall continue to render necessary care to the Plan Member until Company, in conjunction with the Plan Member, has arranged an alternative means for the provision of such care, provided that, if after the date of termination the Class Member determines that Company has not used due diligence to arrange alternative care the Class Member may take such action as is necessary to terminate the Physician relationship. Company shall pay claims by such terminating Participating Physician or Physician Group consisting of fewer than six Participating Physicians for such services or supplies at rates provided by the contract to be terminated through the date of termination and thereafter, until such time as an alternative means for the provision of such care is arranged, at the lower of the reasonable and customary rates then prevailing for that geographical area or the rates prescribed by applicable state or federal law.

(d) Rights of Class Members to Refuse to Accept New Patients.

Company will not prohibit Participating Physicians from declining to accept Plan Members as new patients while remaining open to members of plans insured or administered by other managed care companies once the number of Plan Members who are patients of the Participating Physician reaches a certain numerical or percentage threshold established by the Participating Physician provided that (a) the number of Plan Members who are patients of the Participating Physician exceeds the number of patients who are members of plans insured or administered by any other single managed care organization at the time the Participating Physician closes his practice to Plan Members; (b) if the acceptance of new patients causes the number of patients who are members of plans insured or administered by any other managed care organization to exceed the number of Plan Members, the Participating Physician must begin accepting new patients who are Plan Members; and (c) if a patient of the Participating Physician becomes a Plan Member by switching from a plan insured or administered by another managed care organization to one insured or administered by Company, the Participating Physician must continue as the patient's Physician. Furthermore, Company will not prevent Participating Physicians from closing their practices to all new patients. Participating Physicians will cooperate and provide all documents and information reasonably requested to demonstrate to Company that the foregoing conditions are met before closing the practice.

7.14 Fee Schedule Changes

(a) Notices Regarding Fee Schedules

Company agrees not to reduce its contracted fee schedule for a Participating Physician under a direct contract with Company more than once a calendar year (except as provided below in this Section 7.14(a)) and shall give notice of any such change as a material adverse change subject to the provisions of § 7.6 hereof. Notwithstanding the foregoing, in the first year of a Physician's contract, a change in fee schedule may be made before December 31st of the year in which the contract became effective. In between such annual updates Company may increase or decrease the fee schedule payment rates for vaccines, pharmaceuticals, durable medical supplies or other goods or non-Physician Services to reflect changes in market prices, and Company may update fee schedules for Physician Services to

add payment rates for newly-adopted CPT® codes and for new technologies, and new uses of established technologies that Company concludes are eligible for payment, and to update such fee schedules to reflect any applicable interim revisions made by CMS or other reference source where the fee schedule is stated as a formula based on a reference source agreed to by the Physician. Company may also update its fee schedules for the cost of vaccines and injectibles under § 7.14(b) on a quarterly basis. Nothing contained herein shall prevent Company from maintaining, altering or expanding the use of capitation or other compensation methodologies.

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

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

(c) Appeals of Reasonable and Customary Determinations.

At least until the Termination Date, if a Class Member initiates a dispute using Company's internal dispute resolution procedures over how Company has determined the "reasonable and customary" charge for a given health care service or supply and, consequently, over how Company has computed the benefits payable for that health care service or supply, Company shall disclose to the Class Member initiating the dispute the data used by Company to determine the "reasonable and customary" charge for that given health care service or supply.

7.15 Recognition of Assignments of Benefits by Plan Members

When billed by a Non-Participating Physician Class Member for health care services or supplies provided to a Plan Member, Company will require that the Non-Participating Physician Class Member shall have received a valid Assignment of Benefits from the Plan Member and shall have so evidenced the Assignment to Company. Company shall recognize all valid assignments by Plan Members of Plan benefits to Physicians.

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

(a) Patient-specific Issues Involving Clinical Judgment.

(1) Medical Necessity Definition

Except where state or federal law or regulation requires a different definition Company shall apply the following definition of "Medically Necessary" or comparable term in each agreement with Physicians, Physician Groups, and Physician Organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition:

"**Medically Necessary**" or "**Medical Necessity**" shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

(A) in accordance with generally accepted standards of medical practice;

(B) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

(C) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Preventive care may be Medically Necessary, but coverage for Medically Necessary preventive care is governed by the terms of the applicable Plan Documents.

When considering whether a service or treatment is "experimental or investigational" if such service or treatment is Medically Necessary as defined above said service or treatment will be paid for unless specifically excluded from coverage in the Plan.

(2) External Review Statistics

Within not more than ninety (90) days after the end of each calendar year, Company shall post on its Website, for each geographic area or licensed plan, the number of Medical Necessity appeals sent to an External Review

Organization for final determination for the preceding calendar year and the percentage of such appeals that are upheld or reversed.

(b) Policy Issues Involving Clinical Judgment.

In adopting clinical policies with respect to Covered Services, Company shall rely on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, and shall take into account national Physician Specialty Society recommendations and the views of prudent Physicians practicing in relevant clinical areas and any other clinically relevant factors. Company shall continue to make such policies readily available to Members and Participating Physicians via the Website or by other electronic means. Promptly after adoption, Company shall file a copy of each new policy or guideline with the Physicians' Advisory Committee.

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

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

7.17 Billing and Payment

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

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

(b) Claims Submission.

Company agrees to accept both properly completed paper claims submitted on Form CMS-1500, UB 92 or the equivalent, and also electronic claims populated with similar information in HIPAA-compliant format or fields. Company shall not require Non-Participating Physicians to utilize electronic transactions. Company may continue to require submission of additional information in connection with

review of specific claims and as contemplated elsewhere in this Agreement, including without limitation §§ 7.8, 7.19 and 7.20; provided that nothing in this sentence is intended or shall be construed to alter or limit any restrictions set forth elsewhere in this Agreement concerning Company's ability to make requests for Clinical Information in connection with adjudication of claims. Company shall disclose on its Website its policies and procedures regarding the appropriate format for claims submissions and requests for additional information.

7.18 Timelines for Processing and Payment of Complete Claims

Company shall pay interest as set forth below on all Complete Claims for Covered Services that are paid (meaning the check is mailed or electronic funds transferred) beyond the following time periods, in each case measured from the later of Company's receipt of such claim or the date on which Company is in receipt of all information needed and in a format required for such claim to constitute a Complete Claim, including without limitation all documentation reasonably needed by Company to determine that such claim does not contain any material defect or error and Company has received such other information as may be reasonably necessary for the adjudication of the claim; provided that nothing contained herein is intended or shall be construed to alter Company's ability to request documentation consistent with the provisions of § 7.8(c): 30 days for all claims, and by December 31, 2005, 15 business days for claims that Physicians submit electronically. For claims submitted on paper, Company shall date stamp paper claims for Covered Services upon receipt in the mail facility. For claims submitted electronically, Company will generate an electronic acknowledgment of receipt of electronic claims for Covered Services when received by applicable Company computer system. Commencing one year after the Implementation Date, for each Complete Claim with respect to which Company has directed the issuance of a check or electronic funds transfer later than the applicable period specified in the preceding sentence Company shall pay interest at six percent (6 %) per annum on the balance due on each such claim from the end of the applicable specified period up to but excluding the date on which Company directs the issuance of the check (or electronic funds transfer) for payment of such Complete Claim; provided that to the extent that payment is made later than the period specified by applicable law, Company shall pay interest at any rate specified by such law or regulation in lieu of the interest payment otherwise contemplated by this sentence. Notwithstanding the foregoing, Company shall have no obligation to make any interest payment (i) with respect to any Complete Claim if, within 30 days of the submission of an original claim, a duplicate claim is submitted while adjudication of the original claim is still in process; (ii) to any Physician who balance bills a Plan Member in violation of such Physician's agreement(s) with Company or applicable law or regulation; or (iii) with respect to any time period during which a Force Majeure, as defined in § 7.32 of this Agreement, prevents adjudication of claims. Company shall attempt to include in its contracts with each clearinghouse a requirement that each such clearinghouse transmit claims to Company within twenty four (24) hours after such clearinghouse's receipt thereof.

The date of "receipt" means the business day on which the Complete Claim is received or the next business day if the claim is received on a weekend or holiday when claims are not being routinely loaded on the MACESS or equivalent system or after business hours.

Interest computed under this section shall, at Company's election, either be included in the claim payment check or electronic funds transfer or be remitted in a separate check or electronic transfer.

7.19 No Automatic Downcoding of Evaluation and Management Claims

As of the Implementation Date, Company shall not automatically reduce the code level or reassign the category (e.g., a change of consult to office visit) of evaluation and management codes billed for Covered Services (**"Downcoding"**). Notwithstanding the foregoing sentence, Company shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level or reassign the category for selected claims for Covered Services (or claims for Covered Services submitted by selected Physicians or Physician Groups or Physician Organizations) based on a review of Clinical Information, a review of information derived from Company's fraud and abuse detection programs or other programs that create reasonable cause to believe there may be fraudulent, abusive or other billing practices which would be inappropriate according to CPT codes, guidelines and conventions; provided that the decision to reduce is based on a review of the Clinical Information for that patient encounter. Company may also reassign a CPT code to correct coding errors based on objective non-diagnostic patient information on the face of the claim (such as new to established ~~patient,~~ correcting age inconsistencies, or similar objective changes).

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 such software to any extent necessary to conform to such standards; provided that nothing in this paragraph is intended or shall be construed to require Company to pay for anything other than Covered Services for Plan Members, to make payment at any particular rates, to limit Company's right to deny or adjust claims based on a reasonable cause to believe there may be fraudulent, abusive or other billing practices which would be inappropriate according to CPT® codes, guidelines and conventions or inconsistent with other coding and reimbursement policies required or permitted by this Agreement (so long as the Physician has been given the opportunity to provide clinical records and Company has reviewed any Clinical Information so provided), or to supersede Individually Negotiated Contracts that specifically provide for alternative payment logic. Such provisions may only be included when the Physician or Physician Group has agreed in writing that alternative payment logic be used in Individually Negotiated Contracts. 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 payments to Physicians to be consistent with the commitments set forth in this § 7.20. Except as set forth below, the obligations set forth below in this § 7.20 shall take effect as of the Implementation Date.

(a) Company will process and separately reimburse modifier 51 exempt codes without reducing payment under Company's Multiple Procedure Logic, except that Company may apply specific reimbursement policies for CPT modifier 51 exempt codes that are consistent with CPT codes, guidelines and conventions.

"Add-on" codes, as designated by CPT®, shall be recognized and eligible for payment as separate codes and shall not be subject to Multiple Procedure Logic; provided that the add-on codes are billed with a proper primary procedure code according to CPT® codes, guidelines and conventions.

(1) Company shall not require a Physician to submit Clinical Information of their patient encounters solely because the Physician 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.

(2) If a bill contains a CPT® code for an Evaluation and Management service appended with a 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 the CPT® modifier 25 was inappropriate or Company has disclosed pursuant to § 7.8(c)(iii) the limited and reasonable number of finite code combinations that are not appropriately reported together. Payment shall only be made for one Evaluation and Management service for any single day unless payment for more than one is appropriate pursuant to CPT codes, guidelines and conventions.

(3) Company will remove from its claim review and payment systems those Claim Coding and Bundling Edits that result in denial of payment for CPT® Evaluation and Management Codes with a 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 Website.

(4) Nothing in this Agreement shall (i) prohibit Company from requiring 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 (ii) preclude Company from requiring Participating Physicians and Non-Participating Physicians (to the extent the Non-Participating Physician has elected to continue to assert a claim for payment pursuant to an assignment of benefits after a request for Clinical Information, and 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), and to allow access to their Clinical Information in connection with such an audit.

(b) A five-digit CPT® code for supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that (i) the supervision and interpretation service is not included in another CPT code submitted therewith according to CPT codes, guidelines and conventions, and (ii) for each such

procedure (e.g., review of x-ray or biopsy analysis), Company shall not be required to pay for supervision or interpretation by more than one Physician.

(c) 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 (i.e., indented codes).

(d) A CPT® code submitted with a CPT® modifier 59 shall be recognized and separately eligible for payment to the extent it designates a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that (1) although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances and (2) it would not be more appropriate to append any other CPT® modifier to such code or codes.

(e) No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict Company from establishing a global period for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days).

(f) Company shall not automatically change a code to one reflecting a reduced intensity of the service when such 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.

(g) Commencing six (6) months after the Implementation Date, or as soon thereafter as is reasonably practicable, Company shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as to modifier 51 exempt status since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, Company shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require Company to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.

(h) 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. Company agrees to recognize and consider for reimbursement all CPT® modifiers appropriately coded pursuant to CPT®.

7.21 EOB and Remittance Advice Content

Company has already and will spend resources reasonably sufficient to revise the EOB forms for its products to contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, any adjustment to the

invoice submitted and generic explanation therefor in compliance with HIPAA requirements and such EOB shall specify an address and phone number for questions regarding the claim described on such EOB. Consistent with the desire that Plan Members receive accurate communications that do not disparage Non-Participating Physicians, each such EOB shall indicate the amount for which the Physician may bill the Member and state "Physician may bill you" such amount, or contain language to substantially similar effect, and shall not characterize disallowed amounts as unreasonable. The explanation of payment or similar forms that Company sends to Physicians communicating the results of claims adjudications shall contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, the procedure code(s), the amount of payment, any adjustment to the invoice submitted and generic explanation therefor in compliance with HIPAA requirements, and by December 31, 2005, any adjustments or change in any code on a line by line basis, and shall specify an address and phone number for questions by the Physician regarding the claim described on such explanation of payment or comparable form. The forgoing sentence is not intended and shall not be construed to limit Company's right to replace the communications referred to in the preceding sentence with electronic remittance advices or the equivalent, to the extent such electronic remittances or the equivalent provide similar information and are consistent with legal requirements.

This Agreement is not intended to alter or change any right of a Non-Participating Physician to balance bill or to bill the Plan Member at rates and on terms that are agreed to between the Non-Participating Physician and the Plan Member.

7.22 Overpayment Recovery Procedures

As of the Implementation Date, Company shall initiate or continue to take actions reasonably designed to reduce Overpayments. Such actions may include, without limitation, system enhancements to identify duplicate invoices prior to payment and construction and maintenance of a common Physician database for use in connection with payment of Physician invoices. Company shall publish on the Public Website and the Provider Website an address and procedures for Physicians to return Overpayments. In addition, other than for recovery of duplicate payments, Company shall provide Physicians with 30 days written notice before initiating Overpayment recovery efforts. The notice shall state the patient name, service date, payment amount, proposed adjustment, and explanation or other information (including without limitation procedure code, where appropriate) giving Physicians reasonably specific notice of the proposed adjustment. Company shall not initiate Overpayment recovery efforts more than 12 months after the original payment; provided that this time limit shall not apply to initiation of Overpayment recovery efforts based on fraud or other intentional misconduct, or initiated at the request of a Self Funded Plan, and in the event that a Physician asserts a claim of underpayment Company may defend or set off such claim based on Overpayments going back in time as far as the claimed underpayment.

When Company makes a determination to retrospectively deny or adjust a fee-for-service payment for a medical service that was previously paid, or to re-code such a service, the Physician rendering the service, and in the case of a non-participating Physician, the patient who received the service, shall receive from the Company written notification in a timely manner that includes a clear explanation of the specific reasons for the action taken and a statement describing the process for appeal.

Company shall not require Class Members to repay contested overpayments before an actual appeal is rejected or a final administrative decision or a court or arbitration order is rendered.

Company shall reimburse physicians for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. No determination of recoupment, denial or overpayment recovery shall be based on extrapolation or statistical sampling.

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

Commencing with the Implementation Date, Company shall initiate or continue to take actions reasonably designed to improve the speed, accuracy and efficiency of current information about eligibility of Plan Members. Such actions will include, without limitation, the following or comparable measures in one or more regions:

(a) Implement a system whereby Participating Providers have online access to Company's current electronic eligibility information based on eligibility information received from subscriber groups.

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

(c) Offering to work collaboratively with large third party eligibility administrators to develop systems that extract Plan Member termination information directly from a customer's payroll system to reduce the turnaround time for transmitting such information and the likelihood of errors.

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

(e) Contacting mid- and large-size plan sponsors by telephone prior to their contract renewal date to determine in as high a percentage as practicable whether the customer intends to terminate or renew coverage for its employees with Company.

7.24 Response to Physician Inquiries

Since the inception of this Litigation, Company has already made substantial expenditures to address Physician concerns and to improve the speed, accuracy and efficiency of responses to Physician inquiries. Using Company's Northeast Region by way of example, provider telephone call volume decreased by over 4.5 percent (net of membership changes) between 2003 and 2004; provider administrative grievances decreased between the first and last quarters of 2004 from an average of over 400/month to less than 100/month; and provider administrative grievance handling time decreased throughout 2004 to an average turnaround time of less than 20 days (compared to the regulatory requirement of 30 days). Company will continue to consider whether, at its option, to take additional actions reasonably designed to improve the speed, accuracy and efficiency of responding to Physician inquiries, including whether to expand the operations of its provider service units and/or to provide dedicated processor teams for selected providers.

7.25 Effect of Company Confirmation of Patient/Procedure Medical Necessity

Company agrees that if Company certifies that a proposed treatment is medically necessary for a particular Plan Member, Company shall not subsequently revoke that medical necessity determination absent fraud, information submitted that was materially erroneous or incomplete, the person was not a Plan Member or was not eligible for such service, or material change in the Plan Member's health condition between the date that the certification was provided and the date of the treatment that makes the proposed treatment no longer medically necessary for such Plan Member. In the event that Company certifies the medical necessity of a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the certified course of treatment shall be deemed to be a new request and Company's denial of such request shall not be deemed to be inconsistent with the preceding sentence. This section and section 13 do not preclude a Physician or Physician Group from claiming based on fact specific circumstances that a revocation based on member eligibility is not effective, and such claim may be asserted under section 7.10.

7.26 Electronic Connectivity

The Provider Website shall operate at times and with a degree of reliability comparable to that for Company's other websites. If for any 15-day period during the Effective Period, the Provider Website is inoperable or lacks reliability comparable to that for Company's other websites, Company shall take commercially reasonable measures to enhance the operability and reliability of the Provider Website.

7.27 Information About Physicians on the Public Website

Information currently posted on the Public Website about individual Physicians is derived from data supplied by those Physicians or by their Physician Groups or Physician Organizations or from applicable agreements between Company and that Physician. Company shall provide and post on the Provider Website an email address to which Participating Physicians may send requests to update their name, address, and telephone number or to otherwise correct information about them on the Company's website. When Company receives such a request from a Physician at the email address provided, and Company does not contest the correctness of the request, Company shall correct the website information as soon as practicable but in no event longer than twenty (20) Business Days after receipt of such request and shall make corresponding changes in systems affecting the level of payments and generation of EOBs. If Company contests the correctness of the request, it will so notify the Physician within the same time period, including the basis on which it contests the request.

7.28 Capitation and Physician Organization – Specific Issues

(a) Capitation Reporting

Company agrees to provide monthly reports to Participating Physicians, Physician Groups and Physician Organizations that receive Capitation payments directly from Company. Where Company directly capitates a Participating Physician under a commercial or Medicare plan, these monthly reports will include membership information to allow reconciliation by Participating Physicians of Capitation Payments, including without limitation, the Plan Member identification number or

the equivalent, name, age, gender, medical group/Physician Organization number where applicable, copayment, monthly capitation amount, primary care Physician where applicable, enrollment date, provider effective date, and, in the monthly report following an applicable change (e.g., selection of new PCP) a report of such change, as well as an explanation of any deductions. Company will comply with its contracts with Physician Groups and Physician Organizations regarding capitation reporting requirements.

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

For a Plan Member who is enrolled in a Plan requiring selection of a capitated primary care Participating Physician or Physician Group or Physician Organization, and the Plan Member does not choose a primary care Participating Physician or Physician Group or Physician Organization upon enrollment, or within thirty (30) calendar days after enrollment, then within forty-five (45) calendar days after enrollment, Company shall assign the Plan Member to a primary care Participating Physician or Physician Group or Physician Organization randomly related to the Plan Member's home address zip code or on the basis of any other reasonable method developed by Company. The Plan Member shall have the right thereafter to designate a primary care Participating Physician or Physician Group or Physician Organization or to select a new primary care Participating Physician or Physician Group or Physician Organization at any time in accordance with such Plan Member's Plan. Company shall pay Capitation or other contract rates, and the assigned primary care Participating Physician or Physician Group or Physician Organization shall become financially responsible for the care of the Plan Member in accordance with the applicable terms of such Participating Physician's or Physician Group's or Physician Organization's agreement with Company, from the effective date of assignment; provided that if Company sends the notice of assignment after the Plan Member's coverage becomes effective, then Company shall pay such Participating Physician, Physician Group or Physician Organization, as applicable, the applicable rate retroactive to the Plan Member's effective date, subject to any limitations in an Individually Negotiated Contract.

(c) Capitation Disclosures

Company will disclose to Class Members that contract directly with Company on a Capitation basis, at the time of contracting, the following information for each line of business under the contract for which Company makes per member per month Capitation payments:

(1) a matrix of responsibility for medical expenses that will be allocated to the provider or the Plan under the risk arrangement;

(2) a projection of utilization rates and unit costs for each applicable major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment, ambulance and other) that would support the contracted Capitation amount; and

(3) the factors used by the Company to adjust Capitation payments based on age, sex, localized geographic area, family size, experience rated, and benefit plan design.

(d) Withholds.

Company agrees that it shall not apply withholds or risk pools to Capitation arrangements except pursuant to Individually Negotiated Contracts.

7.29 Miscellaneous

(a) "Gag" Clauses.

Company does not include in its contracts with Class Members, and will not include in its contracts, any provision limiting the free, open and unrestricted exchange of information between Class Members and Plan Members regarding 1) the nature of the Plan Member's medical conditions or treatment, 2) the relative risks, benefits and costs of such treatment and provider options, 3) whether or not such treatment is covered under the Plan Member's Plan, and 4) 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 Class Members in any way for engaging in any free, open and unrestricted communication with a Plan Member on the foregoing subjects or for advocating for any service on behalf of a Plan Member.

(b) Ownership of Medical Records.

Company's standard agreements shall confirm that, as between Company and Participating Physicians, Physicians own their medical records and that Company has a right to receive or review such records only as reasonably needed in the ordinary course for customary uses; provided that nothing herein is intended or construed to convey to Physicians any property interest in Company's data or intellectual property that incorporates any medical records or related data obtained by Company from such Physician.

(c) Arbitration.

In any arbitration proceeding between Company and a Participating Physician who practices individually or in a Physician Group of less than six Physicians involving a billing dispute, the maximum administrative costs and fees of the arbitrator payable by such Participating Physician shall be the lesser of fifty percent (50%) of the total fees and costs, or $1,000. Company agrees not to include language in any agreement between Company and a Participating Physician (or Physician Group of less than six Physicians) any provision (A) requiring that an arbitration proceeding occur more than 100 miles from the principal office of the Participating Physician or Physician Group, or (B) requiring for disputes where the amount in controversy is less than $500,000, an arbitration panel having multiple members.

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

Company's standard agreements and/or ancillary documents (e.g., criteria schedule) shall incorporate or be consistent with the commitments and undertakings Company makes in this Agreement. Nothing in this Agreement is intended to limit Company's ability to enter into Individually Negotiated Contracts as a result of negotiations with a Physician, Physician Group or Physician Organization that alter or omit any of the terms of this Section 7. To the extent that Company's existing non-Individually Negotiated Contracts with Participating Physicians (or Physician Group or Physician Organization) contain provisions inconsistent with the terms hereof, Company shall administer such agreements consistent with the terms set forth in this Agreement. If Company and a Participating Physician (or Physician Group or Physician Organization that consists of 5 or less Participating Physicians) have an Individually Negotiated Contract, this Agreement shall not modify or nullify the individually negotiated terms of such Individually Negotiated Contracts unless such Participating Physician (or Physician Group or Physician Organization that consists of 5 or less Participating Physicians) notifies Company in writing, specifically setting forth the negotiated terms it seeks to have modified or nullified by this Agreement. Upon such notification, either party to the Individually Negotiated Contract may then elect to renegotiate the Individually Negotiated Contract or terminate it. Furthermore, in Individually Negotiated Contracts, Company may separately agree with individual Participating Physicians (upon request by such Participating Physician), Physician Groups or Physician Organizations on customized rates and/or payment methodologies that deviate from the terms of its standard agreements.

With respect to Individually Negotiated Contracts with Physician Groups or Physician Organizations with more than 5 Participating Physicians, such contracts are not subject to amendment or renegotiation, but upon written request from such Physician Group or Physician Organization made within sixty (60) days of Final Order and Judgment, Company will provide to the requesting Physician Group or Physician Organization the same rights as Participating Physicians have under the following sections of this Agreement: 7.10 (Billing Dispute External Review Board), 7.11(c) (external review board), 7.13(a) (credentialing), 7.28(b) & (c)(capitation), 7.29(a)("gag" clauses), 7.29(b) (ownership of medical records), 7.29(f) (privacy of records), 7.29(g) (pharmacy risk pools, provided that pharmacy risk pools in existing contracts will not be amended or terminated by this provision), and 7.29(l) (copies of contracts). Any such written request must include all of the sections listed above.

In addition to the foregoing, and pursuant to the settlement agreement reached in *Gray v. Foundation Health Systems, Inc., Superior Ct. of Ct No. X06CV990158549S*, Company will offer to the Connecticut State Medical Society IPA (CSMS-IPA) the opportunity to include in its contract with Company all or any of the terms of this Section 7 for Participating Physicians who participate through the CSMS-IPA provided that CSMS-IPA extends all the rights and benefits contained in such terms uniformly to all its Participating Physicians pursuant to the terms of their contracts and provides written notification thereof to such physicians. To the extent that such Section 7 commitment is performed by Company under the

contract between the Company and CSMS-IPA and CSMS-IPA extends all the rights and benefits contained in such terms uniformly to all its Participating Physicians pursuant to the terms of their contracts and provides written notification thereof to such physicians, such commitment will be considered to be an obligation performed directly by Company under Section 7.29(k).

(e) Impact of this Agreement on Covered Services

Notwithstanding anything to the contrary contained in this Agreement, nothing contained in this § 7 shall supercede or otherwise alter the scope of Covered Services of any Plan or require payment by Company or a Plan for services that are not Covered Services.

(f) Privacy of Records.

Company shall safeguard the confidentiality of Plan Member medical records in accordance with HIPAA, state and other federal law and any other applicable legal requirements; provided, however, that this undertaking shall not be the subject of a Compliance Dispute, and that Physicians may resort to any other remedial measures that they may have outside this Agreement to protect their interests. Company shall not require Physicians to use electronic transactions. Instead, it will maintain reasonable non-electronic systems to serve the information needs of such Physicians.

(g) Pharmacy Risk Pools.

Company shall not require the use of pharmacy risk pools. However, any Physician, Physician Group, or Physician Organization may participate in a pharmacy risk pool or otherwise assume financial risk for pharmacy after making the request in writing at the time of negotiating an initial contract or renewing a contract with Company and entering into an Individually Negotiated Contract. For purposes of this provision, a "pharmacy risk pool" is a fund or account whereby the Physician, Physician Group, or Physician Organization assumes some or all of the financial risk of pharmacy utilization by Plan Members above a target amount. This provision does not prohibit a bonus program where pharmacy usage is a factor.

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

Company shall not restrict Physicians from purchasing stop loss coverage from insurers other than Company.

(i) Pharmacy Provisions.

Company shall disclose to Company Members whether that Member's Plan uses a formulary and, if so, explain what a formulary is, how Company determines which prescription medications are included in the formulary, and how often Company reviews the formulary list; and Company shall provide Company Members with formulary lists upon request. Company shall maintain the exception process that is in place on the Execution Date (as such process may be reasonably amended by

Company) by which coverage for medications not included on the formulary may be requested. 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 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: (1) the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information; or (2) results of controlled clinical studies published in at least two peer-reviewed national professional medical journals.

(j) Restrictive Endorsements.

Where reimbursement for services is a partial payment of allowable charges, a Class Member 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.

(k) Scope of Company's Responsibilities.

The obligations undertaken by Company under § 7 of this Agreement shall be applicable only to those functions or activities performed directly by Company and its employees, or third parties (other than Delegated Entities) performing functions on Company's behalf. Upon entering a new contract or renewing an existing contract, to the extent applicable to the Delegated Entity's obligations under the contract, Company shall offer with its contracts entered into with Delegated Entities subsequent to the Implementation Date an addendum whereby the Delegated Entity obligates itself, with respect to its dealings with Physicians, to perform its contract with Company on terms that are substantially equivalent to the terms of this Agreement; provided that Company shall not be liable hereunder in the event any Delegated Entity declines all or any part of such addendum or acts in a manner inconsistent with the terms of this Agreement, and this Agreement shall not be construed to require Company to pay any additional compensation based upon the Delegated Entity's acceptance of some or all such terms. Nothing in this Agreement, shall be construed as making the Company responsible for its Delegated Entities, except as provided by state or federal law. However, Company agrees to consult periodically with Signatory Medical Societies in states where Company does business, regarding issues raised in connection with Delegated Entities including but not limited to financial insolvency.

(l) Copies of Contract.

Company will continue its practice of providing copies to Class Members of their contracts, along with all attachments, within thirty (30) days or as soon as practical, upon request of the Class Member. In addition, subject to the permission of a Participating Physician Group or Physician Organization with which Company has a contract, Company will provide a copy of that contract to a Class Member participant in such Physician Group or Physician Organization upon request of the Class Member. In its agreements with Physician Groups or Physician Organizations, Company will not require that a restriction on distribution of the

Physician Group or Physician Organization agreement to a Physician in such Group or Organization be included.

(m) State and Federal Laws and Regulations.

Nothing contained in Section 7 of this Agreement is intended to, or shall in any way waive, reduce, eliminate or supersede any Party's obligation to comply with applicable provisions of relevant state and federal law and regulations, and to the extent federal or state law or regulation imposes obligations greater than those set forth in this Agreement, Company shall comply with said law or regulation; and provided that nothing in this Section 7.29 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 (whether under a breach of contract theory or any other theory) where federal or state law does not allow a private right of action for such violation. The pursuit of a Compliance Dispute under Section 12 is not considered a private right of action for purposes of this paragraph.

(n) 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.

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

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

(p) Limitation on Rental Networks.

(1) Whenever Company pays a Non-Participating Physician a fee based on a contract that the Physician entered into with another entity (a "rental network"), Company will disclose on each EOB or remittance advice the identity of the other entity in sufficient detail for the Physician to be able to identify and contact it, and within thirty (30) days of a request by the Physician, Company will provide the Physician with a copy of the signed agreement between Physician and the other entity evidencing Company's authorization to use the fee, or else Company will not be entitled to the fee based on that contract.

(2) Company will not require Participating Physicians to participate in a product through which Company offers a provider network for use by entities other than Company, Company Affiliates or their Self-Funded Plan customers. Upon entering into new agreements with Participating Physicians, Company will offer the opportunity for Participating Physicians

to decline participation in such a product offered by Company. During the six months following Preliminary Approval, Company will post on its provider website for a period of not less than 90 days a notice that existing Participating Physicians may decline continued participation in such a product, including the applicable procedure to be used to indicate such declination.

(q) Most Favored Nations Clauses

Company will not include any "most favored nations" clauses in its contracts with Physicians.

7.30 Compliance With Applicable Law and Requirements of Government Contracts

(a) 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+Choice, Medicaid, FEHBP, Children's Health, the administration of Medicare Part A or Part B, etc.) except as set forth in this section 7.30.

(b) The Company will present the requirements of Section 7 of this Agreement to the Tricare Management Activity ("TMA") for consideration of incorporating such requirements into the Company's Tricare North Region Contract pursuant to the changes clause of such contract. Unless and until such time that the Company and TMA so amend the North Region Contract, 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. Company agrees to comply with those rules and regulations, including the mechanisms to enforce those rules and regulations.

(c) Notwithstanding any other term of this Agreement, for Plan Members covered under a Plan pursuant to a contract with a state or federal government (other than Tricare) including but not limited to Medicare, Medicaid, Healthy Families etc. (but not routine group health insurance for federal or state employees such as Cal-PERS), where the federal or state government has addressed, by way of law, regulation, contract provisions, guideline or program requirement, a subject matter that is also addressed by a term of this Agreement, Company may comply with such governmental law, regulation, contract provision, guideline or requirement instead of this Agreement. Company may also apply any billing or payment practice that is consistent with billing and payment practices used by the federal or state governmental program in the comparable non-managed care governmental program (for example, traditional Medicare or fee-for-service Medicaid).

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

of a government contract and shall continue to fulfill its other obligations under this Agreement, to the extent permitted by applicable law or by government contract. To the extent that any state or federal regulatory approval is required for any Party to implement any part of this Agreement, such Party shall make all reasonable efforts to obtain any necessary approvals of state or federal regulators as needed for the implementation of this Agreement. For any act required by this Agreement that cannot be undertaken without regulatory approval, the Implementation Date or Effective Date as to that act shall be delayed until such approval is granted. Nothing in this Agreement is intended to relieve Company from its obligation to readjudicate certain Physician claims as required by the Consent Agreement with the California Department of Managed Health Care No. 04-300 dated January 12, 2005.

7.31 Estimated Value of Section 7 Initiatives

The Parties estimate that the approximate aggregate direct and indirect cost to the Company of the initiatives and other commitments with respect to Company's business practices set forth in § 7 of this Agreement, exceeds Eighty Million Dollars ($ 80 Million).

7.32 Force Majeure

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

7.33 Managed Care Issues Relating to Mental Health and Substance Abuse

(a) The following provisions shall apply where Company is responsible for insuring or administering mental health services under a Plan.

(b) Company agrees that it will reimburse Physicians for appropriately coded Medically Necessary Covered Services for mental health care, including treatment for psychiatric illness and substance abuse, in the same manner in which it applies the definition of Medical Necessity to all clinical conditions, and in accordance with the definition of Medical Necessity set forth in Section 7.16 of this Agreement and subject to the terms of Plan Documents; provided that considering the appropriateness of any level of care, the following standards relevant to mental health care must be met:

(1) A diagnosis as defined by standard diagnostic nomenclatures (DSM-IV-TR or its equivalent in ICD-9-CM) and an individualized treatment plan appropriate for the patient's illness or condition; and

(2) A reasonable expectation that the patient's illness, condition, or level of functioning will be stabilized, improved, or maintained through ambulatory care, through treatment known to be effective for the patient's illness; and

(3) Is not primarily for the avoidance of incarceration of the patient;

(4) Is not primarily for convenience of the patient or his/her family or his/her treating Physician or other Physician.

(c) Company agrees that participating psychiatrists will be listed in Company's provider directory via a website link or otherwise. Company will allow its primary care Physicians to make direct referrals to Company's in-network psychiatrists, provided that any such referral is subject to the same precertification provisions as for other Participating Physicians.

(d) Company agrees that, where a Physician has not entered into a rate agreement with Company or with the hospital or other mental health care facility where the mental health services are rendered, Company will reimburse the psychiatrist in accordance with his or her patient's Plan terms based on the reasonable and customary value of the service, taking into account the Physician's appropriately billed charges.

(e) Company adheres to state "prudent layperson" laws which require payment of benefits for medical or psychiatric services in the event of an emergency under prudent layperson standards. An emergency department Physician can make a decision regarding admission or physical or chemical restraints, subject to any applicable pre-certification requirements under the applicable Plan. In the event of an emergency, the Physician shall be reimbursed for Medically Necessary Covered Services resulting from the admission and/or restraints, in accordance with prudent layperson standards and the definition of Medical Necessity in Section 7.16.

(f) Company will post on its website a record release form that Physicians may print or download to obtain patient consent for release of Clinical Information to Company, if needed for processing of claims for payment.

(g) Nothing in this section is intended to change the categories of services that a Participating Physician may provide pursuant his/her contract with Company.

8. Other Settlement Consideration

In addition to the initiatives and other commitments set forth in Section 7 of this Agreement, the consideration supporting this Settlement shall include the payment by Company of Forty Million Dollars ($40,000,000.00) (the **"Settlement Amount"**) to be used for distribution to Class Members and for compliance purposes as set forth in this Section 8. Company will pay, within five (5) business days after the Effective Date by wire transfer to an escrow agent acceptable to both Class Counsel and Company and held pursuant to an order of the Court, the Settlement Amount plus interest accrued on the Settlement Amount at the Interest Rate from the Preliminary Approval Date to the Effective Date.

8.1 Selection of Settlement Administrator

Within thirty days after the Preliminary Approval Date, Class Counsel and Defendants' Counsel will jointly select the **"Settlement Administrator"** to carry out the terms of the Agreement and orders of the Court. The Settlement Administrator shall have the duties and responsibilities set forth in this Agreement.

8.2 Responsibilities of Settlement Administrator

The Settlement Administrator that is selected and retained by Company, under the joint supervision of Company and Class Counsel or their designees, and subject to the supervision, direction and approval of the Court, shall be responsible for the administration of all amounts paid to and accrued in the settlement escrow account. The responsibilities of the Settlement Administrator shall expressly include without limitation: (a) creation of the Compliance Fund as described in Section 8.3; (b) the determination of the eligibility of any Class Member to receive payment from the Settlement Fund and the amount of payment to be made to each Class Member, in accordance with the provisions of § 8.4 of this Agreement; (c) the determination as to whether the election of any Class Member to transfer a settlement payment to the Foundation has been authorized by such Class Member, in accordance with the provisions of § 8.4 of this Agreement; (d) the administration of an appropriate procedure for the adjudication of disputes that may arise with respect to the eligibility of a Class Member to receive a payment from the Settlement Fund or the amount of the payment authorized to be made by the Settlement Fund to any Class Member under the provisions of this Agreement; (e) the filing of any tax returns necessary to report any income earned by the Settlement Fund and the payment from the Settlement Fund, as and when legally required, of any tax payments (including interest and penalties) due on income earned by the Settlement Fund and to request refunds, when and if appropriate, with any such tax refunds that are issued to become part of the Settlement Fund; and (f) the compliance by the Settlement Fund with any other applicable law. The fees and expenses of the Settlement Administrator shall be paid by Company; provided that neither Company nor Class Counsel shall be responsible for any other costs, expenses or liabilities of the Settlement Funds.

8.3 Settlement Compliance Fund

Within ten (10) business days after the Company's payment into the settlement escrow, the Settlement Administrator will create a fund for compliance purposes ("the Compliance Fund") by disbursing from the settlement escrow the amount of One Million Dollars ($1,000,000.00) into a separate interest bearing account with an escrow agent acceptable to both Notice Counsel and Company and held pursuant to an order of the Court. The Compliance Fund is to be used only for the purpose of monitoring or enforcing compliance with settlements entered into in the Action. Class Counsel will appoint a Committee of General Counsel and/or Executives of Signatory Medical Societies to monitor the Compliance Fund and to determine expenditures to be made from it. The Court retains jurisdiction over the Compliance Fund and any disputes arising as to expenditures from it.

8.4 Settlement Fund for Distribution to Class Members

The amount remaining in the settlement escrow after creation of the Compliance Fund, including all interest accrued in the settlement escrow, will be known as the **"Settlement Fund."**

(a) The portion of the Settlement Fund that will be available in the aggregate to satisfy claims by Retired Physicians (the **"Retired Physician Amount"**) shall be equal to the Settlement Amount multiplied by two times the quotient derived by dividing the number of Retired Physicians who file valid Proofs of Claim by the total number of Class Members. Each Retired Physician who files a valid Proof of Claim

shall be entitled to receive a payment from the Settlement Fund equal to the Retired Physician Amount divided by the total number of Retired Physician valid proofs of Claim.

(b) The amount remaining in the Settlement Fund after subtracting the Retired Physician Amount will be available in the aggregate to satisfy claims by Class Members other than Retired Physicians (the **"Active Physician Amount"**).

(c) Each Actively Practicing Physician who files a valid Proof of Claim shall be entitled to receive payment from the Settlement Fund in an amount to be determined according to whether the Actively Practicing Physician's gross receipts for providing Covered Services to Company Plan Members during the three calendar year period of 2002, 2003 and 2004 were (x) less than $5,000, (y) at least $5,000 but less than $50,000, or (z) $50,000 or greater. For purposes of this determination, amounts received include amounts paid by Company or by Delegated Entities for providing Covered Services to Company Plan Members. The Settlement Administrator shall determine the category for each Actively Practicing Physician based upon the certification in the Proof of Claim and/or such independent verification, if any, that the Settlement Administrator may undertake in its sole discretion.

(d) The Settlement Administrator shall determine the total number of Actively Practicing Physicians who fall within each of the three categories set forth in § 8.4(c) and determine the total number of distribution shares (each a **"Base Amount"**) necessary to make distributions according to the following formula: The Active Physician Amount shall be allocated among Actively Practicing Physicians who file valid Proofs of Claim such that each such Actively Practicing Physician who falls within § 8.4(c)(x) shall be entitled to receive a single Base Amount, each such Actively Practicing Physician who falls within § 8.4(c)(y) shall be entitled to receive five times the Base Amount and each such Actively Practicing Physician who falls within §8.4(c)(z) shall be entitled to receive ten times the Base Amount. A Class Member who files an otherwise valid Proof of Claim but does not certify whether they are a Retired or Actively Practicing Physician or specify a category of gross receipts for Covered Services to Company Plan Members, shall be deemed to be entitled to a single Base Amount, and the Settlement Administrator has no obligation to pursue additional information about the Class Member's status or amount of receipts.

(e) The Settlement Administrator shall establish procedures to permit an Actively Practicing Physician to establish, through the submission of billing records or similar information, that he or she should fall into a category entitled to a higher payment from the Settlement Fund based on aggregate payments received for providing Covered Services to Company Plan Members over any other consecutive three-year period from January 1, 1996 through December 31, 2004.

(f) The Settlement Administrator shall determine the total number of Retired Physicians filing valid Proofs of Claim and divide that number into the Retired Physician Amount to determine the amount to distribute to each Retired Physician. The Settlement Administrator shall determine the total number of Actively Practicing Physicians filing valid Proofs of Claim, calculate the total number of

Base Amounts to be distributed for Actively Practicing Physicians as set forth in § 8.4(d) above, and divide that number into the Active Physician Amount to determine the dollar value of each Base Amount to be distributed to each Actively Practicing Physician according to the number of Base Amounts to which they are entitled under § 8.4(d). The result for each category shall determine the amount to be distributed to eligible Class Members submitting a valid Proof of Claim for each category.

(g) Each Class Member who files a valid Proof of Claim may elect either to receive the payment from the Settlement Fund or to direct that such amount be contributed on his, her or its behalf to the **Physicians' Foundation for Health Systems Innovations ("Foundation")** or to another foundation established by a Signatory Medical Society which is approved by Class Counsel and Company and set forth on the list of available foundations attached to the Proof of Claim Form.

8.5 Submission of Settlement Fund Claim Forms and Payment.

An eligible Class Member must submit a timely claim form (the "Proof of Claim Form") to the Settlement Administrator using the Proof of Claim Form attached as Exhibit A hereto and in accordance with the instructions included in the Mailed Notice and in the claim forms in order for such Class Member to have a valid right to receive payment from the Settlement Fund. Promptly after receipt of all timely Proofs of Claims, the Settlement Administrator shall calculate the amount that is payable to, or on behalf of, each Class Member (or to the Foundation) pursuant to the provisions of Section 8.4. Reasonably promptly upon completion by the Settlement Administrator of the calculations of the amounts that are payable, the Settlement Administrator shall cause the Settlement Fund to issue payment to Class Members in each Category who or which submitted valid Proofs of Claim in accordance with Section 8.4 or to the Foundation as directed by such Class Members. Any Class Member submitting a Proof of Claim shall, through the act of submitting that Proof of Claim, be subject to the jurisdiction of the Court for any related proceedings. Physician Groups and Physician Organizations shall be allowed to file Proofs of Claims on behalf of Physicians employed by or otherwise working with them at the time that the claims are made, without the necessity of individual signatures from the individual Physicians, but only if the Physician does not submit an individual claim on his/her own behalf.

8.6 Payment to Foundation of Unclaimed Amounts

At a reasonable time determined by the Settlement Administrator not less than 120 days after all amounts have been paid to Class Members or to the Foundation at the direction of Class Members, in each case pursuant to Section 8.4 of this Agreement, the Settlement Administrator shall determine the amount of unclaimed funds remaining in the Settlement Fund (e.g., uncashed checks), including interest earned on such funds after the date of distribution but excluding taxes owed. The Settlement Administrator shall provide written notice of this amount to Company and Class Counsel and, no later than twenty (20) Business Days after providing such written notice, the Settlement Administrator shall cause the Settlement Fund to remit the amount to the Foundation by wire transfer. Following the Settlement Administrator's determination of unclaimed amounts, stop payment orders may be placed on all unclaimed funds, and no Class Member shall have

any claim on the Settlement Fund or the Parties or their Counsel or the Settlement Administrator thereafter.

8.7 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 I.R.C. § 468B and the regulations or proposed regulations promulgated thereunder (including without limitation Treasury Reg. § 1.468B-1-5 or any successor regulation).

(b) The Settling Parties, Class Counsel and Defendants' Counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to the investment of or distribution of the Settlement Fund. Settling Parties, Class Counsel and Defendants' 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 escrow agent(s) with whom the Settlement Fund is deposited shall invest the monies in those funds solely in interest bearing investments which the escrow agent(s) consider(s) to involve no substantial risk to payment of principal at maturity.

(d) No Person shall have any cause of action against the Plaintiffs, Class Counsel, the Settlement Administrator, Company, the Released Persons, or Defendants' Counsel, including any counsel representing Company in connection with this Litigation, 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 Section 12.

(e) The Settlement Administrator shall make appropriate reports under Internal Revenue Code § 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 (or, if refunds are received after distribution, to the Foundation).

(f) If a Class Member submits a Proof of Claim requesting compensation under the wrong compensation category (e.g., a request under the retired Physician Amount which should have been submitted as a request under the Active Physician Amount), the Settlement Administrator may at its sole discretion review the Proof of Claim under the provisions set forth herein for the correct settlement category unless the documentation submitted with said Proof of Claim is insufficient under those provisions.

(g) 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 Section 13.6(c)), then at such time as the time for any appeal from the final order of set aside or reversal 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 Representative Plaintiffs' Fees

9.1 Company Shall Pay Attorneys' Fees

Class Counsel intend to apply to the Court for an award of Attorneys' Fees in an amount not to exceed Twenty Million Dollars ($20,000,000.00), which application Company agrees not to oppose. Company shall pay such Attorneys' Fees in the amount awarded by the Court up to but not exceeding such unopposed amount in accordance with § 9.3 of this Agreement. If the Court awards Attorneys' Fees in excess of $ 20,000,000.00, Class Counsel, on behalf of themselves and the Class, hereby covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The Attorneys' Fees agreed to be paid pursuant to this provision are in addition to and separate from all other consideration and remedies paid to and available to the Class Members who have not validly and timely requested to Opt-Out of this Agreement. Company shall not be obligated to pay any attorneys' fees or expenses incurred by or on behalf of any Releasing Party in connection with the Action, other than the payment of Attorneys' Fees in accordance with this § 9.1.

9.2 Company Shall Pay Representative Plaintiffs' Fees

In addition to Attorney's Fees, Class Counsel intends to apply to the Court for an award of fees for each Representative Plaintiff in the amount of $ 7,500, which application Company agrees not to oppose. Company shall pay such fees to Representative Plaintiffs in the amount awarded by the Court up to but not exceeding such unopposed amount in accordance with § 9.3. If the Court awards fees to Representative Plaintiffs in excess of $ 7,500 each, Representative Plaintiffs hereby covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The fees to Representative Plaintiffs agreed to be paid pursuant to this § 9.2 are in addition to the other consideration afforded the Class Members who have not validly and timely requested to Opt-Out of this Agreement. Company shall support the award of fees to Representative Plaintiffs up to $ 7,500 as reasonable and appropriate and shall not to object to such request nor appeal an award up to the amounts specified above. Such amounts are the only consideration and fees that Released Persons shall be obligated to give Class Counsel or Representative Plaintiffs as a result of prosecuting and settling this Action, other than the additional express agreements made herein.

9.3 Timing of Fee Payments

Within five (5) Business Days after the Effective Date, Company shall pay the Attorneys' Fees and Representative Plaintiffs' fees as determined in Sections 9.1 and 9.2 above, plus interest accrued at the Interest Rate on such amounts from the Preliminary Approval Date to the Effective Date. Payment shall be made by wire transfer to the Trust Account of the

Law Office of Archie C. Lamb, L.L.C., for the benefit of Class Counsel and for the distribution by Class Counsel of the Representative Plaintiffs' fees.

10. Application to Fully Funded and Self Funded Plans

This Agreement applies to Company's conduct with respect to both Fully-Insured Plans and Self-Funded Plans, except where otherwise specified.

11. Limited Liability

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

12. Compliance Disputes Arising Under This Agreement

12.1 Jurisdiction

(a) Compliance Dispute Facilitator.

All Compliance Disputes shall be directed not to the Court nor to any other state court, federal court, arbitration panel or any other binding or non-binding dispute resolution mechanism but to the Compliance Dispute Facilitator to be designated by Class Counsel. Company shall publish on the Public Website the name and address of the Compliance Dispute Facilitator. The proposed 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.

(b) Compliance Dispute Review Officer.

Pursuant to §§ 12.3 – 12.6, and subject to § 12.5, the Compliance Dispute Facilitator shall refer Compliance Disputes that satisfy the requirements of § 12.3(b) to the Compliance Dispute Review Officer for resolution. The Compliance Dispute Review Officer shall be appointed by mutual agreement of Company and Class Counsel within 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.

(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. Who May Petition the Compliance Dispute Facilitator

12.2 The following may petition the Compliance Dispute Facilitator (each a "Petitioner"):

(a) any Signatory Medical Society or Class Member who has not validly and timely requested to Opt-Out of this Agreement and who or which alleges, with sufficient factual information to understand the nature of the complaint, that Company has materially failed to perform specific obligations under § 7 of this Agreement, and that such Class Member is, or the Class Members who belong to the Signatory Medical Society are, adversely affected by Company's failure to comply with such specific obligations under § 7 ; and

(b) Nothing in subsection (a) of this § 12.2 is intended or shall be construed to limit the remedies that the Compliance Dispute Review Officer may order pursuant to § 12.6(f) herein.

12.3 Procedure for Submission, and Requirements, of Compliance Disputes

(a) Compliance Dispute Claim Form

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

(b) Qualifying Submissions

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

(1) the Petitioner has satisfied the requirements of § 12.2;

(2) the Petitioner has submitted a properly completed Submission not later than 90 days after such Compliance Dispute arose or when the petitioner reasonably became aware of the Dispute, whichever is later; and

(3) 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 – 12.5 that the Compliance Dispute Review Officer should resolve a particular Compliance Dispute, the Compliance Dispute Facilitator shall notify the Compliance Dispute Review Officer, Petitioner and Company of such determination and the basis therefor. Unless the Petitioner specifies otherwise, the Compliance Dispute Facilitator shall serve as the Petitioner's representative in the Compliance Dispute process thereafter with respect to such Compliance Dispute. 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 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 Negotiation and Mediation, the Compliance Dispute Review Officer shall request written memoranda from the Petitioner and Company as to the merits of the Compliance Dispute and appropriate remedies for such Compliance Dispute. The Petitioner shall have 15 days from the date of the Compliance Dispute Review Officer's request to submit its memorandum and appropriate supporting exhibits, and Company shall respond within 15 days after Company's receipt of Petitioner's memorandum and accompanying exhibits. Requests for extensions of time for the submission of such materials must be submitted to the Compliance Dispute Review Officer no less than five (5) days before the date the memoranda and supporting exhibits in question are due.

(c) Oral Argument Concerning Compliance Dispute.

Petitioner or Company may, at the time of submission of the memoranda described in § 12.6(b), request oral argument before the Compliance Dispute Review Officer on the subject of the Compliance Dispute and appropriate remedies, if any. If either Person so requests, the Compliance Dispute Review Officer shall hear such argument at a time and place convenient to the Compliance Dispute Review Officer, the Petitioner, and Company, but no later than thirty (30) days after the submission of the Company's submission of the Memorandum in compliance with section 12.6(b), and shall accept and consider any evidence 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 evidence that the Compliance Dispute Review Officer in his or her sole discretion deems necessary, whether Company has failed to comply with its obligations under § 7 of this Agreement, and if so, direct what actions are to be taken by Company 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 of this Agreement for any violations of this Agreement, including without limitation any systemic violation under Section 12.6(f). Except where systemic violations are alleged, the Compliance Dispute Review Officer must base his or her decision solely on the evidence received on the issue 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), 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 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 Society, any arbitration panel or any other binding or non-binding dispute resolution mechanism. In the event that Petitioner or Company seeks review in the Court of a final decision of the Compliance Dispute Review Officer, the Court shall consider only whether the Compliance Dispute Review Officer's final decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," as defined by 5 U.S.C. § 706(2)(A), and whether the decision was contrary to or inconsistent with the second sentence of § 12.6(d) of this Agreement. If and only if the Court finds the final decision was "arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with law," or that the decision was contrary to or inconsistent with the second sentence of § 12.6(d) of this Agreement, the Court may resolve the dispute or remand the Dispute to the Compliance Dispute Review Officer for further proceedings.

(h) Enforcement by the Court.

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

12.7 Internal Compliance Officer

In addition to and separate from the Compliance Dispute Review Officer and the Compliance Dispute Facilitator, Company shall designate an Internal Compliance Officer to generally monitor and facilitate Company's compliance with the obligations set forth in this Agreement. The Internal Compliance Officer shall report to Company's president, chief executive officer or general counsel (**"Senior Management"**) and shall take whatever steps and conduct whatever compliance checks and investigations as he and Senior Management deem reasonably necessary and appropriate to monitor Company's compliance with this Agreement. Within 30 days after the end of each calendar year during the Effective Period, the Internal Compliance Officer shall file a written report with the Compliance Dispute Review Officer, the Compliance Facilitator, Signatory and, Class Counsel summarizing the Internal Compliance Officer's activities during the prior year and evaluating any noncompliance and/or problems or difficulties that Company encountered in complying with the terms of this Agreement, and shall simultaneously provide a copy of such report to the Physician Advisory Committee. Each annual report shall contain all the certifications required in the Certification to be filed at the end of the Effective Period; provided that following the initial annual report, subsequent reports may incorporate by reference any materials in prior year's reports that remain operative and have not been amended during the interim. Each Annual Report will contain a certification as to the Company's compliance with each subsection of section 7.

13. Release and Covenant Not to Sue

13.1 Discharge of All Released Claims

Upon the Effective Date, the Releasing Parties and each of them shall hereby be deemed to have, and by operation of the Final Order and Judgment shall have, fully, finally, and forever, remised, released, relinquished, compromised and discharged all Released Claims against each Released Person, whether or not any such Releasing Party submits any Proofs of Claim or otherwise seeks any payment under the terms of this Agreement. With respect to any claims released under this Agreement, Class Members also release Plan Members for any amounts due for Covered Services that Class Members claim the Company should have paid, provided that Class Members are not required to return to Plan Members any such amounts collected on or before the Preliminary Approval Date.

13.2 Covenant Not to Sue

(a) The Releasing Parties and each of them agree and covenant not to sue or prosecute, institute or cooperate in the institution, commencement, filing, or prosecution of any suit on the basis of any Released Claim against any Released Person.

(b) Upon the 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 in any way relates to, arises from, is similar to, or is based on, the causes of action and/or factual allegations in the Complaint, but only to the extent such cause of action,

judgment, lien, indebtedness, cost, damage, obligation, attorneys' fee, loss, claim, liability or demand is based on any actions or omissions by the Company that are consistent with Company's practices and procedures as of the Execution Date, as modified by the requirements and provisions of this Agreement. Provided, however, the 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 Section 7 commitment, which claim arises between the Preliminary Approval Date and the Implementation Date of that commitment.

13.3 Waiver of California Civil Code Section 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 Section 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 favor at the time of executing the release which if known by him must have materially affected his 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 Section 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 Medical Society may hereafter discover facts other than or different from those which he, she or it knows or believes to be true with respect to the claims which are the subject matter of the provisions of 13, but each such Class Member and each Signatory Medical Society hereby expressly waives and fully, finally and forever settles and releases, upon the entry of Final Order and Judgment, any known or unknown, suspected or unsuspected, contingent or non contingent claim with respect to the subject matter of the provisions of § 13, whether or not concealed or hidden, without regard to the discovery or existence of such different or additional facts,

13.4 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, (i) no claim with respect to such Covered Services has been filed with Company; provided that the applicable period for filing such claim has not elapsed; or (ii) a claim with respect to such Covered Services has been filed with Company but such claim has not been finally adjudicated by Company. For purposes of clause (ii), above, final adjudication shall mean completion of Company's internal appeals process. In the event that a claim referred to in clause (ii) is finally adjudicated less than thirty (30) days prior to the Effective Date, such claim shall constitute a Retained Claim if a Physician seeks relief under Section 7.10 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.

13.5 Covenant Not to Sue in Any Other Forum

Upon the Effective Date and through the Effective Period, 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 forum other than the United States District Court for the Southern District of Florida (i) any Retained Claim, (ii) any dispute subject to Section 7.11, or (iii) any Compliance Dispute, which respectively shall be asserted and pursued only pursuant, to the provisions of Section 7.10, Section 7.11 and Section 15.2 of this Agreement (it being understood that this Section 13.5 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 Section 12; provided that any Retained Claim, any dispute subject to Section 7.11, any Compliance Dispute, and any claims that could not reasonably be presented or resolved pursuant to the procedures set forth in Section 12, shall be prosecuted on an individual basis only and not otherwise.

13.6 Non-Released Persons and Non-Released Claims

(a) Nothing in this Agreement is intended to relieve any Person that is not a Released Person from responsibility for its own conduct or conduct of other Persons who are not Released Persons for claims that are not Released Claims, or to preclude any Representative Plaintiffs from introducing any competent and admissible evidence to the extent consistent with Sections 14 and 16.

(b) Except as provided in Sections 13.1 and 23.2(c), nothing in this Agreement prevents the Plaintiffs and the Class from pursuing claims to hold any person or party that is not a Released Person liable for damages caused by any Released Person.

(c) Section 13.6(b) of this Agreement is intended to be severable. Should it 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 the Section 13.6(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.

13.7 Limitations on Release

Notwithstanding the foregoing, Releasing Parties shall retain the rights: (i) to enforce Company's obligations under Section 7.29(m) pursuant to the dispute resolution procedures set forth in this Agreement; and (ii) to bring an action asserting claims against Company by or on behalf of Physicians to recover amounts alleged to be owed to such Physicians by any Physician Organization that has become insolvent, provided that no such action may be commenced or maintained against Company unless substantially all health

plans or insurers who contracted with such Physician Organization and have not paid all amounts allegedly owed to health care providers with respect to such insolvent Physician Organization are named as defendants in addition to Company and further provided that in any such action Company may assert all available legal claims and defenses, including without limitation defenses based on the fraudulent conduct of such Physician Organization.

13.8 Irreparable Harm

The Settling Parties agree that Company shall suffer irreparable harm if a Releasing Party takes action inconsistent with either Section 13.1, Section 13.2, or Section 13.5, and that in that event Company may seek an injunction from the Court as to such action without further showing of irreparable harm.

13.9 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 permitted under this Agreement.

14. Stay of Proceedings, Termination, and Effective Date of Agreement

14.1 Stay of Proceedings

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

(b) Upon entry of the Preliminary Approval Order, all proceedings against or concerning Health Net in the Action, 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 Ordershall 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 this Action 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 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 A, D, E and F, each of Class Counsel and Company shall have the right, in the sole and absolute discretion of such Party, to terminate this Agreement by delivering a notice of termination to the other, it being understood that, notwithstanding the foregoing, if the Court does not grant the stay of discovery as to Company and the interim injunction with respect to the Tag Along Actions, each in the form contained in the Preliminary Approval Order, Company may in its sole and absolute discretion terminate this Agreement by delivering a notice of termination to Class Counsel. In the event of any termination pursuant to the terms hereof, the Parties shall be restored to their original positions, except as expressly provided herein.

14.3 Notice of Termination

If the Court has not entered the Final Order and Judgment substantially in the form attached hereto as Exhibit C by the date that is 180 calendar days after the Preliminary Approval Date, each of Class Counsel and Company may, in the sole and absolute discretion of such Party, terminate this Agreement by delivering a notice of termination to the other.

14.4 Effective Date

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

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 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 Appeal

Notwithstanding § 14.4, if one or more notices of appeal are filed from the Final Order and Judgment, Company shall have the right, in its sole and absolute discretion, to provide notice of the occurrence of the Effective Date and the signatory Parties shall thereafter be bound by this Agreement and shall perform their respective obligations as if the Final Order and Judgment had been affirmed. If the Final Order and Judgment is not affirmed in their entirety on any such appeal or discretionary review (except for a matter found to be severable under Section 13.6(c)), either Class Counsel or Company may terminate this Agreement by delivering a notice of termination to the other. If both Company and Class Counsel do not elect to so terminate this Agreement, Company shall be entitled to provide notice of the occurrence of the Effective Date (if the Company has not already done so pursuant to the first sentence of this paragraph) and the Parties shall continue to be bound

by this Agreement and shall perform their respective obligations hereunder as if the Final Order and Judgment had been affirmed in its entirety on such appeal or discretionary review.

14.7 Termination Date of Agreement

This Agreement shall terminate (the **"Termination Date"**) upon the earlier to occur of (i) termination of this Agreement by any Party pursuant to the terms hereof and (ii) the four-year anniversary of the Effective Date. Effective on the Termination Date, the provisions of this Agreement shall immediately become void and of no further force and effect and there shall be no liability 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 (ii) of this § 14.7, (a) the provisions of §§ 11, 13, 15, 16, 17, 18, and 19 shall survive such termination indefinitely, (B) the provisions of § 7.10 and § 7.11 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Billing Disputes that are in the process of being resolved by the Billing Dispute External Review Board as of the date of such termination and any disputes described in § 7.11 that are being resolved pursuant to the Medical Necessity External Review Process as of the date of such termination and (b) the provisions of §§ 12.1 through 12.6 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Compliance Disputes that are in the process of being resolved by the Compliance Dispute Review Officer as of the date of such termination. On the Termination Date, all of Company's obligations under this Agreement shall be satisfied. Except as provided below in this Section 14.7, 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. If Class Counsel believe that the Company has willfully delayed implementation of any material provision of this Agreement, then they may petition the Compliance Dispute Resolution Officer for a recommendation that the term of the Agreement be extended for a period of time equal to the delay of the Company for the delayed provision. Upon a recommendation by the Compliance Dispute Resolution Officer, Class Counsel or the Company may petition the Court for an extension of the Effective Period.

15. Related Provider Track Actions

15.1 Ordered Stays and Dismissals in Tag-Along Actions

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

for orders from the Court dismissing each of the Tag-Along Actions with prejudice as to Company, to the extent that they assert Released Claims.

15.2 Certain Related State Court Actions

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

15.3 Other Related Actions

As to any action not referred to in §§ 15.1 or 15.2 that is now pending or hereafter may be filed in any court that asserts any of the Released Claims against Company on behalf of any Class Member who has not timely submitted a valid and timely Opt-Out request, Representative Plaintiffs, the Signatory Medical Societies and Class Counsel agree that they will cooperate with Company, to the extent reasonably practicable, in Company's effort to seek relief from the Court or the forum court to obtain the interim stay and dismissal with prejudice of such action as to Company to the extent necessary to effectuate the other provisions of this Agreement.

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 Action, in any other action, or in any judicial, administrative, regulatory or other proceeding, except in a proceeding to enforce this Agreement. Without limiting the foregoing, neither this Agreement nor any related negotiations, statements or proceedings shall be construed as, offered as, received as, used as or deemed to be evidence, or an admission or concession of liability or wrongdoing whatsoever or breach of any duty on the part of Company, the Defendants, the Representative Plaintiffs or the Signatory Medical Societies, or as a waiver by Company, the Defendants, the Representative Plaintiffs or the Signatory Medical Societies of any applicable defense, including without limitation any applicable statute of limitations. None of the Parties waives or intends to waive any applicable attorney-client privilege or work product protection for any negotiations, statements or proceedings relating to this Agreement. 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 Signatory Medical Societies regarding the subject matter of the Action or this Agreement. This Agreement shall not be modified in any respect except by a writing executed by Class Counsel and the Company.

17.2 Amendment Generally

This Agreement may be amended or modified only as provided in by 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 Section 17.3.

17.3 Amendment for Change in Circumstances

Beginning eighteen (18) months after Final Approval, 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 disadvantage, or would make performance or maintenance unduly burdensome, or would, on account of new technology, make continued performance or maintenance significantly inefficient or less cost-effective relative to use of the new technology. A settlement in this Action or in *Thomas v. Blue Cross Blue Shield Association et al, Master File No. 03-21296-CIV-Moreno-Klein* 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 section 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 Settlement 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 Settlement Agreement. The fact that a sale of Company or a substantial part of its assets has occurred shall not constitute a change in circumstances within the meaning of this provision, but the Company and/or Acquirer may seek modification at any time as provided in Section 23.2(b). Company shall not use this Section 17.3 to refuse to accept paper claims.

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.

19. Continuing Jurisdiction and Exclusive Venue

19.1 Continuing Jurisdiction

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

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

19.2 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 § 19 in its Final Order and Judgment approving this Agreement.

20. Cooperation

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

21. 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.

22. Additional Signatory Medical Societies

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

23. Successors and Assigns

23.1 No Assignment Without Consent

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. Under no circumstances shall this Agreement create a right of Class Members or Class Counsel to review, approve or consent to any transaction involving the merger or acquisition or other form of transaction resulting in a change of control of Company or any transaction whereby all or substantially all of Company's assets or more than 50% of Company's stock are transferred to an acquiring company.

23.2 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 transferred to an acquiring 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 this 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 this Action or in *Thomas v. Blue Cross Blue Shield Association et al, Master File No. 03-21296-CIV-Moreno-Klein*, 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 Section 17.3. A modification triggered under this Section 23.2(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 Section 7 and the compliance procedures under Section 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 Section 13.6(b) 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) The term "Acquirer" includes an entity that has entered or enters 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 publicly announced. 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. 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.

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CLASS COUNSEL:

LAW OFFICES OF ARCHIE LAMB, LLC

Name:
Title:

KOZYAK TROPIN & THROCKMORTON

Name:
Title:

DOFFERMYRE, SHIELDS, CANFIELD, KNOWLES & DEVINE

Name:
Title:

DRUBNER, HARTLEY & O'CONNOR, LLC

Name:
Title:

EYSTER, KEY, TUBB, WEAVER & ROTH, LLP

Name:
Title:

FOOTE, MEYERS, MIELKE & FLOWERS

Name:
Title:

GRAY & WEISS

Name:
Title:

LOWE, MOBLEY & LOWE

Name:
Title:

MILBERG WEISS BERSHAD HYNES & LERACH LLP

Name:
Title:

SAVERI & SAVERI, INC.

Name:
Title:

STEWART, TILGHMAN, FOX & BIANCHI

Name:
Title:

WHATLEY DRAKE, LLC

Name:
Title:

WHITE, DUNN & BOOKER

Name:
Title:

CLASS COUNSEL:

LAW OFFICES OF ARCHIE LAMB, LLC

Name:
Title:

KOZYAK TROPIN & THROCKMORTON

Name:
Title:

DOFFERMYRE, SHIELDS, CANFIELD, KNOWLES & DEVINE

Name:
Title:

DRUBNER, HARTLEY & O'CONNOR, LLC

Name:
Title:

EYSTER, KEY, TUBB, WEAVER & ROTH, LLP

Name:
Title:

FOOTE, MEYERS, MIELKE & FLOWERS

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GRAY & WEISS

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LOWE, MOBLEY & LOWE

Name:
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MILBERG WEISS BERSHAD HYNES & LERACH LLP

Name:
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Name:
Title:

STEWART, TILGHMAN, FOX & BIANCHI

Name:
Title:

WHATLEY DRAKE, LLC

Name:
Title:

WHITE, DUNN & BOOKER

Name:
Title:

CLASS COUNSEL:

LAW OFFICES OF ARCHIE LAMB, LLC

Name:
Title:

KOZYAK TROPIN & THROCKMORTON

Name: HARLEY S. TROPIN
Title: PARTNER

DOFFERMYRE, SHIELDS, CANFIELD, KNOWLES & DEVINE

Name:
Title:

DRUBNER, HARTLEY & O'CONNOR, LLC

Name:
Title:

EYSTER, KEY, TUBB, WEAVER & ROTH, LLP

Name:
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LOWE, MOBLEY & LOWE

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WHATLEY DRAKE, LLC

Name:
Title:

WHITE, DUNN & BOOKER

Name:
Title:

PODHURST ORSECK, P.A.

Name: Aaron S. Podhurst
Title: Partner

CLASS COUNSEL:

LAW OFFICES OF ARCHIE LAMB, LLC

Name:
Title:

KOZYAK TROPIN & THROCKMORTON

Name: HARLEY S. TROPIN
Title: PARTNER

DOFFERMYRE, SHIELDS, CANFIELD, KNOWLES & DEVINE

Name:
Title:

DRUBNER, HARTLEY & O'CONNOR, LLC

Name:
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EYSTER, KEY, TUBB, WEAVER & ROTH, LLP

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MILBERG WEISS BERSHAD & SCHULMAN, LLP

Edith M. Kallas

Name: Edith M. Kallas
Title: Partner

FOOTE, MEYERS, MIELKE & FLOWERS

Name:
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WIGGINS CHILDS QUINN & PANTAZIS, P.C.

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Title: PARTNER

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Title:

SIGNATORY MEDICAL SOCIETIES:

CONNECTICUT STATE MEDICAL SOCIETY

Timothy B. Norbeck

Name:
Title: Executive Director

EL PASO COUNTY MEDICAL SOCIETY

Name:
Title:

HAWAII MEDICAL ASSOCIATION

Name:
Title:

NEBRASKA MEDICAL ASSOCIATION

Name:
Title:

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Name:
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Name:
Title:

EL PASO COUNTY MEDICAL SOCIETY

Carol A. [illegible]

Name:
Title: Executive Vice Pres.

HAWAII MEDICAL ASSOCIATION

Name:
Title:

NEBRASKA MEDICAL ASSOCIATION

Name:
Title:

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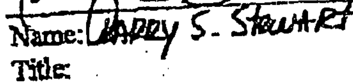

Name: Larry S. Stewart
Title:

WHATLEY DRAKE, LLC

Name:
Title:

WHITE, DUNN & BOOKER

Name:
Title:

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CALIFORNIA MEDICAL ASSOCIATION

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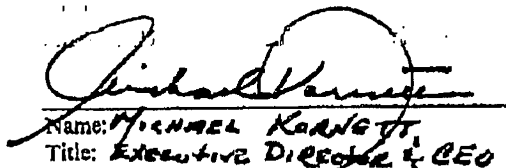

Name: MICHAEL KORNETT
Title: Executive Director & CEO

MEDICAL SOCIETY OF NEW JERSEY

NORTH CAROLINA MEDICAL SOCIETY

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Title:

SOUTH CAROLINA MEDICAL ASSOCIATION

Name:
Title:

TENNESSEE MEDICAL ASSOCIATION

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Name:
Title:

WHATLEY DRAKE, LLC

Name:
Title:

WHITE, DUNN & BOOKER

Name:
Title:

NORTHERN VIRGINIA MEDICAL SOCIETIES

Name: Russell C. Libby MD
Title: Past President

WASHINGTON STATE MEDICAL ASSOCIATION

Name:
Title:

MEDICAL ASSOCIATION OF GEORGIA

Name:
Title:

NORTHERN VIRGINIA MEDICAL SOCIETIES

____
Name:
Title:

WASHINGTON STATE MEDICAL ASSOCIATION

Thomas J. Curry
____
Name: Thomas J. Curry
Title: Executive Director/CEO

MEDICAL ASSOCIATION OF GEORGIA

____
Name:
Title:

WASHINGTON STATE MEDICAL ASSOCIATION

Name:
Title:

CALIFORNIA MEDICAL ASSOCIATION

NAME:
Title:

MEDICAL ASSOCIATION OF GEORGIA

Deborah Winegard

Name: Deborah I. Winegard
Title: General Counsel

FLORIDA MEDICAL ASSOCIATION

Name:
Title:

LOUISIANA STATE MEDICAL SOCIETY

Name:
Title: